DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

Ms. Allison Spruill
Attorney
Best & Spruill, P.C.
6805 N Cap of Texas Hwy
Suite 330
Austin, TX 78731-1791

Mr. Michael Redmond, Manager
JH & JL Provider Audit & Reimbursement
GuideWell Source/
Novitas Solutions, Inc. (J-H)
2020 Technology Parkway
Suite 100
Mechanicsburg, PA 17050

RE: The Plaza at Richardson (676098)
Appealed Period: FFY 2025
PRRB Case No.: 25-3974

Dear Ms. Spruill and Mr. Redmond:

The above-captioned appeal was filed with the Provider Reimbursement Review Board ("Board") via the Office of Hearings Case and Document Management System ("OH CDMS"). After review of the facts outlined below, the Board has determined that the appeal request was not filed in accordance with the Board Rules and regulations. The Board's review and determination is set forth below.

BACKGROUND:

On March 21, 2025, Best & Spruill, P.C. filed an appeal request on behalf of the above referenced Provider for Federal Fiscal Year ("FFY") 2025. The subject appeal is based on a *Notice of Quality Reporting Program Noncompliance Decision Upheld* issued by the Medicare Contractor ("MAC") on October 4, 2024. The appeal request identified a sole issue in dispute, 2% Reduction.

Upon review of the appeal request and the supporting jurisdictional documentation, it is noted that the Provider has entered the aggregate controversy amount as $2. After review, it is noted that the Provider did not file any further documentation or calculation as to how the 2% reduction would be applied to their projected revenue.

RULES/REGULATIONS:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the contractor's final determination, the ***amount in controversy is $10,000 or more*** (or $50,000 for a group), and the request for a hearing is filed within 180 of receipt of the final determination.

Board Rule 6.1.1 states,

> **Request and Supporting Documentation** To file an individual appeal, the case representative must log onto OH CDMS and follow the prompts. Reference Rules 7 and 9 as well as Model Form A – Individual Appeal Request (Appendix A) for guidance on all required OH CDMS data fields and supporting documentation. ***The Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b) or (d), as relevant.***

BOARD DETERMINATION:

After review of the appeal request and filed jurisdictional documentation, the Board finds that the Provider failed to meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b) or (d). The Provider entered an aggregate controversy amount of $2 and did not submit any further jurisdictional documents to indicate that the appeal met the required $10,000 amount in controversy threshold at the time of filing.

As a result, the Board has determined that the required $10,000 controversy amount has not been met and hereby dismisses case number 25-3974, in its entirety, pursuant to the above cited rules and regulations.

Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 105.1877.

Board Members:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

FOR THE BOARD:

4/1/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

James Ravindran, President
Quality Reimbursement Services, Inc.
150 North Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Board Determination – Improper Representation Letters***
Banner Health FFY 2025 IPPS Understated Standardized Payment Amount CIRP Group
Case Number: 25-3353GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the "Board") has reviewed the subject common issue related party ("CIRP") group which was filed by Quality Reimbursement Services, Inc. ("QRS"). The pertinent facts, a brief discussion of the Board's Rules and Regulations and the Board' Determination are set forth below.

Pertinent Facts:

On **February 24, 2025**, the Banner Health FFY 2025 IPPS Understated Standardized Payment Amount CIRP Group was filed from the August 28, 2024 Federal Register and was formed with nineteen providers. The Appointment of Designated Representative letter ("Representative Letter") uploaded for all participants was a letter signed by the Senior Director of Reimbursement Services at Banner Health, dated October 19, 2022 which referenced fiscal years ("FYs") 2017 through 2023. The Representative Letter did not include the Federal FY 2025, which is the period under appeal in this group.

On **March 20, 2025**, the Board issued an Acknowledgement & Critical Due Dates notice ("ACDD") in which it set the due dates for the Medicare Contractor's review of the group formation and for the Group's full formation comments. The Board also notified the Representative that the Representative Letter filed with the appeal request was unacceptable and requested an updated version for all participants be filed by **March 27, 2025**.

Six days after the deadline, on **April 2, 2025**, QRS uploaded copies of the Board's March 20, 2025 ACDD notice using the group supplement button for seventeen of the nineteen participants in the group.[1] To date, QRS has not provided a corrected Representative Letter referencing the correct FFY under appeal as required.

[1] The Board notes the uploads were started at 1:37 a.m. and were completed at 2:04 a.m. Supplements were not filed for Prov. No. 53-0012 and Prov. No. 03-0147.

Discussion of Regulations, Rules and Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final contractor determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

Further 42 C.F.R. § 405.1868 states that:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. *The Board's powers include the authority to take appropriate actions in response to the* ***failure of a party*** *to a Board appeal* ***to comply with Board*** rules and ***orders*** or for inappropriate conduct during proceedings in the appeal.
>
> (b) *If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—*
>
> *(1) Dismiss the appeal with prejudice***;**
>
> *(2)* Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
>
> *(3)* Take any other remedial action it considers appropriate.[2]

Board Determination:

When a Representative files an appeal for a provider (whether it be an individual appeal or a direct addition to a group), the Representative is required to certify that it is authorized to make the filing on behalf of the provider by including a copy of the Representation Letter evidencing that authorization.[3] Requiring Representation Letters to be properly executed for the fiscal year at issue protects providers and health chains from potentially coercive or abusive representation situations, whether in the context of an individual or group appeal.

The submission of an authorization letter that was dated well over 2 years earlier and did not reference the correct period under appeal leads the Board to surmise that the Providers may

[2] Emphasis added.
[3] See Board Rules 5, 6.1.1, 6.5, 12.8, 12.10, Model Form A, Model Form E.

have been unaware of QRS' filings on their behalf. Therefore, because QRS has failed to timely file the perfected Representative Letters by the March 27, 2025 deadline (as required in the March 20, 2025 ACDD notice), the Board finds it appropriate to dismiss Case No. 25-3353GC pursuant to its authority under 42 C.F.R. § 405.1868.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

4/2/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: Kevin D. Smith -A

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Dean Wolfe, Noridian Healthcare Solutions (J-F)
Andrew Wegman, Senior Reimbursement Consultant, Banner Health

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Via Electronic Delivery

James Ravindran, President
Quality Reimbursement Services, Inc.
150 North Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Board Determination – Failure to File Proper Representation Letters & Failure to Respond***

Orlando Health FFY 2025 IPPS Understated Standardized Payment Amount CIRP Group
Case Number: 25-3363GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the "Board") has reviewed the subject common issue related party ("CIRP") group which was filed by Quality Reimbursement Services, Inc. ("QRS"). The pertinent facts and the Board' Determination are set forth below.

Pertinent Facts:

On **February 24, 2025**, QRS filed the Orlando Health FFY 2025 IPPS Understated Standardized Payment Amount CIRP Group from the August 28, 2024 Federal Register. The CIRP group was formed with five providers. The Appointment of Designated Representative letter ("Representative Letter") uploaded for all participants was a letter signed by the Senior Director of Finance/Reimbursement at Orlando Health, dated February 6, 2023 which referenced Federal fiscal years ("FFYs") 2018 through 2024. The Representative Letter did not include the FFY 2025, which is the period under appeal in this group, nor did it include a listing of participants.[1]

On **March 21, 2025**, the Board issued an Acknowledgement & Critical Due Dates notice ("ACDD") in which it set the due dates for the Medicare Contractor's review of the group formation and for the Group's full formation comments. The Board also notified the Representative that the Representative Letter filed with the appeal request was unacceptable and requested an updated version for all participants be filed by **March 28, 2025**.

To date, QRS has not provided an updated Representative Letter referencing the correct FFY under appeal as required.

[1] The subject line of the Representative Letter indicated the Provider names and numbers were on an attached list, which was not part of the upload.

Discussion of Regulations and Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final contractor determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

Further 42 C.F.R. § 405.1868 states that:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. *The Board's powers include the authority to take appropriate actions in response to the* ***failure of a party*** *to a Board appeal* ***to comply with Board*** rules and ***orders*** or for inappropriate conduct during proceedings in the appeal.
>
> (b) *If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—*
>
> *(1) Dismiss the appeal with prejudice***;**
>
> *(2)* Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
>
> *(3)* Take any other remedial action it considers appropriate.[2]

Board Determination:

When a Representative files an appeal for a provider (whether it be an individual appeal or a direct addition to a group), the Representative is required to certify that it is authorized to make the filing on behalf of the provider by including a copy of the Representation Letter evidencing that authorization.[3] Requiring Representation Letters to be properly executed for the fiscal year at issue protects providers and health chains from potentially coercive or abusive representation situations, whether in the context of an individual or group appeal.

The submission of an authorization letter that was 2 years old, did not specifically identify the providers, and did not reference the correct period under appeal leads the Board to surmise

[2] Emphasis added.
[3] See Board Rules 5, 6.1.1, 6.5, 12.8, 12.10, Model Form A, Model Form E.

that the Providers may have been unaware of QRS' filings on its behalf. Therefore, because QRS has failed to timely file the perfected Representative Letters by the March 28, 2025 deadline (as required in the March 21, 2025 ACDD notice), the Board finds it appropriate to dismiss Case No. 25-3363GC pursuant to its authority under 42 C.F.R. § 405.1868.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

4/2/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: Kevin D. Smith -A

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Dean Wolfe, Noridian Healthcare Solutions (J-F)
Timothy Powell, Financial Manager, Orlando Health

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Via Electronic Delivery

James Ravindran, President
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: **EJR Determination AHMC Healthcare 1988-2013 Medicare Fraction (SSI) – Statutory and Systemic Errors CIRP Groups**
Case Numbers: 25-1882GC *et al*. (26 Cases – See **Appendix A**)

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Requests for Expedited Judicial Review ("EJR") filed March 13, 2025, in the above-referenced appeals. The Board's decision ***denying*** EJR is set forth below.

I. Introduction:

The Board received a Request for EJR for the above-referenced appeals on March 13, 2025. The Providers in the Groups contend that their Medicare/SSI Fractions were determined incorrectly pursuant to CMS transmittals 12747 and 12785 due to the inclusion of Medicare Part C days in the denominator of the Fraction and the exclusion from the numerator of the Fraction of days associated with individuals who were entitled to Supplemental Security Income (SSI) during their hospital stay but who were not in SSI pay status during such stays, or were in SSI pay status during their hospital stay but were not assigned payment status code C01, M01 or M02.[1] Each of these group appeals contain substantively identical filings.

The Providers in these Groups have requested EJR over whether the calculation of Medicare/SSI Fractions for the fiscal years at issue were "determined correctly in CMS transmittals 12747 and 12785."[2] The Providers contend that EJR is warranted because they have met the jurisdictional requirements for a hearing before the Board pursuant to 42 U.S.C. § 1395oo(a),[3] but "the Board lacks authority to order a recalculation of Medicare [SSI] Fractions published under the Secretary's direction by CMS."[4]

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[1] *See e.g.*, Case No. 25-1882GC, Provider's Request for EJR (hereinafter, "EJR Request") at 2 (Mar. 13, 2025).
[2] *Id.*
[3] *Id.*
[4] *Id.* at 3.

II. Background:

A. Medicare DSH Payment and Realignment

Part A of the Medicare statute covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system ("PPS").[5] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[6]

The PPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[7] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[8]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[9] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH and the amount of the DSH payment to be paid to a qualifying hospital.[10] The DPP is defined as the sum of two fractions expressed as percentages.[11] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction."

This matter concerns the Medicare/SSI fraction.[12] The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), defines the Medicare/SSI fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[13]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's

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[5] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[6] *Id.*
[7] *See* 42 U.S.C. § 1395ww(d)(5).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[11] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[12] The other component of the DPP not at issue in this matter is the "Medicaid Fraction" which is the number of hospital patient days for patients eligible for medical assistance under a State Medicaid plan (*i.e.* a plan approved by the Secretary under 42 U.S.C. § 1396 *et* seq.) but who were not entitled to Medicare Part A, divided by the total number of hospital patient days. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). *See also* 42 C.F.R. § 412.106(b)(4).
[13] (Emphasis added.)

DSH payment adjustment.[14] CMS calculates the Medicare/SSI Fractions used to calculate Medicare DSH payments based on discharges in the respective federal fiscal year, but hospitals are permitted under 42 C.F.R. § 412.106(b)(3) to request that CMS recalculate, or "realign," their Medicare/SSI Fractions based on discharges in the hospital's cost reporting period.

B. CMS Transmittals 12747 and 12785

CMS Transmittal 12747, originally issued on July 26, 2024, was subsequently replaced and updated by Transmittal 12785, published on August 13, 2024. The original Transmittal 12747 announced that CMS was resuming the processing of realignment requests for cost reporting periods starting before October 1, 2013. The original Transmittal 12747 describes how CMS temporarily halted the processing of realignment requests for cost reporting periods starting before October 1, 2013, due "to a lack of policy established through notice-and-comment rulemaking regarding the treatment of Part C days for that period of time."[15] However, on June 9, 2023, CMS issued Final Ruling CMS-1739-F, finalizing the treatment of Medicare Part C days in determining a hospital's disproportionate patient percentage, whereby such days are to be included in the Medicare/SSI Fraction and excluded from the numerator of the Medicaid fraction.[16] Transmittals 12747 and 12785 announce that with the issuance of final ruling CMS-1739-F, and the publication of provider Medicare/SSI Fractions on the CMS website, the agency was resuming the processing of realignment requests for such cost reporting periods.

The original Transmittal 12747 states that the Medicare/SSI Fractions available on the CMS website for cost reporting periods starting before October 1, 2013, like the federal fiscal year Medicare/SSI Fractions for the same period that were already available on the CMS website, were determined pursuant to final ruling CMS-1739-F. The transmittal directs Medicare contractors to use such fractions "to determine hospitals' DSH payments for realignment requests in appropriate cases."[17] The Transmittal explains that for realignment requests for such cost reporting periods, "CMS will calculate cost reporting period SSI ratios for all periods, for all hospitals, and post those ratios to the CMS DSH website . . . ."[18] Both Transmittal 12785 and the earlier Transmittal 12747 which it updates are nearly identical and focused on the realignment process. The only change in Transmittal 12785 from the earlier Transmittal 12747 is addressing a formatting change "to update the DSH Adjustment and Realignment files for years 1988-2013, so that the SSI Ratio column is consistently rounded to four (4) decimals in all files. All other information remains the same."[19]

III. Providers' EJR Request:

The Providers in these Groups have requested EJR over whether the calculation of Medicare/SSI Fractions for the fiscal years at issue were "determined correctly in CMS transmittals 12747 and 12785."[20] The Providers contend that EJR is warranted because they have met the jurisdictional

[14] 42 C.F.R. § 412.106(b)(2)-(3).
[15] CMS Transmittal 12747 at 3 (Jul. 26, 2024).
[16] *Id.*
[17] *Id.*
[18] *Id.*
[19] CMS Transmittal 12785 at 1 (Aug. 13, 2024).
[20] EJR Request at 2.

requirements for a hearing before the Board pursuant to 42 U.S.C. § 1395oo(a), but the "Board lacks authority to order a recalculation of Medicare Fractions published under the Secretary's direction by CMS."[21]

IV. Medicare Contractor's Response to Providers' EJR Request and Jurisdictional Challenge:

On March 20, 2025, the Medicare Contractor filed a response opposing the EJR Requests and on April 1, 2025, filed separate Jurisdictional Challenges, arguing that the Board lacks jurisdiction over the Providers and their group appeals. According to the Medicare Contractor, the Board does not have jurisdiction over the Providers' appeals because the CMS Transmittals from which the Providers appeal are not final appealable determinations.[22] The Medicare Contractor also notes that, even if the Board were to determine that the publication of the CMS Transmittals and accompanying Medicare/SSI Fraction data were final appealable determinations, the Providers' appeals would be untimely.[23]

V. Decision of the Board:

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), the Board is required to grant an EJR request if it determines that (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

The Medicare statute authorizes providers to seek hearings before the PRRB in two sets of circumstances: First, where the provider is dissatisfied with "the amount of total program reimbursement" as set forth in a Notice of Program Reimbursement (NPR), 42 U.S.C. § 1395oo(a)(1)(A)(i); and second, where the provider is dissatisfied with a "final determination" "as to the amount of the payment" under the prospective payment system, *id*. § 1395oo(a)(1)(A)(ii). In addition, for groups like the ones here, the amount in controversy in the aggregate must be $50,000 or more,[24] the matters at issue must involve a common question of fact or interpretation of law, regulations, or CMS Rulings,[25] and the request for a hearing must be filed within 180 days of the date of receipt of the final determination.[26]

In this case, the Providers in these groups have not yet received NPRs and have based their appeals on their dissatisfaction with Medicare/SSI Fraction data that was published on the CMS website in conjunction with Transmittals 12747 and 12785, pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(ii). However, the publication of Medicare/SSI Fraction data in conjunction with the Transmittals is not a "final determination" from which a provider may appeal.

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[21] *Id.* at 2-3.
[22] Medicare Administrative Contractor Jurisdictional Challenge (Case Nos. 25-1882GC et al) at 2 (Apr. 1, 2025).
[23] Federal Specialized Services' EJR Response (hereinafter, "FSS EJR Response") at 2 (Mar. 20, 2025).
[24] 42 U.S.C. § 1395oo(b); 42 C.F.R. § 405.1837(a)(3).
[25] 42 U.S.C. § 1395oo(b); 42 C.F.R. § 405.1837(a)(2).
[26] 42 U.S.C. § 1395oo(a)(3); 42 C.F.R. § 405.1835(a)(3).

Therefore, as the Providers have failed to meet the jurisdictional requirements for a hearing, the Board denies their requests for EJR and dismisses their appeals.

The Providers acknowledge that "the Board has taken the position that publication of the SSI Ratio and Medicare Fraction data [on CMS' website] is not a final determination."[27] But, the Providers also note disagreement with the Board's position, citing *Battle Creek Health Sys. v. Becerra*, 2023 WL 7156125 (D.D.C. Oct. 31, 2023), *appeal docketed*, No. 23-5310 (D.C. Cir. Dec. 29, 2023) and *Baylor All Saints Med. Ctr. v. Becerra*, 745 F.Supp.3d 464 (N.D. Tex. Aug. 15, 2024), *appeal docketed*, No. 24-10934 (5th Cir. Oct. 14, 2024), decisions in which courts held that providers met the requirements for a Board appeal before receiving a final appealable determination as to the amount of DSH payment.

In response, the Medicare Contractor describes the court's decision in *Battle Creek* as being "unavailing" because unlike in the instant case, the challenged Transmittal and publication of data in that case was described by the court as being a "*fait accompli*."[28] The court in *Battle Creek* observed that the challenged Transmittal and publication of data there "provided, with some finality, advance knowledge of the amount of [the DSH] payment."[29] Yet, in the instant case, the publication of the challenged Transmittals and accompanying Medicare/SSI Fraction data, provided by CMS for the purpose of informing provider choice as to whether to request realignment of the Medicare/SSI Fraction, does not definitively inform whether a provider qualifies for the DSH adjustment, much less the amount of DSH reimbursement that a provider could receive.

In recent Board decisions, the Board has continued to notice its disagreement with *Battle Creek* and by extension, other court decisions like *Baylor All Saints*.[30] The Board has maintained that *Memorial Hospital v. Becerra*[31] is a better-reasoned decision and provides a more thoughtful analysis. In *Memorial Hospital*, a group of providers filed an appeal similar to the Providers' appeals in this matter. The *Memorial Hospital* providers challenged CMS' publication of Medicare/SSI Fraction data, arguing that there are certain instances where a provider can file a Board appeal prior to receiving an NPR. The court in *Memorial Hospital* ultimately agreed with the Board that CMS' publication of Medicare/SSI Fractions was not an appealable final determination.

The court distilled the parties' positions as "boil[ing] down to a dispute about whether Plaintiffs have conflated a determination by the Secretary about one of several undetermined elements that eventually flows into the amount of payment and 'a final determination of the Secretary as to the amount of payment.'"[32] The court held that CMS' publication of Medicare/SSI Fractions, even if the publication of such fractions had been issued as "final," could and would not be a final determination "as to the amount of payment" because the Medicare/SSI Fractions are "just one of the variables that determines whether hospitals receive a DSH payment and, if so, for how

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[27] EJR Request at 2.
[28] FSS EJR Response at 1, citing *Battle Creek*, 2023 WL 7156125 at *5.
[29] *Battle Creek*, 2023 WL 7156125 at *5.
[30] *See, e.g.*, Board decisions in PRRB Case Nos. 24-0491, 24-1531GC, and 24-0413GC.
[31] 2022 WL 888190 (D.D.C. Mar. 25, 2022).
[32] *Id*. at *8.

much."[33] For the court, a challenge to an element of payment under 42 U.S.C. § 1395oo(a)(1)(A)(ii) is only appropriate if, as the D.C. Circuit has explained, "the Secretary ha[s] firmly established 'the only variable factor in the final determination as to the amount of payment under § 1395ww(d).'"[34]

Using the reasoning in *Memorial Hospital*, given the nature of the DSH adjustment, the publication of hospitals' Medicare/SSI Fractions on CMS' website is not final a determination as to the amount of payment due to any provider because the Medicare/SSI Fraction alone does not determine the amounts hospitals will be paid under the adjustment. Instead, the Medicare/SSI Fraction is incorporated, along with the Medicaid Fraction, into the DPP, which is ultimately the calculation that determines eligibility for and the amount of any DSH adjustment. The DPP must also exceed certain thresholds to qualify for any DSH adjustment.[35] Thus, although CMS calculates and publishes the Medicare/SSI Fraction for every hospital that receives Medicare reimbursement, the determination of whether a hospital receives reimbursement is made only after the hospital submits its year-end cost report.

In this matter, the Providers challenge CMS' publication of Medicare/SSI Fractions pursuant to Transmittals 12747 and 12785, which are focused on the realignment process. This information is published so that providers have sufficient information available to inform whether they want to request realignment. Providers cannot claim that with publication of the Transmittals and accompanying Medicare/SSI Fraction data, they are "dissatisfied with a final determination of Secretary as to the amount of payment." Neither the publication of the Transmittals nor the Medicare/SSI Fraction data informs whether a provider qualifies for the DSH adjustment, much less the amount of DSH reimbursement that a provider could receive. That CMS is providing such information to inform a provider's choice as to whether to request realignment of the Medicare/SSI Fraction that will be calculated for use in determining the DPP that ultimately determines whether a provider qualifies for DSH and how much they could receive, clearly indicates that the publication of Medicare/SSI Fraction data is not a final determination as to the amount of payment.

The Providers state that they are appealing the inclusion of Medicare Part C days in the denominator of the Medicare/SSI Fraction and exclusion from the numerator of the Fraction of days associated with individuals who were entitled to Supplemental Security Income (SSI) during their hospital stay but who were not in SSI pay status during such stays, or were in SSI pay status during their hospital stay but were not assigned payment status code C01, M01 or M02.[36] Neither of the Transmittals, which are focused on the realignment process, bear any

---

[33] *Id.* at *9.
[34] *Id*. at *8 (quoting *Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807, 811 (D.C. Cir. 2001) (quoting *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 147 (D.C. Cir. 1986)) (emphasis added); *see also Samaritan Health Serv. v. Sullivan*, 1990 WL 33141 at *3 (9th Cir. 1990) (unpublished table decision) ("We have held that if the Secretary's classification of a hospital effectively fixes the hospital's reimbursement rate, then that decision is a 'final determination' as referred to 42 U.S.C. § 1395oo(a)(1)(A)(ii).").
[35] 42 C.F.R. § 412.106(d)(2)(i)-(ii).
[36] EJR Request at 2. Although the Providers characterize the issue under appeal as a "single issue," it appears to encompass two separate issues: 1) the inclusion of Medicare Part C days in the denominator of the Medicare/SSI Fraction; and 2) the exclusion of patient days for individuals eligible for both Medicare and SSI from the numerator of the Medicare/SSI Fraction. This conflation of issues is contrary to 42 C.F.R. § 405.1837(a)(2) which restricts a

connection to the issue under appeal. In addition, the Providers here have included no proof that they have requested realignment in any of these cases, nor even that with realignment they would be eligible for DSH reimbursement (changes in either the Medicare/SSI or Medicaid fractions could potentially result in a DPP below that required to qualify for the DSH adjustment). Moreover, appeal of Transmittal 12785 which only rounded the published Medicare/SSI Fraction data to four decimal places, concerns only one factor of the DPP and is almost certainly unlikely to result in a change in DSH reimbursement sufficient to meet the amount in controversy required for a group appeal ($50,000 or more).[37]

Assuming *arguendo* that the Providers could persuade the Board that the Transmittals and accompanying SSI Fraction data are final appealable determinations, the Board must still dismiss the majority of the Providers' appeals because such appeal requests would be untimely. Pursuant to 42 U.S.C. § 1395oo(a)(3), a provider's request for a hearing must be filed within 180 days of the date of receipt of the final determination.[38] The Providers identify the "single issue involved in these appeals [as] whether the calculation of the Provider's Medicare Fractions was determined correctly in CMS Transmittals 12747 and 12785."[39] But given the nature of the Group's challenge, it appears that they are actually challenging Final Ruling CMS-1739-F rather than the Transmittals and accompanying SSI Fraction data. The Transmittals merely implement the Ruling in providing the providers with SSI Fractions recalculated or "realigned" based on the hospitals' cost reporting period instead of the federal fiscal year. Final Ruling CMS-1739-F was issued June 9, 2023, and the Providers' appeals were all filed in early 2025, long past the expiration of the 180-day period to file an appeal. Moreover, CMS Transmittal 12747 was originally issued on July 26, 2024, and a large majority of the Providers filed their appeals between February 4 - 5, 2025, nearly two weeks after the 180-day period had expired, if calculated from that date. Even if such Providers were to argue that the appeals were timely based on the later issuance of Transmittal 12785 on August 13, 2024, this Transmittal bears no connection to the issue under appeal as the Transmittal merely implements a formatting change to the SSI Fraction data that was previously made available through the earlier Transmittal 12747 so that the SSI Ratio column is consistently rounded to four decimals in all files.

VI. Conclusion

As the Providers in these twenty-six (26) groups have failed to meet the jurisdictional requirements for a hearing, the Board ***denies*** their requests for EJR and dismisses their appeals.

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group appeal to a "single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." *See also* PRRB Rule 13.

[37] *See* 42 U.S.C. § 1395oo(b); 42 C.F.R. § 405.1837(a)(3).

[38] *See also* 42 C.F.R. § 405.1835(a)(3).

[39] EJR Request at 2.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

FOR THE BOARD:

4/3/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: Kevin D. Smith -A

cc: Wilson Leong, Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators

Appendix A
AHMC Healthcare 1988-2013 Medicare Fraction (SSI) –
Statutory and Systemic Errors CIRP Groups

25-1882GC	AHMC Healthcare CY 1988 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1883GC	AHMC Healthcare CY 1989 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1884GC	AHMC Healthcare CY 1990 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1885GC	AHMC Healthcare CY 1991 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1886GC	AHMC Healthcare CY 1992 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1887GC	AHMC Healthcare CY 1993 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1888GC	AHMC Healthcare CY 1994 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1889GC	AHMC Healthcare CY 1995 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1890GC	AHMC Healthcare CY 1996 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1891GC	AHMC Healthcare CY 1997 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1893GC	AHMC Healthcare CY 1998 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1895GC	AHMC Healthcare CY 1999 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1896GC	AHMC Healthcare CY 2000 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1898GC	AHMC Healthcare CY 2001 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1899GC	AHMC Healthcare CY 2002 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1901GC	AHMC Healthcare CY 2003 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1902GC	AHMC Healthcare CY 2004 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1903GC	AHMC Healthcare CY 2005 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1904GC	AHMC Healthcare CY 2006 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1905GC	AHMC Healthcare CY 2007 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1906GC	AHMC Healthcare CY 2008 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1907GC	AHMC Healthcare CY 2009 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1569GC	AHMC Healthcare CY 2013 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1554GC	AHMC Healthcare CY 2010 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1562GC	AHMC Healthcare CY 2011 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1566GC	AHMC Healthcare CY 2012 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

Mr. Hamid Mirbod, CEO
Elite Hospice and Palliative Care
106 S. Grape St., Suite 2
Escondido, CA 92025-4407

Ms. Pamela VanArsdale
Appeals Lead
National Government Services, Inc. (J-6)
MP: INA 101 – AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: **Determination re: Filing Requirements**
Elite Hospice and Palliative Care (B3-1779)
Appealed Period: FFY 2025
PRRB Case No.: 25-4176

Dear Mr. Mirbod and Ms. VanArsdale:

The above-captioned appeal was filed with the Provider Reimbursement Review Board ("Board") via the Office of Hearings Case and Document Management System ("OH CDMS"). After review of the facts outlined below, the Board has determined that the appeal request was not filed in accordance with the Board Rules and regulations. The Board's review and determination is set forth below.

BACKGROUND:

On March 28, 2025, the Provider filed the above-referenced appeal request relative to the Quality Reporting Program. The Provider stated that the sole issue in dispute involved the 4% Reduction of projected revenue.

The Provider indicated that the appeal was based on a *Notice of Quality Reporting Program Noncompliance Decision Upheld* with a final determination date of 9/30/2024. However, the Board notes that the *Notice of Quality Reporting Program Noncompliance Decision Upheld* decision issued by CMS dated 9/30/2024 was omitted from the Provider's initial appeal request as the final determination support document.

After review of the case record, the Board finds that the Provider failed to file a copy of the final determination, the *Notice of Quality Reporting Program Noncompliance Decision Upheld* decision dated 9/30/2024.

RULES/REGULATIONS:

Board Rule 4.1 General Requirements

See 42 C.F.R. §§ 405.1835 - 405.1840.

> **The Board will dismiss appeals that fail to meet the timely filing requirements and/or jurisdictional requirements.** A jurisdictional challenge (see Rule 44.4) may be raised at any time during the appeal; however, for judicial economy, the Board strongly encourages filing any challenges as soon as possible. The Board may review jurisdiction on its own motion at any time. The parties cannot waive jurisdictional requirements.

Board Rule 6.1 Initial Filing

6.1.1 **Request and Supporting Documentation** To file an individual appeal, the case representative must log onto OH CDMS and follow the prompts. Reference Rules 7 and 9 as well as Model Form A – Individual Appeal Request (Appendix A) for guidance on all required OH CDMS data fields and supporting documentation. **The Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b) or (d), as relevant.**

Board Rule 7.1 Final Determination

7.1.1. **General Requirements**

Identify the appealed period. This is typically the fiscal year end ("FYE") covered by the cost report but may include an alternative period such as a calendar year ending 12/31, a federal fiscal year ending 9/30, or another period for which you must identify the beginning and ending dates. If the period is something other than a traditional cost report FYE, you must identify the cost reporting periods affected by the determination.

Example: Provider has a 6/30 FYE and is appealing a Federal Register notice applicable to 9/30/18. The impacted cost reporting periods would be FYE 6/30/18 (based on the portion of the FFY from 10/1/17 through 6/30/18) and FYE 6/30/19 (based on the remainder of the FFY from 7/1/18 through 9/30/18).

Include a copy of the final determination, such as the NPR, revised NPR, exception determination letter, Federal Register notice, or **quality reporting payment reduction decision. Note that preliminary determinations are not appealable. (See Rule 7.5 for appeals based on the lack of a timely issued determination.)**

Identify the date the final determination was issued. Ensure the appeal is filed timely based on the appeal period in Rule 4.3.

Board Rules 7.1.2 **Additional Requirements for Specific Determination Types**

7.1.2.4 Quality Reporting Payment Reduction Decision

Identify the type of quality reporting payment program. **Also provide the original decision from CMS in which the payment reduction was identified (preliminary decision) and the final reconsideration decision on which the appeal is based.**

BOARD DETERMINATION:,

The Board has determined that the Provider failed to meet the minimum filing requirements as set forth in 42 C.F.R. §§ 405.1835 - 405.1840 and the Board Rules in that it did not file the required final determination on which the appeal is based, the *Notice of Quality Reporting Program Noncompliance Decision Upheld* decision dated 9/30/2024. As a result, the Board hereby dismisses case number 25-4176, in its entirety, and removes it from its docket.

Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 105.1877.

Board Members:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba Dubose, Esq.

FOR THE BOARD:

4/4/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Blvd.
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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Notice of Dismissal***
Mountain West Medical Center, Prov. No. 46-0014, FYE 12/31/2016
Case No. 20-0321

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 20-0321. Set forth below is the decision of the Board to dismiss the 2 remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) and Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 20-0321*

On **April 29, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2016.

On **October 22, 2019**, the Board received the Provider's individual appeal request. The Individual Appeal Request contained five (5) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage[1]
3. DSH Payment – Medicaid Eligible Days
4. Uncompensated Care ("UCC") Distribution Pool[2]
5. 2 Midnight Census IPPS Payment Reduction[3]

On **November 13, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

[1] On May 21, 2020, this issue was transferred to PRRB Case No. 19-1503GC.
[2] On August 21, 2023, the Provider withdrew this issue.
[3] On May 21, 2020, this issue was transferred to PRRB Case No. 19-1504GC.

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[4]

In letters dated **November 14, 2019** and **January 28, 2020**, the Medicare Contractor requested DSH packages[5] from the Provider.

On **May 18, 2020**, the Provider filed its preliminary position paper.

On **May 21, 2020**, the Provider transferred Issues 2 and 5 to Quorum groups because the Provider is commonly owned/controlled by Quorum Health (hereinafter "Quorum") and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1).

On **August 7, 2020**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1. Board Rule 44.4.3. specifies that "[p]roviders must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order" and "[f]ailure to respond will result in the Board making a jurisdictional determination with the information contained in the record."[6] The Provider did not file a response to the jurisdictional challenge.

On **September 23, 2020**, the Medicare Contractor filed its preliminary position paper.

On **January 10, 2023**, the Medicare Contractor issued a third and final request to the Provider for a DSH package.

On **March 2, 2023**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 3. Here again, the Provider did not file a response to the jurisdictional challenge.

On **August 18, 2023**, the Provider requested a Change of Representative to Quality Reimbursement Services, Inc.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-1503GC

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[4] (Emphasis added).
[5] "DSH packages" typically include support documentation for calculations including Medicaid Eligible Days listings for those days that a provider avers should be included in the calculation of the provider's Medicaid fraction of the DSH Patient Percentage.
[6] Board Rule 44.4.3, v. 3.2 (Dec. 2023).

In its Individual Appeal Request, the Provider summarizes the legal basis for its Issue 1: DSH Payment/SSI Percentage (Provider Specific) as follows:

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[7]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $5,000.

The Provider's position on Issue 1: DSH/SSI (Provider Specific) as set forth in its Preliminary Position Paper states in its entirety:

[7] Issue Statement at 1 (Oct. 22, 2019).

> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (January 31).[8]
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' [sic] records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[9]

The DSH/SSI (Systemic Errors) group issue statement in Case No. 19-1503GC to which the Provider transferred Issue 2: DSH/SSI (Systemic Errors) states:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in

[8] Note that Board records show that the fiscal year end at issue in this case is December 31, 2016.
[9] Provider's Preliminary Position Paper at 8-9 (May 18, 2020).

accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

The Providers challenge their SSI percentages based on the following reasons:

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.

COVERED VS. TOTAL DAYS

The statutory language defines the Medicare/SSI fraction as consisting solely of days for patients who were "entitled to benefits under part A" of Medicare. The numerator includes only those Part A days for patients who are also entitled to SSI benefits. The denominator of the Medicare/SSI fraction includes all Part A days. As set forth in the statutory language above, the numerator of the Medicaid fraction consists of days of patients who were both eligible for medical assistance under Title XIX, or Medicaid, and not entitled to benefits under Part A of Title XVIII, or Medicare. The denominator for the Medicaid fraction is the hospital's total patient days for the period.

CMS considers an individual to be "entitled to benefits under Part A" regardless of whether the days were "covered" or paid by Medicare. This means that now Part C days, Exhausted Benefit days, and Medicare Secondary Payor ("MSP") days are included in the denominator of the Medicare/SSI fraction even when there is no payment by Medicare, which is a departure from the treatment of these days as excluded from the Medicare/SSI fraction prior to the 2004 rule.

The Provider(s) also contend(s) that if CMS includes unpaid Medicare Part A days in the denominator of the Medicare/SSI fraction, then unpaid SSI eligible patient days must be included in the numerator of the Medicare/SSI fraction, utilizing SSI payment

> codes that reflect the individuals' eligibility for SSI – even if the individuals did not receive SSI payments, as a matter of statutory consistency. [10]

C. Description of Issue 3 in the Appeal Request

In its Individual Appeal Request, the Provider summarizes its DSH Payment – Medicaid Eligible Days issue as follows:

> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[11]

The Provider estimated the reimbursement impact of the issue at $23,867 based on an increase of 50 additional Medicaid days but failed to include a list of the additional days.[12]

The Provider's position on Issue 3 as set forth in its Preliminary Position Paper states in its entirety:

> Specifically, the Provider disagrees with the MAC's calculation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp., Inc. v. Secretary of Health and Human Servs.* 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: [citations omitted].

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[10] Group Issue Statement at 1-2 (Mar. 25, 2019).
[11] Issue Statement at 3 (Oct. 22, 2019).
[12] *Id*.

> [CMS] acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its 2016 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal court decisions.[13]

MAC's Jurisdictional Challenges

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)

The Medicare Contractor notes that according to the Provider's appeal request, Issue 1 has three components: 1) SSI data accuracy; 2) realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment.[14]

The Medicare Contractor contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2 which was transferred to Group Case No. 19-1503GC, Quorum Health CY 201 and CY 2016 DSH SSI Percentage CIRP Group. This means that the Provider is appealing an issue from a single final determination in more than one appeal, which is prohibited by Board Rule 4.6.1.[15]

The Medicare Contractor asserts that the Board does not have jurisdiction over the SSI realignment component. To date the Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. 412.106(b)(3). There was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies for this issue.[16]

Issue 3 – DSH Payment – Medicaid Eligible Days

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[13] Provider's Preliminary Position Paper at 7-8 (May 18, 2020).
[14] Medicare Contractor's Jurisdictional Challenge at 2 (Aug. 7, 2020).
[15] *Id.* at 2 and 4 (Aug. 7, 2020).
[16] *Id.* at 5 (Aug. 7, 2020).

The Medicare Contractor contends that this issue should be dismissed because the Provider abandoned the issue when the Provider failed to file a **complete** preliminary position paper with a fully developed narrative, all exhibits, and a listing of exhibits in accordance with Board Rule 25.3. Additionally, the Provider has failed to provide a list of additional Medicaid eligible days or any other supporting documents without explanation for why it cannot produce those documents in accordance with Board Rule 25.2.2.[17] The Provider also failed to respond to the Medicare Contractor's various requests to submit the required Medicaid Eligible Days documentation.[18]

The Medicare Contractor notes that the Provider makes a broad allegation that the total number of days reflected in its cost report does not reflect an accurate number of Medicaid eligible days. However, the Provider has failed to include any evidence to establish the material facts in the case relating to the inaccuracies in the Medicaid Percentage calculation at issue. [19]

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's two (2) remaining issues.

A. DSH Payment/SSI Percentage (Provider Specific)

The jurisdictional analysis for Issue 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. As set forth below, the Board dismisses both aspects of Issue 1.

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 19-1503GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income

[17] Medicare Contractor's Jurisdictional Challenge at 1 and 4 (Mar. 2, 2023).
[18] *Id.* at 4 (Mar. 2, 2023).
[19] *Id.* at 4 (Mar. 2, 2023).

percentage in the Disproportionate Share Hospital calculation."[20] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[21] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[22]

The Provider's DSH SSI Percentage (Systemic Errors) issue in group Case No. 19-1503GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH SSI Percentage (Systemic Errors) in Case No. 19-1503GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6.1,[23] the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

Additionally, the Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[24] Accordingly, Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 19-1503GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 19-1503GC but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rules 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop

[20] Issue Statement at 1.
[21] *Id.*
[22] *Id.*
[23] Board Rules v. 2.0 (Aug. 29, 2018).
[24] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

the merits of its position on Issue 1 and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

Moreover, the Board finds that the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable, i*dentify the missing documents; explain why the documents remain unavailable; state the efforts made to obtain the documents; and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[25]

Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 19-1503GC. The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[26]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[27]

---

[25] Board Rules v. 2.0 (Aug. 29, 2018) (Emphasis added).
[26] Last accessed March 31, 2025.
[27] Emphasis added.

Accordingly, the Board finds that the issue in the instant appeal and the group issue from Group Case 19-1503GC are the same issue.[28] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6.1, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request[.]" Moreover, there is nothing in the record to indicate that a proper realignment request was made by the Provider, and that the Medicare Contractor has made a final determination regarding DSH SSI Percentage *realignment* from which the Provider can appeal. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

The Provider's appeal request did not include a finalized list of the specific additional Medicaid eligible days that are in dispute in this appeal in either the initial appeal or the preliminary position paper.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Aug. 2018) states:

> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**

[28] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Quorum CIRP group per 42 C.F.R. § 405.1837(b)(1).

> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[29]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Aug. 2018) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

> **Rule 25 Preliminary Position Papers**
>
> **COMMENTARY**:
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties, and, therefore, require analysis well in advance of the filing deadline.
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the following sub-sections.
>
> **25.1.1 Provider's Position Paper**
>
> The provider's preliminary position paper must:
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.

[29] (Bold emphasis added.)

B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

***

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

Parties should file with the Board a **complete** preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on November 13, 2019, included instructions on the content of the Provider's preliminary position paper consistent with the above-mentioned Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iv) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[30]

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),

[30] (Emphasis added.)

- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On May 18, 2020, the Provider filed its preliminary position paper in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[31] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $23,867 based on an estimated 50 days).

Notably, the Medicare Contractor sent three (3) separate requests for the Provider's list of Medicaid Eligible days (and also discussed the lack of the listing in the Medicare Contractor's own position paper filing). The first notice was sent to the Provider on November 14, 2019 and the second request was sent to the Provider on January 28, 2020. The third, final request was filed formally with the Board in OH CDMS on January 10, 2023, *over six years after the end of the Provider's cost reporting period*. The Medicare Contractor also informed the Provider in its final request for information that the deadline to respond was February 9, 2023. The Provider failed to file any response to the 3rd and final request.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[32] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to submit a finalized listing of Medicaid eligible days, notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position paper and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-

[31] Provider's Preliminary Position Paper at 10.
[32] (Emphasis added.)

(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[33]

Based on the foregoing, the Board dismisses the two (2) remaining issues in this case – (Issues 1 and 3). As no issues remain, the Board hereby closes Case No. 20-0321 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

4/4/2025

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson Leong, Federal Specialized Services

[33] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: Untimely Appeal of Federal Register
25-3378GC MultiCare Health CY 2025 ATRA IPPS Payment Reduction CIRP Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") is in receipt of the above-referenced group appeal filed by Quality Reimbursement Services, Inc. ("QRS"). Upon review, the Board notes an impediment to jurisdiction. The background and the Board's decision are set forth below.

Background

On February 25, 2025, QRS filed the "MultiCare Health CY 2025 ATRA IPPS Payment Reduction CIRP Group" in the Office of Hearings Case and Document Management System ("OH CDMS"). The group, which includes seven providers, was filed from the Federal Register dated August 28, 2024.

Decision of the Board

The Board finds that the group appeal was not timely filed as required by the Board's enabling statute at 42 U.S.C. § 1395oo(a)(3), which requires an appeal be filed "*within 180 days after notice of the . . . Secretary's final determination.*"[1] This appeal was filed in OH CDMS 181 days after the issuance of the August 28, 2024 Federal Register provision that implemented the Final Rule related to the increase to the Inpatient Prospective Payment System Rates ("IPPS").

The Board is bound by all of the provisions of Title XVIII of the Act (the Social Security Act, as amended) and the regulations issued thereunder.[2] The Board cannot apply a regulation or instruction which is contrary to a statute and other regulations that deal specifically with the matter at hand: the date a provider is deemed to have notice of the contents of the Federal Register. In this case, the laws and regulations governing the publication of Federal Register notices specifically define the time of notice as that of publication. These laws and regulations have been incorporated into Title XVIII.

The Secretary[3] has enacted Part 401 of Title 42 of the Code of Federal Regulations which is entitled "General Administrative Requirements." Subpart B, sections 401.101(a)(1) and (2) of this Part states

[1] (Emphasis added).
[2] *See* 42 C.F.R. § 405.1867.
[3] of the Department of Health and Human Services.

that "[t]he regulations in this subpart: (1) Implement section 1106(a)[4] of the Social Security Act [relating to disclosure of information] as it applies to [CMS] . . . [and] (2) Relate to the availability to the public, under 5 U.S.C. § 552,[5] of records of CMS." These laws and regulations set out which records are available and how they may be obtained, and they supplement the regulations of CMS relating to the availability of information. Section 401.106 of this subpart, which deals with publication of materials under 5 U.S.C. § 552, requires publication to serve as notice and identifies the Federal Register as the vehicle to be used to give notice. Section 552(a) states in part that:

> (1) Each agency shall separately state and currently publish in the Federal Register for the guidance of the public-
>
> * * * *
>
> (D) substantive rules of general applicability adopted as authorized by law, and statements of general policy or interpretations of general applicability formulated and adopted by the agency; and
>
> (E) each amendment, revision, or repeal of the foregoing.

With regard to the notices published in the Federal Register, 44 U.S.C. § 1507 states in part that:

> A document required. . .to be published in the Federal Register is not valid as against a person who has not had actual knowledge of it until the duplicate originals or certified copies of the document have been filed with the Office of the Federal Register and a copy made available for public inspection as provided by section 1503. . . . *[F]iling of a document, required or authorized to be published [in the Federal Register] by section 1505. . .is sufficient to give notice* of the contents of the document to a person subject to or affected by it.[6]

Reflecting new technology and the ability to transmit information immediately upon publication, the Government Printing Office ("GPO") promulgated 1 C.F.R. § 5.10 which authorizes publication of the Federal Register on the internet at the GPO website.[7] The GPO website containing the Federal Register is updated daily at 6 a.m. Monday through Friday, except holidays.[8] Consequently, the Provider is deemed to have notice of the 0.7 percent reduction to IPPS on the date the Federal Register was published and made available online.

With respect to statutes and regulations dealing with the Federal Register, the Supreme Court has found that:

> Congress has provided that the appearance of rules and regulations in the Federal Register give legal notice of their contents . . . .

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[4] 42 U.S.C. § 1306(a).
[5] 5 U.S.C. § 550 *et seq.* contains the Administrative Procedures Act; 5 U.S.C. § 552 deals with the availability of government information and is known as the Freedom of Information Act ("FOIA").
[6] (Emphasis added).
[7] *See also* 44 U.S.C. § 4101 (the Superintendent of Documents is to maintain an electronic director and system of online access to the Federal Register).
[8] *See* http://www.gpo.gov/help/index.html#about_federal_register.htm.

> . . . Regulations [are] binding on all who sought to come within the [Act], regardless of actual knowledge of what is in the Regulations or of the hardship resulting from innocent ignorance.[9]

The statutes governing the Board (44 U.S.C. § 1507 as applied through the requirements of 42 C.F.R. § 401.101 and the Administrative Procedures Act ("APA")) are clear on their face: the date of publication of the Federal Register is the date the Providers are deemed to have notice of the August 2025 Final Rule. The Board is bound by all of the provisions of Title XVIII which includes, by reference, the provisions of the Administrative Procedures Act and the Public Printing and Documents law which require that CMS publish its notices and regulations in the Federal Register. In publishing materials in the Federal Register, CMS must comply with the statutes and regulations governing the Superintendent of Documents and the Governing Printing Office.

Pursuant 42 U.S.C. § 1395oo(a)(3), the Board's enabling statute, providers have 180 days "after *notice* of the Secretary's final determination" to file an appeal. In this case, the notice of the Secretary's determination is, by law, the date the Federal Register is issued by the Superintendent of Documents, or August 28, 2024. Here, the 180th day for appealing was Monday, February 24, 2025. The subject group appeal was not filed with the Board until Tuesday, February 25, 2025, and thus was not timely filed.

Consequently, the Board concludes that it does not have jurisdiction over this untimely-filed group appeal. Case No. 25-3378GC is hereby dismissed and removed from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq,
Shakeba DuBose, Esq.

For the Board:

4/9/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson Leong, Federal Specialized Services
Dean Wolfe, Noridian Healthcare Solutions (J-F)

[9] *Fed. Crop Ins. Corp. v. Merrill*, 332 U.S. 380, 385 (1947).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Ms. Bethany Viner
Administrator
Autumn Care of Shallotte
237 Mulberry Street
Shallotte, NC 28470

Ms. Dana Johnson
Lead Auditor
National Government Services, Inc.
MP: INA 101-AF42
P.O. Box 6494
Indianapolis, IN 46206-6474

RE: ***Board Decision – Amount in Controversy***
Autumn Care of Shallotte (34-5294)
Appealed Period: FFY 2023
PRRB Case No.: 25-4194

Dear Ms. Viner and Ms. Johnson:

The above-captioned appeal was filed with the Provider Reimbursement Review Board ("Board") via the Office of Hearings Case and Document Management System ("OH CDMS"). After review of the facts outlined below, the Board has determined that the appeal request was not filed in accordance with the Board Rules and regulations. The Board's review and determination is set forth below.

BACKGROUND:

On March 31, 2025, the Provider filed an appeal request regarding the Quality Reporting Program for FFY 2023. The Provider indicated that the appeal is based on a *Notice of Quality Reporting Program Noncompliance Decision Upheld* issued by the Medicare Contractor ("MAC") on October 4, 2024. The Provider stated that the issue in dispute was Quality Reporting Program Payment Reduction with a controversy amount of $2.

The Board notes that the Provider did not submit any documentation or calculation regarding the controversy amount.

BOARD DETERMINATION:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the contractor's final determination, the ***amount in controversy is $10,000 or***

more (or $50,000 for a group), and the request for a hearing is filed within 180 of receipt of the final determination.[1]

With respect to the regulatory amount in controversy requirement, Board Rule 6.4 (Dec. 2023) explains:

> An individual appeal request must have a total amount in controversy of at least $10,000 at the time of filing. *See* 42 C.F.R. §§ 405.1835 and 405.1839. A calculation of the amount in controversy with supporting documentation must be provided for ***each*** issue.

42 C.F.R. § 405.1835(b) outlines the content requirements for a request for Board hearing from a final determination:

> The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing in the manner prescribed by the Board, and the request must include the elements described in paragraphs (b)(1) through (4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (2), or (3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.

Board Rule 6.1.1 (Dec. 2023) provides additional information on what is required with an appeal request, and states:

> **Request and Supporting Documentation** To file an individual appeal, the case representative must log onto OH CDMS and follow the prompts. Reference Rules 7 and 9 as well as Model Form A – Individual Appeal Request (Appendix A) for guidance on all required OH CDMS data fields and supporting documentation. ***The Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b) or (d), as relevant.***

Here, the Provider indicated in its appeal request that the amount in controversy is $2. The Provider did not, however, provide any calculation support or other documents to establish this or a different amount in controversy.

Thus, the Board finds that the appeal, as filed, is jurisdictionally deficient as it does not meet the amount in controversy requirement because the amount in controversy is $2, which is less than the requirement of $10,000 or more. Additionally, the Provider failed to meet the regulatory and Board Rule requirements for filing, as the Provider did not submit any documentation related to the amount in controversy and thus failed to meet the requirements of 42 C.F.R. § 405.1835(b).

[1] Empasis added.

Therefore, the Board hereby ***dismisses*** Case No. 25-4194, in its entirety, and removes it from the Board's docket.

Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 105.1877

Board Members:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba Dubose, Esq.

FOR THE BOARD:

4/9/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electric Delivery

Mr. Danny Ricks
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Mr. Michael Redmond, Manager
JH & JL Provider Audit & Reimbursement
Novitas Solutions, Inc. c/o
GuideWell Source
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Suite 100
Mechanicsburg, PA 17050

RE: ***Board Decision: Filing Requirements***
The Meridian (67-6260)
Appealed Period: FFY 2025
PRRB Case No.: 25-4225

Dear Messrs. Ricks and Redmond:

The above-captioned appeal was filed with the Provider Reimbursement Review Board ("Board") via the Office of Hearings Case and Document Management System ("OH CDMS"). After review of the facts outlined below, the Board has determined that the appeal request was not filed in accordance with the Board Rules and regulations. The Board's review and determination is set forth below.

BACKGROUND:

On April 2, 2025, the Provider filed the above referenced appeal and identified the sole issue in dispute as the 2% APU Reduction of the projected revenue.

The Provider entered the final determination date into OH CDMS as October 4, 2024. However, the support document uploaded for the final determination is a *Notification of Non-Compliance for SNFs that have not submitted required Quality Reporting Program (QRP) Data for Federal Fiscal Year (FY) 2025* dated July 10, 2024. The Provider did not include a final determination document dated October 4, 2024 with its appeal request.

BOARD DECISION:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the contractor's final determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 of receipt of the final determination.

42 C.F.R. § 405.1835(b) outlines the content requirements for a request for Board hearing from a final determination:

> (b) *Contents of request for a Board hearing on a final contractor determination*. The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing in the manner prescribed by the Board, and the request must include the elements described in paragraphs (b)(1) through (4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (2), or (3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.
>
> ***
>
> (3) A copy of the final contractor or Secretary determination under appeal. . .

The Board rules further reiterate the regulatory requirement to submit a copy of the final determination with the Provider's appeal request:

> **Board Rule 6.1 Initial Filing**
>
> **6.1.1 Request and Supporting Documentation** To file an individual appeal, the case representative must log onto OH CDMS and follow the prompts. Reference Rules 7 and 9 as well as Model Form A – Individual Appeal Request (Appendix A) for guidance on all required OH CDMS data fields and supporting documentation. **The Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b) or (d), as relevant.**
>
> ***
>
> **7.1 Final Determination**
>
> 7.1.1. **General Requirements**
>
> Identify the appealed period. This is typically the fiscal year end ("FYE") covered by the cost report but may include an alternative period such as a calendar year ending 12/31, a federal fiscal year ending 9/30, or another period for which you must identify the beginning and ending dates. If the period is something other than a traditional cost report FYE, you must identify the cost reporting periods affected by the determination. . .

> ***Include a copy of the final determination***, such as the NPR, revised NPR, exception determination letter, Federal Register notice, or **quality reporting payment reduction decision. Note that preliminary determinations are not appealable.** (*See* Rule 7.5 for appeals based on the lack of a timely issued determination.)
>
> Identify the date the final determination was issued. Ensure the appeal is filed timely based on the appeal period in Rule 4.3.
>
> **7.1.2 Additional Requirements for Specific Determination Types**
>
> **7.1.2.4 Quality Reporting Payment Reduction Decision**
>
> Identify the type of quality reporting payment program. **Also provide the original decision from CMS in which the payment reduction was identified (preliminary decision) and the final reconsideration decision on which the appeal is based.**[1]

The Board finds that this appeal does not meet the regulatory requirements for filing as the Provider failed to submit the final determination, dated October 4, 2024, on which the appeal is based, as required by 42 C.F.R. § 405.1835(b)(3) and the Board Rules.

The Board has determined that the Provider failed to meet the minimum filing requirements as set forth in 42 C.F.R. § 405.1835(b) and the Board Rules cited above. As a result, the Board hereby dismisses Case No. 25-4225, in its entirety, and removes it from its docket.

Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba Dubose, Esq.

FOR THE BOARD:

4/10/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Federal Specialized Services

[1] Emphasis added.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

Via Electric Delivery

Mr. Danny Ricks
LVN MDS Nurse Consultant
Meridian Care Center
7181 Crestway Drive
San Antonio, TX 78239-3002

Mr. Michael Redmond, Manager
JH & JL Provider Audit & Reimbursement
Novitas Solutions, Inc. c/o
GuideWell Source
2020 Technology Parkway
Suite 100
Mechanicsburg, PA 17050

RE: **Determination re: Filing Requirements**
Meridian Care of Hebbronville (67-5796)
Appealed Period: FFY 2025
PRRB Case No.: 25-4226

Dear Messrs. Ricks and Redmond:

The above-captioned appeal was filed with the Provider Reimbursement Review Board ("Board") via the Office of Hearings Case and Document Management System ("OH CDMS"). After review of the facts outlined below, the Board has determined that the appeal request was not filed in accordance with the Board Rules and regulations. The Board's review and determination is set forth below.

BACKGROUND:

On April 2, 2025, the Provider filed the above referenced appeal request and identified the sole issue in dispute as the 2% APU Reduction of the projected revenue.

The Provider entered the final determination date into OH CDMS as 10/4/2024. However, the support document uploaded for the final determination is a *Notification of Non-Compliance for SNFs that have not submitted required Quality Reporting Program (QRP) Data for Federal Fiscal Year (FY) 2025* dated July 10, 2024. This is the initial notice of non-compliance that was sent to the Provider. The Provider did not include a final determination document dated October 4, 2024 with its appeal request.

BOARD DECISION:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the contractor's final determination, the amount in controversy is $10,000 or

more (or $50,000 for a group), and the request for a hearing is filed within 180 of receipt of the final determination.

42 C.F.R. § 405.1835(b) outlines the content requirements for a request for Board hearing from a final determination:

> (b) *Contents of request for a Board hearing on a final contractor determination*. The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing in the manner prescribed by the Board, and the request must include the elements described in paragraphs (b)(1) through (4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (2), or (3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.
>
> ***
>
> (3) A copy of the final contractor or Secretary determination under appeal. . .

The Board rules further reiterate the regulatory requirement to submit a copy of the final determination with the Provider's appeal request:

> **Board Rule 6.1 Initial Filing**
>
> **6.1.1 Request and Supporting Documentation** To file an individual appeal, the case representative must log onto OH CDMS and follow the prompts. Reference Rules 7 and 9 as well as Model Form A – Individual Appeal Request (Appendix A) for guidance on all required OH CDMS data fields and supporting documentation. **The Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b) or (d), as relevant.**
>
> ***
>
> **7.1 Final Determination**
>
> 7.1.1. **General Requirements**
>
> Identify the appealed period. This is typically the fiscal year end ("FYE") covered by the cost report but may include an alternative period such as a calendar year ending 12/31, a federal fiscal year ending 9/30, or another period for which you must identify the beginning and ending dates. If the period is something other than a traditional cost report FYE, you must identify the cost reporting periods affected by the determination. . .

Include a copy of the final determination, such as the NPR, revised NPR, exception determination letter, Federal Register notice, or **quality reporting payment reduction decision. Note that preliminary determinations are not appealable.** (*See* Rule 7.5 for appeals based on the lack of a timely issued determination.)

Identify the date the final determination was issued. Ensure the appeal is filed timely based on the appeal period in Rule 4.3.

7.1.2 Additional Requirements for Specific Determination Types

7.1.2.4 Quality Reporting Payment Reduction Decision

Identify the type of quality reporting payment program. **Also provide the original decision from CMS in which the payment reduction was identified (preliminary decision) and the final reconsideration decision on which the appeal is based.**[1]

The Board finds that this appeal does not meet the regulatory requirements for filing as the Provider failed to submit the final determination, dated October 4, 2024, on which the appeal is based, as required by 42 C.F.R. § 405.1835(b)(3) and the Board Rules. Without the final determination document, the Board is not able to determine whether the Provider has filed a jurisdictionally valid appeal.

The Board has determined that the Provider failed to meet the minimum filing requirements as set forth in 42 C.F.R. § 405.1835(b) and the Board Rules cited above. As a result, the Board hereby dismisses Case No. 25-4226, in its entirety, and removes it from its docket.

Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba Dubose, Esq.

FOR THE BOARD:

4/10/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Federal Specialized Services

[1] Emphasis added.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

Via Electric Delivery

Mr. Danny Ricks
LVN MDS Nurse Consultant
Meridian Care Center
7181 Crestway Drive
San Antonio, TX 78239-3002

Mr. Michael Redmond, Manager
JH & JL Provider Audit & Reimbursement
Novitas Solutions, Inc. c/o
GuideWell Source
2020 Technology Parkway
Suite 100
Mechanicsburg, PA 17050

RE: **Determination re: Filing Requirements**
RJ Meridian Care Alta Vista (45-5450)
Appealed Period: FFY 2025
PRRB Case No.: 25-4227

Dear Messrs. Ricks and Redmond:

The above-captioned appeal was filed with the Provider Reimbursement Review Board ("Board") via the Office of Hearings Case and Document Management System ("OH CDMS"). After review of the facts outlined below, the Board has determined that the appeal request was not filed in accordance with the Board Rules and regulations. The Board's review and determination is set forth below.

BACKGROUND:

On April 2, 2025, the Provider filed the above referenced appeal request and identified the sole issue in dispute as the 2% APU Reduction of the projected revenue.

The Provider entered the final determination date into OH CDMS as 10/4/2024. However, the support document uploaded for the final determination is a *Notification of Non-Compliance for SNFs that have not submitted required Quality Reporting Program (QRP) Data for Federal Fiscal Year (FY) 2025* dated July 10, 2024. This is the initial notice of non-compliance that was sent to the Provider. The Provider did not include a final determination document dated October 4, 2024 with its appeal request.

BOARD DECISION:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the contractor's final determination, the amount in controversy is $10,000 or

more (or $50,000 for a group), and the request for a hearing is filed within 180 of receipt of the final determination.

42 C.F.R. § 405.1835(b) outlines the content requirements for a request for Board hearing from a final determination:

> (b) *Contents of request for a Board hearing on a final contractor determination*. The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing in the manner prescribed by the Board, and the request must include the elements described in paragraphs (b)(1) through (4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (2), or (3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.
>
> ***
>
> (3) A copy of the final contractor or Secretary determination under appeal. . .

The Board rules further reiterate the regulatory requirement to submit a copy of the final determination with the Provider's appeal request:

> **Board Rule 6.1 Initial Filing**
>
> **6.1.1 Request and Supporting Documentation** To file an individual appeal, the case representative must log onto OH CDMS and follow the prompts. Reference Rules 7 and 9 as well as Model Form A – Individual Appeal Request (Appendix A) for guidance on all required OH CDMS data fields and supporting documentation. **The Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b) or (d), as relevant.**
>
> ***
>
> **7.1 Final Determination**
>
> 7.1.1. **General Requirements**
>
> Identify the appealed period. This is typically the fiscal year end ("FYE") covered by the cost report but may include an alternative period such as a calendar year ending 12/31, a federal fiscal year ending 9/30, or another period for which you must identify the beginning and ending dates. If the period is something other than a traditional cost report FYE, you must identify the cost reporting periods affected by the determination. . .

Include a copy of the final determination, such as the NPR, revised NPR, exception determination letter, Federal Register notice, or **quality reporting payment reduction decision. Note that preliminary determinations are not appealable.** (*See* Rule 7.5 for appeals based on the lack of a timely issued determination.)

Identify the date the final determination was issued. Ensure the appeal is filed timely based on the appeal period in Rule 4.3.

7.1.2 Additional Requirements for Specific Determination Types

7.1.2.4 Quality Reporting Payment Reduction Decision

Identify the type of quality reporting payment program. **Also provide the original decision from CMS in which the payment reduction was identified (preliminary decision) and the final reconsideration decision on which the appeal is based.**[1]

The Board finds that this appeal does not meet the regulatory requirements for filing as the Provider failed to submit the final determination, dated October 4, 2024, on which the appeal is based, as required by 42 C.F.R. § 405.1835(b)(3) and the Board Rules. Without the final determination document, the Board is not able to determine whether the Provider has filed a jurisdictionally valid appeal.

The Board has determined that the Provider failed to meet the minimum filing requirements as set forth in 42 C.F.R. § 405.1835(b) and the Board Rules cited above. As a result, the Board hereby dismisses Case No. 25-4227, in its entirety, and removes it from its docket.

Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba Dubose, Esq.

FOR THE BOARD:

4/10/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Federal Specialized Services

[1] Emphasis added.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Blvd.
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Notice of Dismissal***
Bayfront Health Dade City, Prov. No. 10-0211, FYE 09/30/2016
Case No. 19-1827

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-1827. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Payment – Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 19-1827*

On **September 21, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2016. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **March 20, 2019**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

1. DSH Payment/SSI Percentage (Provider Specific)[1]
2. DSH/SSI Percentage (Systemic Errors)[2]
3. DSH Payment – SSI Fraction/Medicare Managed Care Part C Days[3]
4. DSH Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[4]
5. DSH Payment – Medicaid Eligible Days[5]
6. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days[6]

[1] The Board dismissed this issue on November 21, 2024.
[2] On October 22, 2019, this issue was transferred to Case No. 19-0173GC.
[3] On October 22, 2019, this issue was transferred to Case No. 19-0175GC.
[4] On October 22, 2019, this issue was transferred to Case No. 19-0198GC.
[5] On January 21, 2025, the Medicare Contractor filed a Motion to Dismiss over Issue 5.
[6] On October 22, 2019, this issue was transferred to Case No. 19-0159GC.

7. DSH Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[7]
8. Uncompensated Care ("UCC") Distribution Pool[8]
9. 2 Midnight Census IPPS Payment Reduction[9]

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **October 22, 2019**, the Provider transferred Issues 2, 3, 4, 6, 7, 8 and 9 to CHS CIRP groups.

As a result of the case transfers, there is one (1) remaining issue in this appeal: Issue 5 (the DSH – Medicaid Eligible Days).

On **May 3, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[10]

On **November 12, 2019**, the Provider timely filed its preliminary position paper. With respect to Issue 5, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days." As a result, the Provider included, as an Exhibit, the original "estimated impact" for this issue of $70,178 based on an *estimated* 150 days.

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[7] On October 22, 2019, this issue was transferred to Case No. 19-0197GC.
[8] On October 22, 2019, this issue was transferred to Case No. 19-0177GC.
[9] On October 22, 2019, this issue was transferred to Case No. 19-0185GC.
[10] (Emphasis added.)

On **March 5, 2020**, the Medicare Contractor filed its preliminary position paper. With regard to Issue 5, the Medicare Contractor's position paper noted that: (1) the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position; and (2) the Provider had failed to respond to any of the Medicare Contractor's requests for that Medicaid eligible days listing.

On **March 24, 2020**, the Medicare Contractor timely filed a Jurisdictional Challenge[11] with the Board over Issue 1 requesting that the Board dismiss these issues. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file until **July 22, 2024**.

On **January 18, 2023**, the Medicare Contractor filed its 3rd and Final Request for Medicaid Eligible Days documentation in connection with Issue 5. In their Preliminary Position Paper, the Medicare Contractor noted that, on August 9, 2019 (1st request) and on November 14, 2019 (2nd request), it had previously requested that the Provider send it a DSH package to resolve Issue 5. As no response was received, the Medicare Contractor formally filed the 3rd and Final Request for DSH Package to formally request that a listing of the Medicaid eligible days at issue plus supporting documentation be provided to the Medicare Contractor on or before February 17, 2023 (*i.e.*, within 30 days). Notwithstanding the formal request, the Provider failed to file any response to the Medicare Contractor.

On **November 20, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **November 22, 2023**, over 10 months after the deadline for responding to the 3rd and Final Request for the Medicaid Eligible Days documentation, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the *caveat* that the "Listing [is] *pending finalization* upon receipt of State eligibility data."[12] The Listing was 3.5 pages with roughly 384 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 384 days) was being submitted at this late date or why it was not final (*i.e.*, why it was "pending finalization") at this late date, ***more than 7 years after the fiscal year at issue had closed***. NOTE—the roughly 384 included in this belated listing is *substantially* larger than the original *estimated* impact of 150 days included with the appeal request.

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[11] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

[12] (Emphasis added.)

On **January 21, 2025**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to furnish documentation in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); (2) the Provider failed to furnish the Medicaid eligible days listing with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2; and (3) the Provider has effectively abandoned Issue 5. Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** timely respond to that Motion, submitting a response on **April 3, 2025**.

MAC's Contentions

The MAC provided additional background on the post-listing conferral between the parties:

> On December 6, 2023, the MAC and representatives with [QRS] held a conference call to discuss listings sent by QRS for several appeals. QRS confirmed that the lists were not final lists and that they do not know how the lists were developed. The MAC never received a refined list of Medicaid eligible days.[13]

The MAC went on to contend that the Provider failed to properly develop its arguments and requested the Board find:

a. That the Provider has failed to furnish documentation in support of its claim for addition Medicaid Eligible Days or describe why such documentation was and continues to be unavailable.
b. That the Provider has made affirmative statements in its appeal request and Preliminary Position Paper that the MAC excluded the Medicaid Eligible Days from the settled cost report yet supplied no evidence of such exclusion.
c. That the Provider's failure to furnish such documentation (or describe why such documentation is unavailable) is in violation of PRRB Rule 7, 25.2.1 and 25.2.2.
d. That the Provider has effectively abandoned its claim for additional Medicaid Eligible Days.
e. That the Provider's claim for additional Medicaid Eligible Days is therefore dismissed.
f. There are no other remaining issues in this appeal.[14]

Provider's Jurisdictional Response

The Board Rules require that responses to all motions must be filed within thirty (30) days of the filing.[15] The Provider failed to file a timely response to the Motion to Dismiss. Board Rule 44.3 specifies: "[u]nless the Board imposes a different deadline, an opposing party may send a

[13] MAC's Motion to Dismiss at ¶ 10 (Jan. 21, 2025).
[14] *Id*. at 5-6.
[15] Board Rule 44.3, v. 3.2 (Dec. 2023).

response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party." The April 3, 2025 Motion to Dismiss Response was untimely and will not be considered in the Board's decision.

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's remaining issue.

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal in either the initial appeal or the position paper.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Aug. 2018) states:

> **No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a**

> **timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[16]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Aug. 2018) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

> **Rule 25 Preliminary Position Papers**[17]
>
> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the following sub-sections.
>
> **25.1.1 The Provider's Position Paper**
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
> B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
> C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
> D. Provide a conclusion applying the material facts to the controlling authorities.

[16] (Bold emphasis added.)
[17] (Underline emphasis added to these excerpts and all other emphasis in original.)

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on May 3, 2019 included instructions on the content of the Provider's preliminary position paper consistent

with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 5, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[18]

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On November 12, 2019, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[19] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the

[18] (Emphasis added.)
[19] Provider's Preliminary Position Paper at 8 (Nov. 12, 2019).

"estimated impact" included with its appeal request (i.e., the estimated impact of $70,178 based on an estimated 150 days). The Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Motion to Dismiss, the Medicare Contractor asserts that the Provider has failed to submit a complete and final list of additional Medicaid eligible days and neglected to include all

supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Medicare Contractor sent three (3) separate requests for the Provider's list of Medicaid Eligible days (and also discussed the lack of the listing in the Medicare Contractor's own position paper filing). The first notice was sent to the Provider on August 9, 2019 and the second request was sent to the Provider on November 14, 2019. The third, final request was filed formally with the Board in OH CMDS on January 18, 2023, *over six years after the end of the Provider's cost reporting period*. The Medicare Contractor also informed the Provider in its final request for information that the deadline to respond was February 17, 2023. The Provider failed to file any response to the 3rd and final request.

However, on November 22, 2023 (9 months after the deadline to respond to the 3rd Request for a listing), QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the caveat that the "Listing [is] pending finalization upon receipt of State eligibility data." The Listing was 3.5 pages with roughly 384 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 384 days) was being submitted at this late date or why it was not final (*i.e.*, why it was "pending finalization") at this late date, ***more than 7 years after the fiscal year at issue had closed***. NOTE—the roughly 384 included in this belated listing is *significantly* larger than the original estimate of 150 days included with the appeal request. Regardless, this filing was more than 9 months past the deadline for responding to the 3rd Request for a listing *and, more importantly,* ***was roughly 4 years past the deadline for including it with its preliminary position paper*** since the position paper deadline was November 15, 2019.

On **January 21, 2025**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish the list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2 (or when request by the Medicare Contractor 3 separate times after that). The Medicare Contractor thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the regulations and the Board Rules.[20]

Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** timely respond to that Motion by the February 20, 2025 filing deadline (*i.e.*, 30 days after January 21, 2025). A late filing was received on April 3, 2025.

[20] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e*., the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

The fact that the Listing was filed merely 2 days after the Provider changed its designated representative to QRS does not excuse the Provider for its failure to include the information with its preliminary position paper or its failure to timely respond to the Motion to Dismiss. Board Rule 5.2 makes clear that "the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings." Moreover, the Board rejects the Provider's attempt to label the November 22, 2023 filing as a "Supplement to Position Paper" and does not accept that filing because:

1. The alleged "Supplement" was filed ***more than 4 years*** *after the deadline* for that exhibit to be included with its preliminary position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)). Indeed, the Provider failed to timely reply to the Medicare Contractor's 3rd Request for a Medicaid Eligible Days listing and the alleged "Supplement" was filed ***more than 9 months*** *after the deadline* for filing a response to the 3rd Request for a Medicaid Eligible Days listing.

2. The alleged "Supplement" fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the roughly 384 days was not previously available, *in whole or in part* (*i.e*., it is not clear why the Provider failed to identify a single day at issue until more than 4 years after this appeal was filed and more than 7 years after the fiscal year at issue had closed); and (c) why the listing still was ***not*** a "*final*" listing at this late date.

3. Neither the Board Rules nor the May 3, 2019 Case Acknowledgment and Critical Due Dates permit the Provider to file a "Supplement" to its preliminary position paper (nor did the Provider allege in the "Supplement" filing that they do).

4. Given the fact that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the position paper filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its preliminary position paper or a supplement of documents that were identified in the preliminary position paper as being unavailable consistent with Board Rule 25.2.2. However, neither the preliminary position paper nor the alleged "Supplement" identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the alleged "Supplement" cannot be

> considered a refinement of the position paper since no specific days or listing were included with the preliminary position paper (indeed the *tentative* 384 days listed in the alleged "Supplement" is, without explanation, *substantially* larger than the original estimated 150 days included with the appeal request).[21]

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[22] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provider the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[23]

* * * * *

Based on the foregoing, the Board has dismissed the remaining issue in this case – (Issue 5- DSH Payment – Medicaid Eligible Days). As no issues remain, the Board hereby closes Case No. 19-1827 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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[21] *See, e.g.,* Board Rule 27.3 (Aug. 2018) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."

[22] (Emphasis added.)

[23] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

4/10/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Blvd.
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410-786-2671

Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Notice of Dismissal***
Baylor Medical Center at Irving, Prov. No. 45-0079, FYE 06/30/2016
Case No. 19-2262

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-2262. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Medicaid Eligible Days.

Background

On **January 25, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2016. The Provider is commonly owned by Baylor Scott & White Health ("BS&W Health").

On **July 16, 2019**, BS&W Health filed the Provider's individual appeal request. The initial Individual Appeal Request contained ten (10) issues[1]:

1. DSH Payment/SSI Percentage (Provider Specific)[2]
2. DSH/SSI Percentage (Systemic Errors)[3]
3. DSH Payment – SSI Fraction/Medicare Managed Care Part C Days[4]
4. DSH Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[5]
5. DSH Payment – Medicaid Eligible Days

[1] The order and issue numbers below reflect how the issues were in the original appeal request submitted by the Provider. This differs from the sequential ordering of the issues in OH CDMS.
[2] This issue was withdrawn on January 26, 2025.
[3] On February 25, 2020, this issue was transferred to PRRB Case No. 19-2456GC.
[4] On February 25, 2020, this issue was transferred to PRRB Case No. 19-2457GC.
[5] On February 25, 2020, this issue was transferred to PRRB Case No. 19-2458GC.

6. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days[6]
7. DSH Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[7]
8. Uncompensated Care ("UCC") Distribution Pool[8]
9. 2 Midnight Census IPPS Payment Reduction[9]
10. Standardized Payment Amount[10]

As the Provider is commonly owned/controlled by BS&W Health, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **February 25, 2020**, the Provider transferred Issues 2, 3, 4, 6, 7, 9 and 10 to BS&W CIRP groups.

As a result of the case transfers, there is one (1) remaining issue in this appeal: Issue 5 (DSH Payment – Medicaid Eligible Days).

On **July 19, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[11]

On **March 11, 2020**, the Provider timely filed its preliminary position paper. With respect to Issue 5, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days." As a result, the

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[6] On February 25, 2020, this issue was transferred to PRRB Case No. 19-2459GC.
[7] On February 25, 2020, this issue was transferred to PRRB Case No. 19-2460GC.
[8] This issue was withdrawn on January 21, 2025.
[9] On February 25, 2020, this issue was transferred to PRRB Case No. 19-2760GC.
[10] On February 25, 2020, this issue was transferred to PRRB Case No. 19-2462GC.
[11] (Emphasis added.)

Provider included, as an Exhibit, the original "estimated impact" for this issue of $19,930 based on an *estimated* 50 days.

On **June 24, 2020**, the Medicare Contractor filed its preliminary position paper. With regard to Issue 5, the Medicare Contractor's position paper noted that the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position.

On **May 9, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **June 3, 2024**, the Board issued the Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

> Provider's Final Position Paper – *For each remaining issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *also include* ***any exhibits*** *the Provider will use to support to support its position*. *See* Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.[12]

On **October 21, 2024**, the Provider timely filed its final position paper. With respect to Issue 5, for the first time in the appeal, the Provider addresses section 1115 waiver days. Again, the Provider included, as an Exhibit,[13] the "estimated impact" for this issue of $19,930 based on an *estimated* 50 days.

On **November 15, 2024**, the Medicare Contractor timely filed its final position paper.

On **November 29, 2024**, QRS filed a "Redacted Medicaid Eligible Days Listing Submission." The Listing was 36 pages with roughly 5,660 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 5,660 days) was being submitted at this late date or whether it was final, at this late date, ***more than 8 years after the fiscal year at issue had closed***. NOTE—the roughly 5,660 included in this belated listing is *exponentially* larger than the original *estimated* impact of 50 days included with the appeal request.

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[12] (Emphasis added.)
[13] Ex. P-2.

On December 10, 2024, the Medicare Contractor filed a second Jurisdictional Challenge with the Board, supplementing their challenge over Issue 1 and additionally challenging Issue 5. The Provider filed a timely response on December 19, 2024.

MAC's Contentions

The MAC argues that the Medicaid Eligible Days issue should be dismissed because the Provider failed to file a complete preliminary and final position paper, including all exhibits, in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rules 25 and 27.[14]

Additionally, the MAC argues the Provider is improperly and untimely attempting to add the Section 1115 Waiver Days issue via its final position paper.[15]

Provider's Jurisdictional Response

The Provider argues that in their initial appeal request, they "appealed all Medicaid eligible days, including section 1115 waiver days".[16] The Provider points the appeal statement reads, in pertinent part:

> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, *including but not limited to* Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[17]

The Provider goes on to argue that Board Rules requiring components be appealed as separate issues does not apply here:

> Because Rule 8 purports to comply with what is in the regulations; and because the regulations deal with appealing issues, not "components" of issues, and because the regulations consider an "issue" to be a specific cost report adjustment, Rule 8's extension to "components" is not consistent with the regulations and is invalid because it is based on a false premise.
>
> Neither "section 1115 waiver days" nor even "Medicaid eligible days" are mentioned in Rule 8. Thus, even if Rule 8's extension to "components of issues" were valid (and the Provider contends it is not), the Provider had no notice that it was required to specify section 1115 waiver days in its appeal request, and it would be

[14] *Id*.
[15] *Id*.
[16] Jurisdictional Response at 3 (Dec. 19, 2024).
[17] *Id*. (Emphasis included).

> denial of due process for the PRRB to dismiss the section 1115 waiver days component of its appeal of Medicaid eligible days.
>
> The fact that the PRRB subsequently modified Rule 8 to mention specifically section 1115 waiver days indicates that the 2015 version of the PRRB's Rules did not contemplate that Plaintiff was required to include the magic language of "section 1115 waiver days" in its appeal request.[18]

The Provider also posits that the MAC's argument that the Provider did not brief the section 1115 waiver days in its Preliminary Position Paper is "not a jurisdictional argument and is inappropriate for a jurisdictional challenge."[19]

Analysis and Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

1. *Medicaid Eligible Days*

The Provider's appeal did not include a list of the specific additional Medicaid eligible days that are in dispute in either the initial appeal, the preliminary position paper, or the final position paper.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Aug. 2018) states:

> **7.3.2 No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper**

[18] *Id*. at 5.
[19] *Id*.

> **must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[20]

So, essentially, the regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal. Board Rule 25 (Aug. 2018) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

> **COMMENTARY**:
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

> **Rule 25 Preliminary Position Papers**[21]
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the following sub-sections.
>
> **25.1.1 The Provider's Position Paper**

[20] (Bold emphasis added.)
[21] (Underline emphasis added to these excerpts and all other emphasis in original.)

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

Parties should file with the Board a **complete** preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on July 19, 2019, included instructions on the content of the Provider's preliminary position paper consistent with the above-referenced Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 5, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[22]

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board

[22] (Emphasis added.)

procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

In their initial appeal request and repeated in the March 11, 2020 filing of their preliminary position paper, the Provider did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $19,930 based on an "at this time" estimated 50 days). The Provider's complete briefing of this issue in its preliminary position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specially, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decision were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996) *aff'g* 912 F.Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS" former HCFA) acquiesced in the above decisions and issue HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.

> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Jurisdictional Challenge and position paper, the Medicare Contractor asserts that the Provider has failed to submit a list of additional Medicaid eligible days and neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rules.

However, on November 29, 2024 (over one month after the final position paper deadline), QRS filed a "Redacted Medicaid Eligible Days Listing Submission." This listing included 5,660 days (significantly more than the initial estimate of 50 days, which was also included in the estimate sent merely a month prior) and did not include any estimate of reimbursement impact. QRS' filing did not explain why the listing of so many days was being submitted at this late date, ***more than 8 years after the fiscal year at issue had closed***. Additionally, the Provider did not explain why the 5,660 included in this belated listing is larger than the original estimate of 50 days included with the appeal request. Regardless, this filing ***was also more than a month past the deadline for including it with its final position paper*** since the position paper deadline was October 22, 2024.

The Medicare Contractor filed subsequently filed a Jurisdictional Challenge requesting dismissal of DSH Payment – Medicaid Eligible Days, as discussed above. The Medicare Contractor asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the regulations and the Board Rules.[23]

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

---

[23] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

The fact that the Listing was filed after the Provider changed its designated representative to QRS does not excuse the Provider for its failure to include the information with its preliminary position paper. Board Rule 5.2 makes clear that "the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings."

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[24] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provide the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board finds that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[25]

2. *Section 1115 Waiver Days*

The Board finds that the section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. The Provider failed to include section 1115 Waiver days as a cost issue in its appeal request and failed to timely and properly add this additional issue to the appeal. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the section 1115 Waiver days.

The appeal was filed with the Board in July of 2019 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing…must

[24] (Emphasis added.)

[25] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

> be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) how and why the provider believes Medicare payment must be determined differently for each disputed item…[26]

Board Rule 7.2.1 elaborated on this regulatory requirement instructing providers:

> The following information and supporting document must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
> - the adjustment, including the adjustment number,
> - the controlling authority,
> - why the adjustment is incorrect,
> - how the payment should be determined differently,
> - the reimbursement effect, and
> - the basis for jurisdiction before the Board.

Board Rule 8 explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include, but are not limited to:
> …
> - ***Section 1115 waiver days (program/waiver specific)***[27]

In the Provider's Jurisdictional Response, the Provider erroneously cites the 2015 version of

[26] 42 C.F.R. § 405.1835(b).
[27] (Bold and italic emphasis added).

PRRB Rules, and points out that they do not specifically name Section 1115 waiver days as a common example component issue.[28] The Instant Appeal was filed in July of 2019, and therefore, the Board Rules in effect is v. 2.0, effective August 29, 2018. As noted above, the Rules specifically mention Section 1115 waiver days.

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[29]

42 C.F.R. § 405.1835(e) provides in relevant part:

> (c) *Adding issues to the hearing request*. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
>
> . . .
>
> (2) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider added the section 1115 Waiver days to the case properly or timely.

In this regard, the Board notes that section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[30] Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program ***and*** not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction.[20] In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient

[28] Jurisdictional Response at 4.
[29] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[30] 65 FR 47054, 47087 (Aug. 1, 2000).

> days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act**.
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the section 1115 Waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The DSH Payment – Medicaid Eligible Days issue as stated in the original appeal request cannot be construed to include section 1115 Waiver days. Additionally, there is no indication that any 1115 waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Regardless, even if the Provider had included in its appeal request (which it did not), the Provider failed to properly develop the issue in its position paper filings. First, the Provider's preliminary position paper does not even mention § 1115 waiver days (much less even identify the specific 1115 waiver day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (2015). As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* § 1115 waiver days sub-issue.

Finally, even in the Provider's final position paper, the Provider fails to identify what § 1115

waiver program(s) are involved and whether or not the § 1115 waive days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the final position paper is perfunctory in that it only makes perfunctory conclusions.[31] Again, the Provider failed to so develop its position paper notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Nov. 2021) as applied via Board Rule 27.2.

The Board's finding that neither the appeal request nor final position paper met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[32] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[33] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[34] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[35] Here, the Board makes the same finding based on similarly *overly generalized language*.

* * * * *

In summary, the Board dismisses Issue 5. As no issues remain, the case is now closed. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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[31] For example, QRS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that "the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." However, QRS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is QRS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? QRS fails to brief the merits of its claims and fails to establish the Board's jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the final position paper references "uncompensated care pool."
[32] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[33] *Id*. at *11.
[34] *Id.*
[35] *Id.*

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

4/10/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Baltimore, MD 21244
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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Notice of Issue Dismissal***
Scott and White Medical Center – Temple (Provider Number 45-0054)
FYE: 08/31/2013
Case Number: 19-1979

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-1979. Set forth below is the decision of the Board to dismiss the Disproportionate Share Hospital ("DSH") Medicaid Eligible Days issue.

Background

A. *Procedural History for Case No. 19-1979*

On **November 21, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end August 31, 2013.

On **May 15, 2019**, the Provider filed an individual appeal request. The initial Individual Appeal Request contained eight (8) issues:

1. DSH Payment/SSI Percentage (Provider Specific)[1]
2. DSH/SSI Percentage[2]
3. DSH SSI Fraction/Medicare Managed Care Part C Days[3]
4. DSH SSI Fraction/Dual Eligible Days[4]
5. DSH Payment – Medicaid Eligible Days
6. DSH Medicaid Fraction/Medicare Managed Care Part C Days[5]
7. DSH Medicaid Fraction/Dual Eligible Days[6]
8. Standardized Amount[7]

[1] On January 3, 2025, the Provider withdrew this issue.
[2] On December 10, 2019, the Provider transferred the issue to PRRB Case No. 17-1532GC.
[3] On December 10, 2019, the Provider transferred the issue to PRRB Case No. 17-1533GC.
[4] On December 10, 2019, the Provider transferred the issue to PRRB Case No. 17-1535GC.
[5] On December 10, 2019, the Provider transferred the issue to PRRB Case No. 17-1534GC.
[6] On December 10, 2019, the Provider transferred the issue to PRRB Case No. 17-1536GC.
[7] On December 10, 2019, the Provider transferred the issue to PRRB Case No. 19-2455GC.

On **May 30, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates providing, among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[8]

On **January 7, 2020**, the Provider filed its Preliminary Position Paper ("PPP"). This PPP identified the same increase of 150 "additional Secondary Medicaid eligible Days" that was noted in the original appeal's calculation of the Amount in Controversy for the Medicaid Eligible Days issue.[9] The Medicare filed its Preliminary Position Paper on **April 28, 2020**.

On **April 24, 2020**, the Medicare Contractor filed a Jurisdictional Challenge over Issue 1, DSH-SSI Percentage (Provider Specific). The Provider filed a Jurisdictional Response on **May 12, 2020**.

On **May 9, 2023**, the Provider filed a Change of Representative request, and the Board acknowledged the request on **May 10, 2023.**

On **January 23, 2024**, the Provider filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission". The Listing was 81 pages with no total, but significantly more than 150 days, and no explanation about the new number of days or why the listing was being submitted at this late date.

On **June 3, 2024**, the Board issued the Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

> Provider's Final Position Paper – *For each remaining issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *also include* ***any exhibits*** *the Provider will use to support to support its position*. *See* Board Rule 27 for more specific content

[8] (Emphasis added.)
[9] Provider's PPP at Exhibit 2.

> requirements. If the Provider misses its due date, the Board will dismiss the case.[10]

On **November 7, 2024**, the Provider filed a Final Position Paper, and the Medicare Contractor filed its Final Position Paper on **December 2, 2024**.

On **December 2, 2024**, the Provider filed an additional "Redacted Medicaid Eligible Days Listing Submission". The Listing was 69 pages, again with no total, and with no explanation about the new number of days or why the listing was being submitted at this late date.

On **December 10, 2024**, the Provider filed a "Request for Expedited Decision on the Section 1115 Waiver Days Isse". QRS request the Board issue a final dismissal decision on the Section 1115 Waiver Days issue, so the Provider can pursue the dismissal in court.

On **December 23, 2024**, the Medicare Contractor filed a filed a superseding Jurisdictional Challenge with the Board over Issue 1, requesting that the Board dismiss this issue. Additionally, the Medicare Contractor filed a Jurisdictional Challenge over Issue 5. The Provider filed a timely Jurisdictional Response on **December 30, 2024**

As a result of the case transfers and a withdrawal, there is one remaining issue in this appeal: Issue 5 (DSH – Medicaid Eligible Days).

B. Description of Issue 5 in the Appeal Request

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the DSH calculation. The Provider describes Issue 5 as:

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after

[10] (Emphasis added.)

the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.

Audit Adjustment Number(s): 4, 5, 12, 48, 49, 55,S-D
Estimated Reimbursement Amount: $92,000[11]

MAC's Contentions

Issue 5 – DSH Payment – Medicaid Eligible Days

In its Jurisdictional Challenge, filed December 23, 2024, the MAC contends that the Provider failed to properly develop its arguments within its preliminary and final position papers in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25. The MAC argues the Provider has not submitted a Medicaid eligible days listing and therefore, requests the Board dismiss the issue.[12]

Additionally, the MAC contends the Provider is attempting to add the Section 1115 Waiver days issue improperly and untimely. The Section 1115 Waiver days were not part of the initial appeal request and untimely added via its Final Position Paper.[13]

Provider's Jurisdictional Response

The Provider contends that it timely filed an appeal which clearly indicated the Provider appealed all Medicaid Eligible days, including section 1115 waiver days. The Provider argues "[n]either 'section 1115 waiver days' nor even 'Medicaid eligible days' are mentioned in Rule 8…the Provider had no notice that it was required to specify section 1115 waiver days in its appeal request, and it would be a denial of due process for the PRRB to dismiss the section 1115 waiver days component of its appeal of Medicaid eligible days." [14]

The Provider maintains "the MAC is required by specific command of CMS to accept and audit the Provider's section 1115 waiver days. CMS has issued instructions that require the inclusion of section 1115 waiver days in providers' Medicaid Fractions."[15]

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

---

[11] Appeal Request at Issue 5.
[12] Medicare Contractor's Jurisdictional Challenge at 14 (Dec. 23, 2024).
[13] *Id.*
[14] Provider's Jurisdictional Response at 5 (Dec. 30, 2024).
[15] *Id.*

A. DSH Payment- Medicaid Eligible Days

1. *Failure to submit documentation to support Medicaid Eligible Days*

The Provider did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal in either the initial appeal or the position papers. The initial appeal identified 150 days in its Amount in Controversy calculation and the same amount was addressed in an Exhibit with the Preliminary Position Paper, filed in 2020. The first listing filed in the Board's OH CDMS system was a "redacted listing" filed as a supplement to the PPP 4 years after that PPP was filed. That redacted listing was not an auditable listing as it contained only a hospital account number, dates of service and a length of stay.[16] Indeed, the column headings for the "redacted" columns did not contain any information about the Medicaid eligibility of such claims identifying only the patient's name, social security number, gender, and date of birth.[17] The revised listing filed in December, 2024 suffered from the same deficiencies, containing the same fields. While the PPP indicated an unredacted listing was being filed with the Medicare Contractor, in 2020,[18] no listing has been produced as of December 23, 2024, according to the Medicare Contractor's Jurisdictional Challenge. The Provider argues that it "submitted a redacted listing on December 02, 2024, and an unredacted listing to the MAC."[19] The Board has no proof that an unredacted listing was sent, and the MAC says it has not received one. Further, as noted above, the field headings in the redacted listing do not provide any data related to Medicaid eligibility.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Aug. 2018) states, at 7.3.2:

> **No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) (2014) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits**

[16] Supplement to Position Paper/Redacted ME Days Listing at 1 (Jan. 23, 2024).
[17] *Id.*
[18] Provider's PPP at 10 (stating, "The Provider requests that the MAC review the Medicaid eligible days listing being dent [*sic*] under separate cover and provide a sample listing as soon as practicable.")
[19] Provider's Response to the Jurisdictional Challenge at 6 (Dec. 30, 2024).

> **of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[20]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Aug. 2018) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

> **Rule 25 Preliminary Position Papers**[21]
>
> **COMMENTARY**:
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the following sub-sections.
>
> **25.1.1 The Provider's Position Paper**
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
> B. For *each* issue that has not been fully resolved, state the

[20] (Bold emphasis added.)
[21] (Underline emphasis added to these excerpts and all other emphasis in original.)

material facts that support the provider's claim.

C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

* * *

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents
If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on May 30, 2019, included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 5, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) (2018) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[22]

Along the same line, 42 C.F.R. § 405.1871(a)(3) (2014) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) (2018) describes adequate cost information, as follows:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 (2018) permits dismissal or closure of a case on the Board's own motion:

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On January 7, 2020, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was "being sent under separate

[22] (Emphasis added.)

cover."[23] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $92,000 based on an estimated 150 days). The Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2013 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

[23] Provider's Preliminary Position Paper at 8.

At the time the PPP was filed, over six years had passed from the Provider's FYE, and no listing had been filed, just "a note [in the preliminary paper] indicating that it will be sent under separate cover."[24] On January 23, 2024, four years after the listing was required to be included in the preliminary paper, the Provider's new representative (representative changed in 2023) filed a "supplement to position paper/redacted ME days listing" with no explanation, but the attachment states "1115 waiver and Additional ME days consolidated". The 80-page listing does not "total" the days, but it includes thousands of days. Then, on November 7, 2024, the same representative files the "final position paper" on behalf of the provider, references the redacted listing uploaded on January 23, 2024 and still includes an exhibit P-2, which continues to reference 150 days in dispute.[25]

A month later on December 2, 2024, QRS filed a new document labeled "Redacted Medicaid Eligible Days Listing Submission". It also does not have a "total" of days, but only includes 68 pages of days, as compared to 80, and does not supply any explanation as to the differences between the two listings. Furthermore, QRS' filing did not explain why the listing of so many days was being submitted at this late date ***more than 11 years after the fiscal year at issue had closed***. Regardless, *and, more importantly,* this listing ***was almost 5 years past the deadline for including it with its preliminary position paper*** since the position paper deadline was January 10, 2020.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e*., the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled payment, consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

The change in the designated representative to QRS does not excuse the Provider for its failure to include the information with its preliminary position paper. Board Rule 5.2 makes clear that "the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings."

Moreover, the Board rejects the January 23, 2024, and December 2, 2024, filing because:

1. The listing was filed ***more than 4 years*** *after the deadline* for that exhibit to be included with its preliminary position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)).

2. The listing fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); (b) *why* the

[24] Medicare Contractor's Jurisdictional Challenge at 7 (Dec. 23, 2024).
[25] Provider's Final Position Paper at 10 (Nov. 7, 2024). *See also*, Exhibit P-2.

listing was not previously available, *in whole or in part* (*i.e.*, it is not clear why the Provider failed to identify a single day at issue until more than 4 years after this appeal was filed and more than 10 years after the fiscal year at issue had closed).

3. Neither the Board Rules nor the May 30, 2019, Case Acknowledgment and Critical Due Dates permit the Provider to file a supplement to its preliminary position paper (nor did the Provider allege in the listing filing that they do).

4. Given the fact that the *material* facts (*e.g.*, the days at issue) and all available exhibits were required to be part of the position paper filing, if the Board were to accept a supplemental listing, it would need to be either be a *refinement* of its preliminary position paper or a supplement of documents that were identified in the preliminary position paper as being unavailable, consistent with Board Rule 25.2.2. However, neither the preliminary position paper nor the listing filed identified any "unavailable" exhibits, consistent with Board Rule 25.2.2. Further, the listing cannot be considered a refinement of the position paper since no specific days or listing were included with the preliminary position paper.[26]

Finally, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[27] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provide the supporting documentation required by 42 C.F.R. § 412.106(b)(4)(iii)), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board finds that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable.[28]

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[26] *See, e.g.,* Board Rule 27.3 (Aug. 2018) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."

[27] (Emphasis added.)

[28] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a Request for a Board Hearing provide an explanation "for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2).
> The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge

2. *1115 Waiver Days*

The Board finds that the section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. The Provider failed to include section 1115 Waiver days as a cost issue in its appeal request and failed to timely and properly add this additional issue to the appeal. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the section 1115 Waiver days.

The appeal was filed with the Board in May of 2019 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing…must be submitted in writing in the manner prescribed by the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) how and why the provider believes Medicare payment must be determined differently for each disputed item…[29]

Board Rule 7.2.1[30] elaborated on this regulatory requirement instructing providers:

> The following information and supporting document must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
> - the adjustment, including the adjustment number,
> - the controlling authority,
> - why the adjustment is incorrect,
> - how the payment should be determined differently,
> - the reimbursement effect, and
> - the basis for jurisdiction before the PRRB.

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to a Disproportionate Share Hospital reimbursement. Board Rule 8.1A (2018) explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.1A.

[29] 42 C.F.R. § 405.1835(b).

[30] v. 2.0 (Aug. 2018).

Board Rule 8 (2018) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…" The Rule goes on:

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> - Common examples include: . . . ***Section 1115 waiver days (program/waiver specific)…***[31]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[32]

42 C.F.R. § 405.1835(e) (2018) provides in relevant part:

> (e) *Adding issues to the hearing request*. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
> . . .
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider added the section 1115 Waiver days to the case properly or timely.

In this regard, the Board notes that section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[33] Rather, these days relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program ***and*** not every inpatient day associated with beneficiaries enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2019) states in pertinent part:

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[31] (Bold and italic emphasis added).
[32] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[33] 65 FR 47054, 47087 (Aug. 1, 2000).

(4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

(iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the section 1115 Waiver days prior to the deadline to add issues, and because it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The DSH Medicaid Eligible Days issue, as stated in the original appeal request, cannot be construed to include section 1115 Waiver days. Additionally, there is no indication that any 1115 waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Regardless, even if the Provider had included 1115 waiver days in its appeal request (which it did not), the Provider failed to properly develop the issue in its position paper filings. First, the Provider's preliminary position paper does not even mention § 1115 waiver days (much less even identify the specific 1115 waiver day program(s) at issue), notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25. As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The

Provider's briefing fails to establish the merits of its position on the *alleged* § 1115 waiver days sub-issue.

Finally, even in the Provider's final position paper, the Provider fails to identify what § 1115 waiver program(s) are involved and whether or not the § 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the final position paper is insufficient in that it only makes perfunctory conclusions.[34] Again, the Provider failed to so develop its position paper, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25, as applied via Board Rule 27.2.

The Board's finding that neither the appeal request nor final position paper met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[35] In that case, the provider's issue was tied to improper calculation of the DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment."[36] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[37] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[38] Here, the Board makes the same finding based on similarly *overly generalized language*.

* * * *

Based on the foregoing, the Board dismisses the DSH-Medicaid Eligible Days Issue. As no issues remain, the Board hereby closes Case No. 19-1979 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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[34] For example, QRS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that "the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." However, QRS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is QRS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? QRS fails to brief the merits of its claims and fails to establish the Board's jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the final position paper references "uncompensated care pool."

[35] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

[36] *Id*. at *5.

[37] *Id.*

[38] *Id.*

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

4/11/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: Kevin D. Smith -A

cc: Michael Redmond, Novitas Solutions, Inc.
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Notice of Dismissal***
Scenic Mountain Medical Center, Prov. No. 45-0653, FYE 12/31/2016
Case No. 20-0435

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 20-0435. Set forth below is the decision of the Board to dismiss the one remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Payment for SSI Percentage (Provider Specific).

Background

A. *Procedural History for Case No. 20-0435*

On **May 10, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2016.

On **November 12, 2019**, the Board received the Provider's individual appeal request. The Individual Appeal Request contained five (5) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – Medicaid Eligible Days[2]
4. Uncompensated Care ("UCC") Distribution Pool[3]
5. 2 Midnight Census IPPS Payment Reduction[4]

On **December 3, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position

[1] On June 18, 2020, this issue was transferred to PRRB Case No. 19-1503GC.
[2] On April 2, 2025, the Provider withdrew this issue.
[3] On August 21, 2023, the Provider withdrew this issue.
[4] On June 18, 2020, this issue was transferred to PRRB Case No. 19-1504GC.

papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[5]

On **June 18, 2020**, the Provider transferred Issues 2 and 5 to Quorum groups because the Provider is commonly owned/controlled by Quorum Health (hereinafter "Quorum") and is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1).

On **July 2, 2020**, the Provider filed its preliminary position paper.

On **August 27, 2020**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1. The Provider did not file a response to the jurisdictional challenge.

On **October 22, 2020**, the Medicare Contractor filed its preliminary position paper.

On **August 18, 2023**, the Provider requested a Change of Representative to Quality Reimbursement Services, Inc.

On **August 26, 2024**, the Board issued a Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

> Provider's Final Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position*. *See* Board Rule 27 for more specific content requirements.[6]

On **April 2, 2025**, the Provider timely filed its final position paper.

B. Provider's Issue 1 in its Individual Appeal and the Provider's Participation in Case No. 19-1503GC

[5] (Emphasis added).
[6] (Emphasis added).

In its Individual Appeal Request, the Provider summarizes the legal basis for its Issue 1: DSH Payment/SSI Percentage (Provider Specific) as follows:

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's regulation.
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. § 1395 (d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment. [7]

Here, it is important to note that the amount in controversy listed for both Issues 1 (Provider Specific) and Issue 2 (Systemic Errors) in the Provider's individual appeal request is $10,405.

The Provider's ***complete*** position on Issue 1: DSH/SSI (Provider Specific) as set forth in its Preliminary Position Paper states in its entirety:

[7] Issue Statement at 1 (Nov. 12, 2019).

> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (December 31).
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV—94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its records with that of CMS, and identify patients believed to entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[8]

The following is the Provider's ***complete*** position on Issue 1 set forth in its Final Position Paper:

> **Calculation of the SSI Percentage**
>
> The Provider contends that the MAC's determination of Medicare Reimbursement for DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(S)(F)(i). The Provider contends that the SSI percentage calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Report was incorrectly computed because of the following reasons:
>
> **Issue #1: Provider Specific**
>
> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of

[8] Provider's Preliminary Position Paper at 8-9 (Jul. 2, 2020).

> the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-2).[9]

The DSH/SSI (Systemic Errors) group issue statement in Case No. 19-1503GC to which the Provider transferred Issue 2: DSH/SSI (Systemic Errors) reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,

[9] Provider's Final Position Paper at 7-8 (Apr. 2, 2025).

4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.

The statutory language defines the Medicare/SSI fraction as consisting solely of days for patients who were "entitled to benefits under part A" of Medicare. The numerator includes only those Part A days for patients who are also entitled to SSI benefits. The denominator of the Medicare/SSI fraction includes all Part A days. As set forth in the statutory language above, the numerator of the Medicaid fraction consists of days of patients who were both eligible for medical assistance under Title XIX, or Medicaid, and not entitled to benefits under Part A of Title XVIII, or Medicare. The denominator for the Medicaid fraction is the hospital's total patient days for the period.

CMS considers an individual to be "entitled to benefits under Part A" regardless of whether the days were "covered" or paid by Medicare. This means that now Part C days, Exhausted Benefit days, and Medicare Secondary Payor ("MSP") days are included in the denominator of the Medicare/SSI fraction even when there is no payment by Medicare, which is a departure from the treatment of these days as excluded from the Medicare/SSI fraction prior to the 2004 rule.

The Provider(s) also contend(s) that if CMS includes unpaid Medicare Part A days in the denominator of the Medicare/SSI fraction, then unpaid SSI eligible patient days must be included in the numerator of the Medicare/SSI fraction, utilizing SSI payment codes that reflect the individuals' eligibility for SSI – even if the individuals did not receive SSI payments, as a matter of statutory consistency. [10]

MAC's Jurisdictional Challenge

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)

The Medicare Contractor notes that according to the Provider's appeal request, Issue 1 has three components: 1) SSI data accuracy; 2) realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. [11]

[10] Group Issue Statement at 1-2 (Mar. 25, 2019).
[11] Medicare Contractor's jurisdictional challenge at 3 (Aug. 27, 2020).

The Medicare Contractor contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2 which was transferred to Group Case No. 19-1503GC, Quorum Health CY 2010 & CY 2016 DSH SSI Percentage CIRP Group. This means that the Provider is appealing an issue from a single final determination in more than one appeal, which is prohibited by Board Rule 4.6.1.[12]

The Medicare Contractor asserts that the Board does not have jurisdiction over the SSI realignment component. To date the Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. 412.106(b)(3). There was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies for this issue.[13]

Provider's Jurisdictional Response

Board Rule 44.4.3. specifies that "[p]roviders must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order" and "[f]ailure to respond will result in the Board making a jurisdictional determination with the information contained in the record."[14] The Provider did not file a response to the jurisdictional challenge.

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's one remaining issue.

A. DSH Payment/SSI Percentage (Provider Specific)

The jurisdictional analysis for Issue 1 has several relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period; and 3) the Provider

[12] Medicare Contractor's jurisdictional challenge at 3 and 6 (Aug. 27, 2020).
[13] Medicare Contractor's jurisdictional challenge at 3 and 6 (Aug. 27, 2020).
[14] Board Rule 44.4.3, v. 3.2 (Dec. 2023).

incorporating the arguments from *Advocate Christ*[15] into its appeal. As set forth below, the Board dismisses all aspects of Issue 1.

1. *First and Third Aspects of Issue 1*

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 19-1503GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[16] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[17] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[18]

The Provider's DSH SSI Percentage (Systemic Errors) issue in group Case No. 19-1503GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH SSI Percentage (Systemic Errors) in Case No. 19-1503GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6.1,[19] the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

Additionally, the Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[20] Accordingly, Provider's reference

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[15] The Provider has included the Appellants' Reply Brief in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214 (D.C. Cir.), which is on appeal from the decision in *Advocate Christ Med. Ctr. V. Azar*, 17-cv-1519 (TSC), 2022 WL 2064830, (D.D.C. June 8, 2022).
[16] Issue Statement at 1.
[17] Issue Statement at 1.
[18] Issue Statement at 1.
[19] PRRB Rules v. 3.2 (Dec. 2023).
[20] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 19-1503GC.

To this end, the Board also reviewed the Provider's Preliminary and Final Position Papers to see if they further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 19-1503GC but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary and Final Position Papers failed to comply with the Board Rules 25 and 27 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of the any alleged "errors" specific to Provider in its Preliminary or Final Position Papers and include *all* exhibits.

Moreover, the Board finds that the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[21]

Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 19-1503GC. The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's

[21] (Emphasis added).

request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[22]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[23]

Accordingly, the Board finds that the issue in the instant appeal and the group issue from Group Case 19-1503GC are the same issue.[24] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6.1, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

The third aspect of Issue No. 1 arises from the Provider's Final Position Paper where the Provider states, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of *Advocate Christ Medical Center, et al, v Xavier Becerra* [sic] (Appellants' reply brief included as Exhibit P-2)." The Board finds that this incorporation by reference does not comply with the regulatory and Board rule requirements to *fully* develop the Provider's position in the position papers. Particularly, 42 C.F.R. § 405.1853 provides in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments regarding the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), *and the merits of the provider's Medicare payment claims for each remaining issue*.[25]

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[22] Last accessed April 3, 2025.
[23] Emphasis added.
[24] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Quorum CIRP group per 42 C.F.R. § 405.1837(b)(1).
[25] (Emphasis added).

An incorporation of arguments by reference from a different case simply fails to do so. Accordingly, the Board dismisses that portion of the issue as well.

2. *Second Aspect of Issue 1*

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request[.]" Moreover, there is nothing in the record to indicate that a proper written realignment request was made by the Provider, and that the Medicare Contractor has made a final determination regarding DSH SSI Percentage *realignment* from which the Provider can appeal. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the issue.

Based on the foregoing, the Board dismisses the one remaining issue in this case – Issue 1: DSH/SSI (Provider Specific). As no issues remain, the Board hereby closes Case No. 20-0435 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

4/11/2025

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision – No Final Determination***
Custom Hospice, LLC (23-1638)
Appeal Period: 12/31/2023[1]
PRRB Case No.: 25-4148

Dear Mr. Estep and Ms. Van Arsdale:

The above-captioned appeal was filed with the Provider Reimbursement Review Board ("Board") via the Office of Hearings Case and Document Management System ("OH CDMS"). After review of the facts outlined below, the Board has determined that the appeal request was not filed in accordance with the Board Rules and regulations. The Board's review and determination is set forth below.

BACKGROUND:

On March 26, 2025, Calhoun Bhella and Sechrest LLP filed the above referenced appeal request on behalf of the Provider and identified that the sole issue in dispute was the 4% APU Reduction.

The Provider entered the final determination date as September 30, 2024. However, the support document uploaded as the final determination is the *Notice of Quality Reporting Program Decision Overturned* dated **October 13, 2023**. The Provider also uploaded, as the Audit Adjustment support document, a copy of the *Non-Compliance Notification that May Result in a 4% Reduction to Your FY 2025 Annual Payment Update for CCN 231638* dated July 1, 2024. This document provided instructions on how to file a reconsideration request. The Provider also included a copy of the reconsideration request, dated July 31, 2024, however the Provider did not include a copy of the reconsideration decision, purportedly dated September 30, 2024.

[1] The appeal period in OH CDMS is listed as 12/31/2023, however, based on the issue statement, it appears that the Provider is challenging the FY 2025 4% reduction.

BOARD DECISION:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the contractor's final determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 of receipt of the final determination.

42 C.F.R. § 405.1835(b) outlines the content requirements for a request for Board hearing from a final determination:

> (b) *Contents of request for a Board hearing on a final contractor determination*. The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing in the manner prescribed by the Board, and the request must include the elements described in paragraphs (b)(1) through (4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (2), or (3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.
>
> ***
>
> (3) A copy of the final contractor or Secretary determination under appeal. . .

The Board rules further reiterate the regulatory requirement to submit a copy of the final determination with the Provider's appeal request:

> **Board Rule 6.1 Initial Filing**
>
> **6.1.1 Request and Supporting Documentation** To file an individual appeal, the case representative must log onto OH CDMS and follow the prompts. Reference Rules 7 and 9 as well as Model Form A – Individual Appeal Request (Appendix A) for guidance on all required OH CDMS data fields and supporting documentation. **The Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b) or (d), as relevant.**
>
> ***
>
> **7.1 Final Determination**
>
> 7.1.1. **General Requirements**
>
> Identify the appealed period. This is typically the fiscal year end ("FYE") covered by the cost report but may include an alternative

> period such as a calendar year ending 12/31, a federal fiscal year ending 9/30, or another period for which you must identify the beginning and ending dates. If the period is something other than a traditional cost report FYE, you must identify the cost reporting periods affected by the determination. . .
>
> ***Include a copy of the final determination***, such as the NPR, revised NPR, exception determination letter, Federal Register notice, or **quality reporting payment reduction decision. Note that preliminary determinations are not appealable.** (*See* Rule 7.5 for appeals based on the lack of a timely issued determination.)
>
> Identify the date the final determination was issued. Ensure the appeal is filed timely based on the appeal period in Rule 4.3.
>
> **7.1.2 Additional Requirements for Specific Determination Types**
>
> **7.1.2.4 Quality Reporting Payment Reduction Decision**
>
> Identify the type of quality reporting payment program. **Also provide the original decision from CMS in which the payment reduction was identified (preliminary decision) and <u>the final reconsideration decision on which the appeal is based</u>.**[2]

The Board finds that this appeal does not meet the regulatory requirements for filing as the Provider failed to submit the final determination, dated September 30, 2024, on which the appeal is based, as required by 42 C.F.R. § 405.1835(b)(3) and the Board Rules. Without the final determination document, the Board is not able to determine whether the Provider has filed a jurisdictionally valid appeal.

The Board has determined that the Provider failed to meet the minimum filing requirements as set forth in 42 C.F.R. § 405.1835(b) and the Board Rules cited above. As a result, the Board hereby dismisses Case No. 25-4148, in its entirety, and removes it from its docket.

Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

<u>Board Members:</u>

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

FOR THE BOARD:

4/14/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

[2] Emphasis added.

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Mr. Thomas Meehan
Administrator
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Ms. Danelle Decker
Lead Auditor
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MP: INA 101-AF42
P.O. Box 6474
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RE: ***Board Decision***
Garden Care Center (33-5187)
Appealed Period: FFY 2025
PRRB Case No.: 25-4213

Dear Mr. Meehan and Ms. Decker:

The above-captioned appeal was filed with the Provider Reimbursement Review Board ("Board") via the Office of Hearings Case and Document Management System ("OH CDMS"). After review of the facts outlined below, the Board has determined that the appeal request was not filed in accordance with the Board Rules and regulations. The Board's review and determination is set forth below.

BACKGROUND:

On April 2, 2025, the Provider filed an appeal request regarding the Quality Reporting Program for FFY 2025. The Provider indicated that the appeal is based on a *Notice of Quality Reporting Program Noncompliance Decision Upheld* issued by the Medicare Contractor ("MAC") on October 4, 2024. The Board notes that the issue in dispute was identified as, "Appeal for NHSN ACCESS ISSUE".

Upon review of the appeal request, the Board notes that the Provider did not enter a controversy amount on OH CDMS nor did it submit any calculation support documents to indicate that the appeal met the $10,000 controversy amount threshold required to file an appeal.

BOARD DETERMINATION:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the contractor's final determination, the ***amount in controversy is $10,000 or more*** (or $50,000 for a group), and the request for a hearing is filed within 180 days of receipt of the final determination.

With respect to the regulatory amount in controversy requirement, Board Rule 6.4 (Dec. 2023) explains:

> An individual appeal request must have a total amount in controversy of at least $10,000 at the time of filing. *See* 42 C.F.R. §§ 405.1835 and 405.1839. A calculation of the amount in controversy with supporting documentation must be provided for ***each*** issue.

42 C.F.R. § 405.1835(b) outlines the content requirements for a request for Board hearing from a final determination:

> The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing in the manner prescribed by the Board, and the request must include the elements described in paragraphs (b)(1) through (4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (2), or (3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.

Board Rule 6.1.1 (Dec. 2023) provides additional information on what is required with an appeal request, and states:

> **Request and Supporting Documentation** To file an individual appeal, the case representative must log onto OH CDMS and follow the prompts. Reference Rules 7 and 9 as well as Model Form A – Individual Appeal Request (Appendix A) for guidance on all required OH CDMS data fields and supporting documentation. ***The Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b) or (d), as relevant.***

Here, the Provider include no information about the amount in controversy, and in fact indicated in the appeal request that it was $0 in OH CDMS. Further, the Provider did not support any documentation that would indicate or explain what the amount in controversy is for this appeal.

Thus, the Board finds that the appeal, as filed, is jurisdictionally deficient as it does not meet the amount in controversy requirement because the amount in controversy is $0, which is less than the requirement of $10,000 or more. Additionally, the Provider failed to meet the regulatory and Board Rule requirements for filing, as the Provider did not submit any documentation related to the amount in controversy and thus failed to meet the requirements of 42 C.F.R. § 405.1835(b). Therefore, the Board hereby ***dismisses*** Case No. 25-4213, in its entirety, and removes it from the Board's docket.

Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

FOR THE BOARD:

4/14/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
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RE: ***Notice of Dismissal***
Houston Methodist Sugar Land Hospital, Prov. No. 45-082, FYE 12/31/2015
Case No. 19-1956

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-1956. Set forth below is the decision of the Board to dismiss the Disproportionate Share Hospital ("DSH") Medicaid Eligible Days issue.

Background

A. *Procedural History for Case No. 19-1956*

On **November 29, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2015.

On **May 24, 2019**, the Provider filed an individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

1. DSH Payment/SSI Percentage (Provider Specific)[1]
2. DSH/SSI Percentage (systemic errors)[2]
3. DSH SSI Fraction/Medicare Managed Care Part C Days[3]
4. DSH SSI Fraction/Dual Eligible Days[4]
5. DSH Payment – Medicaid Eligible Days
6. DSH Medicaid Fraction/Medicare Managed Care Part C Days[5]
7. DSH Medicaid Fraction/Dual Eligible Days[6]
8. Standardized Amount[7]
9. Bad Debts[8]
10. DSH Payment-Medicaid Expansion Eligible Days[9]

[1] On December 27, 2024, the Provider withdrew this issue.
[2] On December 19, 2019, the Provider transferred this issue to PRRB Case No. 20-0068GC.
[3] On December 19, 2019, the Provider transferred this issue to PRRB Case No. 20-0069GC.
[4] On December 19, 2019, the Provider transferred this issue to PRRB Case No. 20-0070GC.
[5] On December 19, 2019, the Provider transferred this issue to PRRB Case No. 20-0071GC.
[6] On December 19, 2019, the Provider transferred this issue to PRRB Case No. 20-0072GC.
[7] On December 19, 2019, the Provider transferred this issue to PRRB Case No. 20-0073GC.
[8] On April 7, 2025, the Provider withdrew the bad debt issue.
[9] On December 19, 2019, the Provider transferred this issue to PRRB Case No. 19-2152GC.

On **May 29, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[10]

On **January 14, 2020**, the Provider filed its Preliminary Position Paper. The Medicare Contractor filed its Preliminary Position Paper on **May 11, 2020**.

On **April 13, 2021**, the Medicare Contractor filed a Jurisdictional Challenge over issues: 1. DSH- SSI Percentage (Provider Specific). The Provider filed a Jurisdictional Response on the same day.

On **June 3, 2024**, the Board issued the Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

> Provider's Final Position Paper – *For each remaining issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *also include* ***any exhibits*** *the Provider will use to support to support its position*. *See* Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.[11]

On **October 29, 2024**, the Provider filed a Final Position Paper, and the Medicare Contractor filed its Final Position Paper on **November 26, 2024**.

On **November 7, 2024**, the Medicare Contractor filed a superseding Jurisdictional Challenge with the Board over Issue 1. Additionally, the Medicare Contractor filed a Jurisdictional Challenge over issue 5. The Provider filed its Jurisdictional Response on **December 3, 2024**.

On **November 12, 2024**, the Provider filed a Change of Representative request, and the Board acknowledged the request on the same day.

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[10] (Emphasis added.)
[11] (Emphasis added.)

On **November 23, 2024**, the Provider filed a "Redacted Medicaid Eligible Days Listing" Submission. The Listing was 27 pages with no explanation about the new number of days or why the listing was being submitted at this late date.

As a result of the case transfers and withdraws, there is one remaining issue in this appeal: Issue 5 (DSH – Medicaid Eligible Days).

Description of Issue 5 in the Appeal Request

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations. The Provider describes Issue 5 as:

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> HMSLH is seeking reimbursement for an additional 155 Medicaid Eligible days. The Provider, in this appeal, contends that the documentation necessary to pursue DSH was not available from the State of Texas in time to include all DSH/Medicaid Eligible Days on the cost report.
>
> Audit Adjustment Number(s): 4, 7, 13, 15, 16
>
> Estimated Reimbursement Amount: $19, 913[12]

MAC's Contentions

Issue 5 – DSH Payment – Medicaid Eligible Days

[12] Appeal Request at Issue 5.

The MAC contends that the Provider failed to properly develop its arguments within its preliminary position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25. The MAC argues the Provider has not submitted a Medicaid eligible days listing and therefore, requests the Board dismiss the issue.

Additionally, the MAC contends the Provider is attempting to add the Section 1115 Waiver days issue improperly and untimely. The Section 1115 Waiver days were not part of the initial appeal request and untimely added via its Final Position Paper.

Provider's Jurisdictional Response

The Provider contends that it timely filed an appeal and clearly indicated the appeal to include all Medicaid Eligible days, including section 1115 waiver days, based on the following appeal statement "[t]he MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation."[13]

Further, the Provider argues neither "section 1115 waiver days nor even Medicaid eligible days are mentioned in Rule 8…the Provider had no notice that it was required to specify section 1115 waiver days in its appeal request, and it would be a denial of due process for the PRRB to dismiss the section 1115 waiver days component of its appeal of Medicaid eligible days." [14]

The Provider maintains "the MAC is required by specific command of CMS to accept and audit the Provider's section 1115 waiver days. CMS has issued instructions that require the inclusion of section 1115 waiver days in providers' Medicaid Fractions."[15]

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. DSH Payment- Medicaid Eligible Days

1. *Medicaid Eligible Days*

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal in either the initial appeal or the position papers.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Aug. 2018) states:

[13] Provider's Jurisdictional Response at 3.
[14] *Id* at 5.
[15] *Id*.

> **No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[16]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Aug. 2018) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

[16] (Bold emphasis added.)

Rule 25 Preliminary Position Papers[17]

> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 The Provider's Position Paper

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4.

Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents
If documents necessary to support your position are still unavailable, identify the missing documents, explain why the

[17] (Underline emphasis added to these excerpts and all other emphasis in original.)

> documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.
>
> **25.2.3 List of Exhibits**
>
> Parties must attach a list of the exhibits exchanged with the position paper.
>
> **25.3 Filing Requirements to the Board**
>
> Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.
>
> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on May 29, 2019, included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 5, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[18]

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

[18] (Emphasis added.)

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On January 14, 2020, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[19] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $19,913). The Provider's complete briefing of this issue in its position paper is as follows:

> **Statement of Facts:**
> HMSLH is a hospital with more than 100 beds and has disproportionate share percentage greater than 15%.
>
> **MAC Position:**
> The MAC has adjusted the DSH days in accordance with Medicare regulations.
>
> **HMSLH Position:**
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(S)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days,

[19] Provider's Preliminary Position Paper at 8.

unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.

HMSLH is seeking reimbursement for an additional 155 Medicaid Eligible days. The Provider, in this appeal, contends that the documentation necessary to pursue DSH was not available from the State of Texas in time to include all DSH/Medicaid Eligible Days on the cost report.

1. A Detailed Description Of The Process That The Provider Used To Identify And Accumulate The Actual Medicaid Paid And Unpaid Eligible Days That Were Reported And Filed On The Medicare Cost Report At Issue.

In summary, HMSLH matches its internal patient account details against the State Medicaid Eligibility file available at the time of preparing/filing costs to identify Medicaid eligible days.

During patient's registration process, patients' insurance (governmental and commercial) information is verified and recorded in the patients' account records. All patients were advised of the charity assistance policy, as well as potential Medicaid qualification. HMSLH also assists patients with Medicaid application when patients indicated interests.

HMSLH uses Meditech system ("Meditech") to accumulate all patient records, including but not limited to patient demographic information and medical record (admission date, discharge date, insurance, DRG, etc.). Meditech generates monthly and annual reports which show patient days/admissions in total as well as by insurance plan. An annual Meditech detailed data file is also generated to include detailed patient demographic information and medical records. The annual Meditech detailed data file is then validated against an annual Meditech summary report to ensure the completeness and accuracy of the detailed data file.
After validation, the detailed data file is then uploaded to a secure portal owned by Trinity, an outside service consultant, which then processes the data against the Medicaid Eligibility data file and returns a report of Medicaid eligible days to be included in the cost report DSH calculation (Trinity data matching). Trinity has access to multiple States' Medicaid records, and this allows HMSLH to identify as many days as possible by the time of cost report filing. In the case when Trinity does not have access to a specific State's Medicaid record, HMSLH will work with Trinity to apply for the access to the specific State's Medicaid record. This process may take several weeks.

As Medicaid Eligibility data file is a dynamic database and changes as new beneficiaries are added or current beneficiaries are dropped, HMSLH normally requests Trinity data matching close to the cost report filing deadline to capture as many eligible days as possible. For the 2015 cost report, the Trinity matching was done in April 2016. However, in spite of performing the eligibility process described, HMSLH was unable to include all eligible days in the cost report for various reasons outside of their control. For example, many patients have their Medicaid status pending and coverage was retroactively determined months or sometimes even years after the cost report was filed. There are numerous other reasons why a patient day cannot consistently be determined to be eligible by the filing date of the cost report. In any event, as already stated, it is beyond the Provider's ability to determine just why patient days or any particular patient day could not be matched by the State as eligible at one point in time (in this case, by the date of the cost report filing), but subsequently is matched as eligible by the State.
As noted above, practical impediments precluded the identification of all additional Medicaid Eligible Days. It is impossible for the Provider to claim all of its Medicaid Eligible Days at the time of filing its cost report.

2. The Number Of Additional Medicaid Paid And Unpaid Eligible Days That The Provider Is Requesting To Be Included In The DSH Calculation.

Medicaid Eligible Days results change over time. For this reason, providers generally prefer to prepare listings as close in time to a Hearing, Audit or Settlement as possible. Accordingly, the number expressed here may not be the number presented at hearing or settlement, but at this time the Provider is seeking to include an additional 155 Medicaid Eligible Days in its cost report.

3. A Detailed Explanation Why The Additional Medicaid Paid And Unpaid Eligible Days At Issue Could Not Be Verified By The State At The Time The Cost Report Was Filed.

Due to the limitation on Medicaid database, HMSLH/Trinity was unable to determine eligibility for several patients and; therefore, decided to exclude such patient days from the DSH calculation in originally filed cost report.

The most common circumstance in which the State of Texas Medicaid agency is unable to verify Medicaid eligible days involves the retroactive eligibility situation. An individual's eligibility for Medicaid commences on the date of her/his application to the program, assuming that individual meets the

> eligibility qualifications for Medicaid at the time of application submission. However, there is frequently considerable lag time between the date on which an individual submits her/his application for Medicaid, and the date on which that individual is determined to be eligible for the program. This lag time typically involves several months, and in some cases, several years. In this circumstance, the State of Texas Medicaid agency will not have the data to verify an individual's eligibility for Medicaid as of the date of the Provider's filing of its Medicare cost report. Of the additional 155 days, all days relate to the eligibility identified subsequent to cost report being filed but before cost report was finally settled.
>
> **CONCLUSION**
>
> The Provider contends that the Board does have jurisdiction as the protesting/presentment requirement does not apply. Furthermore, even should the Board determine that the presentment requirement does apply the Provider respectfully contends that it does not apply in this situation as DSH is not an item that must be adjusted or even claimed on a cost report, which is further supported by the reasons the Provider gave as to the availability of data at the time of the filing of the cost report. In addition, even if the Board finds the presentment requirement is applicable, the MAC adjusted the Provider's DSH percentage. Accordingly, the Provider contends that the requirements for dissatisfaction have been met. Finally, the Provider challenges the validity of Alert 10.

In its Jurisdictional Challenge, the Medicare Contractor asserts that the Provider has failed to submit a list of additional Medicaid eligible days and neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. They referenced 155 days in the Preliminary Position Paper but failed to provide a listing. The Provider then filed its Final Position paper on October 29, 2024, almost five years later, arguing there were 3,951 days in dispute. The listing provided speaks to "uninsured charges" which relate to section 1115 waiver days and not Medicaid Acute Paid days, as initially appealed.[20]

On November 23, 2024, QRS filed a "Redacted Medicaid Eligible Days Listing". QRS' filing did not explain why the listing of so many days was being submitted at this late date ***more than 8 years after the fiscal year at issue had closed***. Regardless, *and, more importantly,* ***was roughly 4 years past the deadline for including it with its preliminary position paper*** since the position paper deadline was January 19, 2020.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R.

[20] Medicare Contractor's Jurisdictional Challenge at 7-8.

§ 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

The fact that the Listing was filed merely 11 days after the Provider changed its designated representative to QRS does not excuse the Provider for its failure to include the information with its preliminary position paper or its failure to timely respond to the Motion to Dismiss. Board Rule 5.2 makes clear that "the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings." Moreover, the Board rejects the November 23, 2024, filing because:

1. The listing was filed ***more than 4 years*** *after the deadline* for that exhibit to be included with its preliminary position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)). Indeed, the Provider failed to timely reply to the Medicare Contractor's Jurisdictional Challenge Issue 5 and the listing was filed ***4 months*** *after the deadline* for filing a response to the Jurisdictional Challenge.

2. The listing fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); (b) *why* the listing was not previously available, *in whole or in part* (*i.e*., it is not clear why the Provider failed to identify a single day at issue until more than 4 years after this appeal was filed and more than 8 years after the fiscal year at issue had closed).

3. Neither the Board Rules nor the May 29, 2019, Case Acknowledgment and Critical Due Dates permit the Provider to file a supplement to its preliminary position paper (nor did the Provider allege in the listing filing that they do).

4. Given the fact that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the position paper filing, if the Board were to accept a supplemental listing, it would need to be either be a *refinement* of its preliminary position paper or a supplement of documents that were identified in the preliminary position paper as being unavailable consistent with Board Rule 25.2.2. However, neither the preliminary position paper nor the listing filed identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the listing cannot be considered a refinement of the position paper since no specific days or listing were included with the preliminary position paper.[21]

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[22] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provider the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under

[21] *See, e.g.,* Board Rule 27.3 (Aug. 2018) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."
[22] (Emphasis added.)

42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board finds that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[23]

Section 1115 Waiver Days

The Board finds that the section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. The Provider failed to include section 1115 Waiver days as a cost report issue in its appeal request and failed to timely and properly add this additional issue to the appeal. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the section 1115 Waiver days.

The appeal was filed with the Board in May of 2019 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) how and why the provider believes Medicare payment must be determined differently for each disputed item…[24]

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[23] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

[24] 42 C.F.R. § 405.1835(b).

Board Rule 7.2.1[25] elaborated on this regulatory requirement instructing providers:

> The following information and supporting document must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>   - the adjustment, including the adjustment number,
>   - the controlling authority,
>   - why the adjustment is incorrect,
>   - how the payment should be determined differently,
>   - the reimbursement effect, and
>   - the basis for jurisdiction before the PRRB.

Board Rule 8 explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include:
> …
> - ***Section 1115 waiver days (program/waiver specific)***[26]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[27]
42 C.F.R. § 405.1835(e) provides in relevant part:

> (c) *Adding issues to the hearing request*. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
> . . .
>
> (2) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider added the section 1115 Waiver days to the case properly or timely.

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[25] v. 2.0 (Aug. 2018).
[26] (Bold and italic emphasis added).
[27] *See* 73 Fed. Reg. 30190 (May 23, 2008).

In this regard, the Board notes that section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[28] Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program ***and*** not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction.[20] In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act**.
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the section 1115 Waiver days prior to the deadline to add issues, and it is a distinct issue, the Board should find that the issue was not properly or timely appealed. The DSH Medicaid Eligible Days issue as stated in the original appeal request cannot be construed to include section 1115 Waiver days. Additionally, there is no indication that any 1115 waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

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[28] 65 FR 47054, 47087 (Aug. 1, 2000).

Regardless, even if the Provider had included in its appeal request (which it did not), the Provider failed to properly develop the issue in its position paper filings. First, the Provider's preliminary position paper does not even mention § 1115 waiver days (much less even identify the specific 1115 waiver day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (2015). As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* § 1115 waiver days sub-issue.

Finally, even in the Provider's final position paper, the Provider fails to identify what § 1115 waiver program(s) are involved and whether or not the § 1115 waive days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the final position paper is perfunctory in that it only makes perfunctory conclusions.[29] Again, the Provider failed to so develop its position paper notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Nov. 2021) as applied via Board Rule 27.2.

The Board's finding that neither the appeal request nor final position paper met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[30] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[31] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[32] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[33] Here, the Board makes the same finding based on similarly *overly generalized language*

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[29] For example, QRS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that "the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." However, QRS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is QRS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? QRS fails to brief the merits of its claims and fails to establish the Board's jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the final position paper references "uncompensated care pool."

[30] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

[31] *Id*. at *11.

[32] *Id.*

[33] *Id.*

* * * *

Based on the foregoing, the Board dismisses the DSH- Medicaid Eligible Days Issue. The appeal is hereby closed. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

4/14/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Michael Redmond, Novitas Solutions, Inc.
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

Sue Liu, Director of Reimbursement
Corewell Health
26935 Northwestern Highway
Southfield, MI 48033

RE: ***Board Determination: Failure to Respond to Show Cause Order***
Beaumont Health CY 2020 SSI % CIRP Group
Case Number: 24-1294GC

Dear Ms. Liu:

The Provider Reimbursement Review Board ("Board") has reviewed the subject common issue related party ("CIRP") group appeal which the Board previously deemed to be complete and for which it issued a Show Cause Order. The pertinent facts regarding the group and the Board's determination are set forth below.

Pertinent Facts:

On **February 14**, **2024**, Beaumont Health (now known as Corewell Health) formed the "Beaumont Health CY 2020 SSI % CIRP Group" under Case No. 24-1294GC with three providers.

On **February 16, 2024**, the Board acknowledged the case in a Case Acknowledgement and Critical Due Dates notification ("ACDD") and set a deadline of **February 13, 2025** for the Representative to file "Comments Regarding Full Formation." The ACDD specified, "[t]he comments *must advise* the Board whether the group is complete, ***and if not***, *must specifically identify* which providers within the related party chain organization have not yet received a final determination for the appealed year. See Board Rule 19."[1]

On **March 20, 2025**, the Board issued a Scheduling Order in which it deemed the group to be fully formed and advised the Representative that it must show cause as to why the group should not be dismissed for failure to timely respond to the previous deadline. The Show Cause Order specified that

[1] The ACDD notification included the following dismissal warning:
"The parties are responsible for pursuing the appeal in accordance with the Board's Rules. The parties must meet the following due dates regardless of any outstanding jurisdictional challenges, motions, or subpoena requests. If the Group misses any of its due dates, the Board will dismiss the appeal. If the Medicare Contractor fails to meet its deadlines, the Board will take actions described under 42 C.F.R. § 405.1868."

"[f]ailure of the Group Representative to file its response" by a deadline of **April 4, 2025**, "will result in the Board taking remedial action and the case will be dismissed."[2]

To date, Corewell Health has ***not*** filed a response to the Board's March 20, 2025 Scheduling Order.

Board Determination:

Board Rule 4.4.2 states the following:

> *All filings* other than an appeal request or request to add issues (*e.g.*, position papers and other responsive documents) ***must*** *be received by the Board no later than the date specified on the Board's notice* or, if silent, the date specified in these Rules. ***If a party fails to file by the established due date***, ***the Board may take action as described in 42 C.F.R. § 405.1868***. For example, Rule 23.4 addresses the timely filing of preliminary position papers and specifies that the Board will dismiss the appeal if the representative for the provider(s) fails to file their preliminary position paper or PJSO by the established due date.[3]

Further, Board Rule 41.2 permits the Board to dismiss a case if it has a reasonable basis to believe that the issues have been fully settled or abandoned, or the group fails to comply with Board filing deadlines.[4]

In this case, the Board finds that the Group Representative has effectively abandoned the appeal through multiple failures to respond to Board requests: First, for comments regarding the group's full formation and second, for failure to submit comments showing cause as to why the group should not be dismissed for failure to timely respond. Consequently, the Board hereby dismisses Case No. 24-1294GC, pursuant to its authority under 42 C.F.R. § 405.1868.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

4/15/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: Kevin D. Smith -A

cc: Byron Lamprecht, WPS Government Health Administrators (J-8)
Wilson C. Leong, FSS

[2] Based on the group's deemed full formation, the Board issued the Group Completion Notice and Critical Due Dates notification setting preliminary position paper due dates on March 24, 2025.
[3] (Emphasis added.)
[4] Board Rule 41.2 Own Motion – The Board may dismiss a case or an issue on its own motion:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
- upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Notice of Dismissal***
Antelope Valley Hospital
Provider Number: 05-0056
Appealed Period: FYEs 06/30/2014
PRRB Case Number: 16-2425

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board" or "PRRB") received an individual appeal request from Antelope Valley Hospital ("Provider') on **September 2, 2016**. The initial request for hearing contained six (6) issues:

1. DSH Reimbursement – Medicaid Ratio: Dual Eligible Part A Days[1]
2. DSH Reimbursement – Medicaid Ratio: Medicare Part C Days[2]
3. DSH Reimbursement – Medicaid Ratio: Accuracy of State Data[3]
4. DSH Reimbursement – SSI Ratio: Medicare Part A Unpaid Days[4]
5. DSH Reimbursement – SSI Ratio: Medicare Part C Days[5]
6. DSH Reimbursement – SSI Ratio: Accuracy of Underlying Data

On **July 18, 2023**, the Provider's designated representative, Quality Reimbursement Services, Inc. ("QRS") requested to transfer Issue 6 to Case 23-1525G. The case was closed on **August 24, 2023**, because there were no remaining issues. On **September 23, 2024**, the Board issued a decision to ***deny*** the request to transfer Issue 6 to Case 23-1525G, finding that the Provider appealed a distinctly different issue in its original appeal than was being pursued in the group case. The Board found that the issue in Case 23-1525G relates to the exclusion of unpaid SSI days from the Medicare Fraction numerator, while the Provider is appealing the "Baystate[6]" aspect of the SSI Accuracy issue which involves SSI data matching and the potential errors in that process. Thus, the Board denied the transfer of Issue 6 to Case 23-1525G, and since Case 16-2425 had been closed, the Board reinstated it for the sole purpose of pursuing the appeal of the SSI Accuracy issue.

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[1] Expedited Judicial Review was granted for this issue on August 24, 2023.
[2] This issue was remanded to the Medicare Contractor pursuant to CMS Ruling 1739-R on August 7, 2023.
[3] This issue was withdrawn by the Provider on November 2, 2017.
[4] Expedited Judicial Review was granted for this issue on August 24, 2023.
[5] This issue was remanded to the Medicare Contractor pursuant to CMS Ruling 1739-R on August 7, 2023.
[6] *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

On **January 13, 2025**, the Board issued a Request for Information to the Provider. It noted that Issue 6 had been returned to Case 16-2425, but "[s]ince it was not addressed in the previously filed final position paper, it must now be briefed. ***File a supplemental final position paper briefing the SSI Accuracy issue by the deadline or it will be dismissed***."[7] The due date for Provider's Supplemental Position Paper was Friday, **February 14, 2025**.

QRS filed Provider's Supplemental Position Paper on Monday, **February 16, 2025**. It did not mention or attempt to illustrate good cause or otherwise justify the belated nature of the filing.

Failure to comply with a deadline established by the Board in an order can be found at 42 C.F.R. § 405.1868:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. **The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders** or for inappropriate conduct during proceedings in the appeal.
>
> (b) **If a provider fails to meet a filing deadline** or other requirement **established by the Board in a** rule or **order**, the Board may—
> (1) **Dismiss the appeal with prejudice;**
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
> (3) Take any other remedial action it considers appropriate.[8]

Board Rule 41.2 (2023) permits dismissal or closure of a case on the Board's own motion:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned,
- ***upon failure of the provider or group to comply with Board procedures or filing deadlines***,
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.[9]

[7] (Emphasis added.)
[8] (Emphasis added.)
[9] (Emphasis added.)

In the Board's January 14, 2025 Request for Information, it plainly stated that the Provider must "File a supplemental final position paper briefing the SSI Accuracy issue by the deadline or it will be dismissed." The Provider did not file its Supplemental Final Position Paper until after the Board's set deadline and did not even attempt to illustrate good cause for the belated filing. Based on the foregoing, the Board is exercising its discretion pursuant to 42 C.F.R. § 405.1868(b) and Board Rule 41.2 to dismiss Issue 6 (DSH Reimbursement – SSI Ratio: Accuracy of Underlying Data) with prejudice. Since this is the last issue in the case the Board will be removing it from its docket.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

4/15/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Esq., Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)

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Via Electronic Delivery

James Ravindran, President
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Dismissal of WellStar CY 1988 Medicare Fraction (SSI) – Statutory & Systemic Errors – GCE CIRP Group***
Case Number: 25-3080GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the "Board") has reviewed the appeal request in Case No. 25-3080GC. Set forth below is the decision of the Board to dismiss the above-captioned common issue related party ("CIRP") group's appeal. The pertinent facts and the Board's determination are set forth below.

Introduction:

On February 21, 2025, Quality Reimbursement Services, Inc. ("QRS") filed the "WellStar Health CY 1988 Medicare Fraction (SSI) – Statutory & Systemic Errors – GCE CIRP Group" under Case No. 25-3080GC in the Office of Hearings Case & Document Management System ("OH CDMS"). The Providers contend that the Medicare/SSI Fractions published on CMS' website on August 13, 2024, pursuant to CMS Transmittal 12785, were determined incorrectly due to the "inclusion of Medicare Part C days in the denominator of the Fraction and . . . exclusion of days from the numerator of the Medicare Fraction associated with individuals who were entitled to Supplemental Security Income ("SSI") during their hospital stay but who were not in SSI pay status during such stays, or were in SSI pay status during their hospital stay but were not assigned payment status code C01, M01 or M02."[1]

Within their Issue Statement, the Providers also request a good cause extension to file this appeal, alleging that the operations of their Provider Representative, Quality Reimbursement Services ("QRS"), faced disruption due to wildfires that occurred in January 2025, in the vicinity of its Arcadia, California location.[2] The group appeal was filed 192 days after the date of the issuance of the Transmittal which the Providers allege forms the basis for their appeals, thus, twelve days after the expiration of the 180-day time limit for filing such an appeal.

[1] Providers' Issue Statement at 1 (Feb. 21, 2025).
[2] *Id.*

Background:

A. Medicare DSH Payment and Realignment

Part A of the Medicare statute covers inpatient hospital services. Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system ("PPS").[3] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4]

The PPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[5] This case involves the hospital-specific disproportionate share hospital ("DSH") adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[6]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and the amount of the DSH payment to be paid to a qualifying hospital.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction."

This matter concerns the Medicare/SSI fraction.[10] The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), defines the Medicare/SSI fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter . . . .

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's

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[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*
[5] *See* 42 U.S.C. § 1395ww(d)(5).
[6] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[10] The other component of the DPP not at issue in this matter is the "Medicaid Fraction" which is the number of hospital patient days for patients eligible for medical assistance under a State Medicaid plan (*i.e.* a plan approved by the Secretary under 42 U.S.C. § 1396 *et* seq.) but who were not entitled to Medicare Part A, divided by the total number of hospital patient days. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). *See also* 42 C.F.R. § 412.106(b)(4).

eligibility for and, if eligible, the amount of any DSH payment adjustment.[11] CMS calculates the Medicare/SSI Fractions used to calculate Medicare DSH payments based on discharges in the respective federal fiscal year, but hospitals are permitted under 42 C.F.R. § 412.106(b)(3) to request that CMS recalculate, or "realign," their Medicare/SSI Fractions based on discharges in the hospital's cost reporting period.

B. Appeal of Publication of Medicare/SSI Fraction Data Pursuant to CMS Transmittal 12785

The Providers in this group state that they are appealing from the publication of Medicare/SSI Fractions on CMS' website on August 13, 2024, that was done pursuant to CMS Transmittal 12785, "Instructions for Processing Requests for SSI Realignment for Cost Reporting Periods Starting Before October 1, 2013." Transmittal 12785 replaced and updated Transmittal 12747 that was originally issued on July 26, 2024. The original Transmittal 12747 announced that CMS was resuming the processing of realignment requests for cost reporting periods starting before October 1, 2013. With realignment, hospitals are permitted under 42 C.F.R. § 412.106(b)(3) to request that CMS recalculate, or "realign," their Medicare/SSI Fractions based on discharges in the hospital's cost reporting period, rather than CMS' calculated Medicare/SSI Fractions based on discharges in the respective federal fiscal year.

The original Transmittal 12747 which Transmittal 12785 updates describes how CMS temporarily halted the processing of realignment requests for cost reporting periods starting before October 1, 2013, "due to a lack of policy established through notice-and-comment rulemaking regarding the treatment of Part C days for that period of time."[12] However, on June 9, 2023, CMS issued Final Rule CMS-1739-F, finalizing the treatment of Medicare Part C days in determining a hospital's DPP, whereby such days are to be included in the Medicare/SSI Fraction and excluded from the numerator of the Medicaid fraction. Both transmittals announce that with the issuance of final rule CMS-1739-F, and the publication of provider Medicare/SSI Fractions on the CMS website, the agency was resuming the processing of realignment requests for such cost reporting periods.

The original Transmittal 12747 states that the Medicare/SSI Fractions available on the CMS website for cost reporting periods starting before October 1, 2013, like the federal fiscal year Medicare/SSI Fractions for the same period, were determined pursuant to final rule CMS-1739-F. The transmittal directs MACs to use such fractions to determine DSH payments for realignment requests in appropriate cases. The Transmittal explains that for realignment requests for such cost reporting periods, "CMS will calculate cost reporting period SSI ratios for all periods, for all hospitals, and post those ratios to the CMS DSH website . . . ."[13] Both Transmittal 12785 and the earlier Transmittal 12747 which it updates are nearly identical and focused on the realignment process. The ***only*** change in Transmittal 12785 from the earlier Transmittal 12747 is addressing a formatting change "to update the DSH Adjustment and

[11] 42 C.F.R. § 412.106(b)(2)-(3).
[12] CMS Transmittal 12747 at 3 (July 26, 2024).
[13] *Id.*

Realignment files years 1988-2013, so that the SSI Ratio column is consistently rounded to four (4) decimals in all files. All other information remains the same."[14]

Board Determination:

In this case, the Providers maintain that CMS' publication of Medicare Fraction data on its website pursuant to Transmittal 12785 on August 13, 2024, "'constitutes a final determination of the Secretary as to the amount of the payment under subsection . . . (d) of section 1886' of the Social Security Act (the Act)" and because the Group "is dissatisfied with this determination . . . the PRRB should accept jurisdiction"[15] over the appeal. However, the publication of Medicare/SSI Fractions in conjunction with Transmittal 12785, which merely requires a formatting change to the Medicare/SSI Fraction data posted on CMS' website so that the "SSI Ratio column is consistently rounded to four (4) decimals in all files" is not a "final determination" from which a provider may appeal. As explained below, the Board dismisses this matter for lack of jurisdiction over the Providers' appeal.

The Medicare statute authorizes providers to seek hearings before the PRRB in two sets of circumstances: First, where the provider is dissatisfied with "the amount of total program reimbursement" as set forth in a Notice of Program Reimbursement ("NPR");[16] and second, where the provider is dissatisfied with a "final determination" "as to the amount of the payment" under the prospective payment system.[17] In this case, the Providers in these groups have not yet received NPRs and have based their appeals, pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(ii), on their dissatisfaction with Medicare/SSI Fraction data that was published on the CMS website in conjunction with Transmittal 12785.

The Providers, in their Issue Statement, acknowledge that the Board "has taken the position that publication of [Medicare/SSI Fraction data on CMS' website] is not a final determination."[18] But the Providers also note disagreement with the Board's position, citing *Battle Creek Health Sys. v. Becerra*,[19] and *Baylor All Saints Med. Ctr. v. Becerra*,[20] decisions where courts held that providers met the requirements for a Board appeal before receiving a final appealable determination as to the amount of DSH payment.[21]

For the Board, the court's decision in *Battle Creek* is inapposite because, unlike in the instant case, the challenged Transmittal and publication of data in that case was described by the court as being a "*fait accompli*."[22] The court in *Battle Creek* observed that the challenged Transmittal and publication of data there "provided, with some finality, 'advance knowledge of the amount of [the DSH] payment.'"[23] Yet, in the instant case, the publication of the challenged Transmittal

[14] CMS Transmittal 12785 at 1 (Aug. 13, 2024).
[15] Providers' Issue Statement at 1.
[16] 42 U.S.C. § 1395oo(a)(1)(A)(i).
[17] *Id*. § 1395oo(a)(1)(A)(ii).
[18] Providers' Issue Statement at 1.
[19] 2023 WL 7156125 (D.D.C. Oct. 31, 2023), *appeal docketed*, No. 23-5310 (D.C. Cir. Dec. 29, 2023).
[20] 2024 WL 3833278 (N.D. Tex. Aug. 15, 2024), *appeal docketed*, No. 24-10934 (5th Cir. Oct. 17, 2024).
[21] Providers' Issue Statement at 1-2.
[22] *Battle Creek,* 2023 WL 7156125 at *5.
[23] *Id.*

and accompanying Medicare/SSI Fraction data, provided by CMS for the purpose of informing provider choice as to whether to request realignment of the Medicare/SSI Fraction, does not definitively inform whether a provider qualifies for the DSH adjustment, much less the amount of DSH reimbursement that a provider could receive.

In recent Board decisions, the Board has continued to notice its disagreement with *Battle Creek* and by extension, other court decisions like *Baylor All Saints*.[24] The Board has maintained that *Memorial Hospital v. Becerra*[25] is a better-reasoned decision and provides a more thoughtful analysis. In *Memorial Hospital*, a group of providers filed an appeal similar to the Providers' appeals in this matter. The *Memorial Hospital* providers challenged CMS' publication of Medicare/SSI Fraction data, arguing that there are certain instances where a provider can file a Board appeal prior to receiving an NPR. The court in *Memorial Hospital* ultimately agreed with the Board that CMS' publication of Medicare/SSI Fractions was not an appealable final determination.

The court distilled the parties' positions as "boil[ing] down to a dispute about whether Plaintiffs have conflated a determination by the Secretary about one of several undetermined elements that eventually flows into the amount of payment and 'a final determination of the Secretary as to the amount of payment.'"[26] The court held that CMS' publication of Medicare/SSI Fractions, even if the publication of such fractions had been issued as "final," could and would not be a final determination "as to the amount of payment" because the Medicare/SSI Fractions are "just one of the variables that determines whether hospitals receive a DSH payment and, if so, for how much."[27] For the court, a challenge to an element of payment under 42 U.S.C. § 1395oo(a)(1)(A)(ii) is only appropriate if, as the D.C. Circuit has explained, "the Secretary ha[s] firmly established 'the only variable factor in the final determination as to the amount of payment under § 1395ww(d).'"[28]

Using the reasoning in *Memorial Hospital*, given the nature of the DSH adjustment, the publication of hospitals' Medicare/SSI Fractions on CMS' website is not a final determination as to the amount of payment due to any provider because the Medicare/SSI Fraction alone does not determine the amounts hospitals will be paid under the adjustment. Instead, the Medicare/SSI Fraction is incorporated, along with the Medicaid Fraction, into the DPP, which is ultimately the calculation that determines eligibility for and the amount of any DSH adjustment. The DPP must also exceed certain thresholds to qualify for any DSH adjustment.[29] Thus, although CMS calculates and publishes the Medicare/SSI Fraction for every hospital that receives Medicare reimbursement, the determination of whether a hospital receives reimbursement is made only after the hospital submits its year-end cost report.

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[24] *See, e.g.*, Board decisions in PRRB Case Nos. 24-0491, 24-1531GC, and 24-0413GC.
[25] 2022 WL 888190 (D.D.C. Mar. 25, 2022).
[26] *Id*. at *8.
[27] *Id*. at *9
[28] *Id*. at *8 (quoting *Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807, 811 (D.C. Cir. 2001) (quoting *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 147 (D.C. Cir. 1986)) (emphasis added); *see also Samaritan Health Serv. v. Sullivan*, 1990 WL 33141 at *3 (9th Cir. 1990) (unpublished table decision) ("We have held that if the Secretary's classification of a hospital effectively fixes the hospital's reimbursement rate, then that decision is a 'final determination' as referred to 42 U.S.C. § 1395oo(a)(1)(A)(ii).").
[29] 42 C.F.R. § 412.106(d)(2)(i)-(ii).

In this matter, the Providers contend that the Medicare/SSI Fractions published on CMS' website on August 13, 2024, pursuant to CMS transmittal 12785, were determined incorrectly due to the "inclusion of Medicare Part C days in the denominator of the Fraction" and . . . exclusion of days from the numerator of the Medicare Fraction associated with individuals who were entitled to [SSI] during their hospital stay but who were not in SSI pay status during such stays, or were in SSI pay status during their hospital stay but were not assigned payment status code C01, M01 or M02."[30] Transmittal 12785 bears no connection to the issue under appeal as the Transmittal merely implements a formatting change to the SSI Fraction data that was previously made available through the earlier Transmittal 12747 in order to ensure that the SSI Ratio column is consistently rounded to four decimals in all files. This information is published so that providers have sufficient information available to inform whether they want to request realignment. Providers cannot claim that with publication of Medicare/SSI Fraction data on CMS' website in a new decimal format pursuant to Transmittal 12785, they are somehow "dissatisfied with a final determination of Secretary as to the amount of payment."[31]

Neither the publication of the Medicare/SSI Fraction data, nor the decimal formatting change described in Transmittal 12785 informs whether a provider qualifies for the DSH adjustment, much less the amount of DSH reimbursement that a provider could receive. The Providers here have included no proof that they have requested realignment, nor even that with realignment they would be eligible for DSH reimbursement (changes in either the Medicare/SSI or Medicaid fractions could potentially result in a DPP below that required to qualify for the DSH adjustment). Moreover, appeal of Transmittal 12785, which only rounded the published Medicare/SSI Fraction data to four decimal places, concerns only one factor of the DPP and is almost certainly unlikely to result in a change in DSH reimbursement sufficient to meet the amount in controversy required for a group appeal ($50,000 or more).[32] That CMS is providing such information to inform a provider's choice as to whether to request realignment of the Medicare/SSI Fraction that will be calculated for use in determining the DPP that ultimately determines whether a provider qualifies for DSH and how much they could receive, clearly indicates that the publication of SSI Fraction data is not a final determination as to the amount of payment.

As the Medicare/SSI Fraction data published pursuant to Transmittal 12785 is not an appropriately appealable final determination, the untimeliness of the Provider's filings is not an issue. Although there is no need to address the Providers' request for a good cause extension, assuming *arguendo* that the Providers could persuade the Board that Transmittal 12785, and accompanying Medicare/SSI Fraction data, is a final appealable determination, the Board would have nevertheless denied the Providers' request for a good cause extension. In this case, the Provider's appeals were filed 192 days after the date of the issuance of the Transmittal and

[30] Providers' Issue Statement at 1. Although the Providers characterizes this as the "sole issue" under appeal, the issue statement appears to encompass two separate and distinct issues: 1) the inclusion of Medicare Part C days in the denominator of the Medicare/SSI Fraction; and 2) the exclusion of patient days for individuals eligible for both Medicare and SSI from the numerator of the Medicare/SSI Fraction. This conflation of issues is contrary to 42 C.F.R. § 405.1837(a)(2) which restricts a group appeal to a "single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." *See also* PRRB Rule 13.
[31] *See* 42 U.S.C. § 1395oo(a)(1)(A)(ii).
[32] *See* 42 U.S.C. § 1395oo(b); 42 C.F.R. § 405.1837(a)(3).

accompanying Medicare/SSI Fraction data which the Providers allege forms the basis for the appeal. The filing was twelve days past the expiration of the 180-day statutory time limit to file an appeal.

In the filing of the appeal for the Providers, QRS embeds in the issue statement a request for good cause extension of the filing deadline. This request argues that the Board's grant of an extension is warranted given the challenges that the Provider Representative, QRS, experienced because of wildfires that occurred in the vicinity of QRS' Arcadia, California location in January 2025. Specifically, the issue statement states, under the heading of "Jurisdiction":

> The operations of Quality Reimbursement Services (QRS) have faced significant disruption due to the recent California wildfires which have directly impacting QRS' ability to meet the appeal deadline. As a California-based firm tasked with filing appeals on behalf of hospitals, QRS experienced substantial operational challenges, including office closures, communication failures, and staff displacement, all of which were entirely beyond QRS' control. The main office of QRS is located in Arcadia, which was one of the areas most put in danger from the fires. Staff in the Arcadia office, as well as the President of QRS, were forced to evacuate both from the QRS office and their homes. QRS was able to complete some of its work and file some appeals timely, but was unable to file all appeals timely. Given the severe impact of the wildfires on QRS's ability to prepare and finalize all of appeal(s) timely, we respectfully request a good cause extension of the filing deadline under this regulation. Granting this exception would acknowledge the significant challenges caused by these natural disasters and uphold the principles of fairness inherent in the PRRB's Rules and the regulations.[33]

Regarding a good cause extension, the regulation at 42 C.F.R. § 405.1836(b) states in pertinent part:

> The Board may find good cause to extend the time limit **only if the provider demonstrates in writing it [could] not reasonably be expected to file timely due to extraordinary circumstances beyond its control** (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180-day limit specified in § 405.1835(a)(3). . . .[34]

In the present case, while the request for a good cause extension refers generally to the California wildfires, it fails to provide any specific "relevant information and documents 'demonstrat[ing] . . . [the provider] could not be expected to file timely due to extraordinary circumstances beyond

[33] Providers' Issue Statement at 1.
[34] (Bold Emphasis added).

its control.'"[35] There is a dearth of "relevant information" or "documents" accompanying the request; in fact, there are no documents accompanying the request, not even an official emergency declaration, news report, or map.

The Board notes that while QRS indicates that it "experienced substantial operational challenges, including office closures, communication failures, and staff displacement,"[36] it has provided no detail regarding the alleged operational challenges. The request is devoid of any information regarding how the QRS office was affected by the wildfires (e.g., building damage, power outages, access to the site). According to QRS' website, QRS' Arcadia, California location is only one of the company's seven offices, with six offices located in other states.[37] The request does not give the Board any information with regard to which employees – especially, the named case representative – were involved in the filing of this appeal, or in which locations they work or how the company's work was distributed among the company's offices. Through its silence, QRS asks the Board to assume that the employees involved in the filing of this appeal work at the Arcadia site but does not inform the Board how and when they were impacted (e.g., access to files, access to systems (internal or to the Board's OH CDMS), personal injury). QRS asks the Board to simply accept that all 7 offices and all employees across the country were equally affected by the wildfires in California and unable to timely file these appeals. QRS does not explain why no one in an office other than Arcadia could have filed the appeal or requested an extension while California-based employees were unavailable. Nor does QRS explain why it "was able to complete some of its work and file some appeals timely, but was unable to file all appeals timely."[38] The Board notes that the wildfires started January 7, 2025, a month before the ostensible deadline that is the subject of this decision (i.e., 180 days from the Aug. 13, 2024 date of Transmittal 12785). QRS should have been aware of this deadline.

In addition to the fact that the Board does not consider the transmittal to be an appealable final determination, the Board finds that QRS has not shown good cause for a filing extension. QRS has not provided sufficient information on which the Board can base a decision. Failure of the case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines.

Conclusion:

As the Medicare/SSI Fraction data published pursuant to Transmittal 12785 is not an appropriately appealable final determination, the Providers have failed to meet the jurisdictional requirements for a hearing and the Board dismisses the group appeal.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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[35] Board Rule 2.1.4 v. 3.2 (Dec. 15, 2023), *see also*, 42 C.F.R. § 405.1836(b).
[36] Providers' Issue Statement at 1.
[37] *See* https://qualityreimbursement.com/contact (last visited April 14, 2025).
[38] Providers' Issue Statement at 1.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

FOR THE BOARD:

4/15/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: Kevin D. Smith -A

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
MailStop B1-01-31
Baltimore, MD 21244 1850
410-786-2671

Via Electronic Delivery

James Ravindran, President
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Board Determination on Optional Group Formed with Single Provider***

QRS CY 2006 Part C Days Retroactive Final Rule Group
Case Number: 25-3066G

Specifically: Larkin Community Hospital (Provider Number 10-0181) FYE 12/31/2006 as a participant

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("the Board") has reviewed the subject optional group appeal and notes an impediment to the Board's jurisdiction in the group. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

On **February 20, 2025**, Quality Reimbursement Services, Inc. ("QRS") filed the referenced optional group for the calendar year ("CY") 2006. The group appeal was formed with one participant, Larkin Community Hospital (Prov. No. 10-0181) which was included as part of the group filing. The provider filed from receipt of its August 23, 2024 revised Notice of Program Reimbursement ("RNPR") and listed its reimbursement impact for the Part C Days Retroactive Final Rule issue at $244,725.

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

Pursuant to 42 C.F.R. § 405.1837(b),

> (2) Optional group appeals. (i) Two or more providers not under common ownership or control may bring a group appeal before the Board under this

> section, if the providers wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers. Alternatively, any provider may appeal to the Board any issues in a single provider appeal brought under §405.1835 of this subpart.

With regard to the establishment of groups in the Office of Hearings Case & Document Management System ("OH CDMS"), the commentary under Board Rule 12.1 indicates:

> . . . if a group is to be formed solely through transfers, it may initially be established in OH CDMS with no participating providers. In such cases, the providers must be transferred i***mmediately*** following the establishment of the group case in order to fulfill the regulatory requirement for the minimum number of providers per Rule 12.6. The Board will close all group cases that do not meet the minimum participant requirements.[1]

Board Rule 12.6.2, goes on to state that "[o]ptional group appeals must have a minimum of two different providers, both at inception and at full formation of the group."

The Board finds that the subject group appeal, under Case No. 25-3066G, is an optional group that was formed with only a single provider and is, therefore, not in compliance with Board Rules or the regulations.

Accordingly, the Board hereby:

1. Disbands the optional group, Case No. 25-3066G;
2. Creates a new individual appeal for Larkin Community Hospital (Prov. No. 10-0181) [2] (The Parties will receive an Acknowledgement and Critical Due Dates notification for the new case under separate cover);
3. Transfers the Part C Days Retroactive Final Rule issue from the group case to the new individual appeal; and
4. Closes Case No. 25-3066G as no participants remain.[3]

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Finally, the Board notes that QRS has filed many group appeals over the years. The improper formation of this optional group appears to be an attempt to cut corners by circumventing the need for QRS to *first* create an individual appeal for the originating provider until a second eligible participant is identified, and ***then*** form an optional group by effectuating the necessary transfers. As noted, this "*shortcut*" violates the Board's rules and creates an unnecessary

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[1] Board Rules v, 3.2 (Dec. 15, 2023).
[2] There was a previous individual appeal for Larkin Community Hospital (Prov. No. 10-0181) for CY 2006 under Case No. 13-1604, which the Board dismissed for lack of jurisdiction on November 18, 2020.
[3] Should QRS identify additional participants appealing this issue for CY 2007, it may form a new optional group and effectuate a transfer of Larkin Community Hospital from the individual appeal.

burden on the Board staff (***i.e.***, having to disband the group and create the individual appeal for the sole provider). As QRS is not new to the regulations governing appeals, nor is it new to the Board's Rules and procedures, the Board admonishes QRS for again failing to follow the Board Rules governing the formation of an optional group.

Board Members:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

4/16/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: Kevin D. Smith -A

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Geoff Pike, First Coast Service Options, Inc. c/o Guidewell Source (J-N)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Randall Gienko
Strategic Reimbursement Group, LLC
360 W. Butterfield Road, Suite 310
Elmhurst, IL 60126

RE: ***Notice of Dismissal***
Advocate Aurora Health CY 2015 Unmatched Medicaid Days CIRP Group
Case No. 20-0219GC

Dear Mr. Gienko:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 20-0219GC. Set forth below is the decision of the Board to dismiss the appeal challenging the Provider's Unmatched Medicaid Eligible Days.

Background

On **October 24, 2019**, Strategic Reimbursement Group, LLC ("SRG") filed request for a Group Appeal on behalf of Advocate Health, the parent organization for the providers in this appeal. The common issue for the participants in this appeal is Unmatched Medicaid Days. The group issue statement reads:

1. **Unmatched Medicaid Days (Unpaid Medicaid Eligible Days)**

   The provider contends that the Medicaid fraction of its Operating Disproportionate Share Hospital ["DSH"] and Capital [DSH] adjustment calculations (collectively "Calculations") has not been calculated in accordance with Medicare regulations and manual provisions as described in 42 CFR 412.106.

   The provider requests that patient days pertaining to additional patient stays that were not paid by Medicaid but related to patients who were eligible for medical assistance under a Medicaid-approved state plan during their stay ("Medicaid Eligible Days") be included in the Medicaid fraction of the Calculations. Based on prior experience with the Medicaid eligibility data compiled by state Medicaid agencies, the provider believes that the number of Medicaid Eligible Days in its Calculations may be materially understated. Among other causes, delays or errors in initial applications for Medicaid recipients can cause the eligibility data

> utilized in the Calculations to be inaccurate at the time the cost report is filed. The provider seeks to ensure a more accurate count of Medicaid Eligible Days is used to determine the proper amount of DSH reimbursement due to the provider. Based on historical industry experience the provider has estimated the amount of appealed reimbursement to be 2% of eligible DSH days, the reimbursement impact is detailed in the attached calculations.

On **October 11, 2021**, SRG notified the Board that the Group was Fully Formed.

On **October 22, 2021**, the Board issued the CIRP Group Fully Formed and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Group Representative regarding the content of its preliminary position paper:

> Group's Preliminary Position Paper – The position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[1]

On **March 31, 2022**, SRG timely filed the Group's preliminary position paper. The Group suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "Alert 10 requests certain detailed information pursuant to the "Danbury Decision", as such please see Exhibit P-4 for each hospital's additional Medicaid days listing containing the days that were incorrectly omitted from the original filing." However, no such exhibit was submitted and the exhibit list states that Exhibit P-4 will be sent under separate cover.

On **July 27, 2022**, the Medicare Contractor filed its preliminary position paper. The Medicare Contractor's position paper noted that in the Group's preliminary position paper the Providers' mentioned the listing would be included under Exhibit P-4 but Exhibit P-4 limited to the Exhibit list nor were they sent to the Medicare Contractor under separate cover.

As no response was received from the Provider, on **March 11, 2025**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the

[1] (Emphasis added.)

Provider failed to comply with Board procedures or filing deadlines under the authority of PRRB Rule 41.2 (Nov. 2021) and 42 C.F.R. § 405.1868(b); (2) the Group has failed to furnish documentation in support of its claim for additional Medicaid Eligible Days or described why such documentation was and continues to be unavailable; (3) the Group has made affirmative statements in both its Preliminary/Final Position Paper[2] that it was developing eligible days listing; and (4) the Group has effectively abandoned its claim for additional Medicaid Eligible Days. Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** timely respond to that Motion.

MAC's Contentions

The MAC contends that the Providers failed to comply with Board procedures or filing deadlines under the authority of the Board Rule 41.2 and 42 C.F.R. § 405.1868(b) and failed to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable.[3] To that end, the Group Representative asserted they were sending the listings for the Medicaid Eligible Days for the providers in the Group under separate cover but never sent these listings.[4] The Group Representative also never responded to two requests (Nov. 5, 2024 and Jan. 6, 2025) from the MAC for the listing of days.[5] The MAC argues the Group has abandoned its claim and therefore, the case should be dismissed.[6]

Provider's Jurisdictional Response

The Group's response to the Motion to Dismiss was due within 30 days but the Group Representative failed to timely file a response. In this regard, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

[2] Note: A final position paper is an optional filing and the Group did not make one.
[3] Motion to Dismiss at 4-5 (Mar. 11, 2025).
[4] *Id*. at 5.
[5] Ex. C-1.
[6] Motion to Dismiss at 5.

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider states Issue 3 as:

> **1. Unmatched Medicaid Days (Unpaid Medicaid Eligible Days)**
>
> The provider contends that the Medicaid fraction of its Operating Disproportionate Share Hospital ["DSH"] and Capital [DSH] adjustment calculations (collectively "Calculations") has not been calculated in accordance with Medicare regulations and manual provisions as described in 42 CFR 412.106.
>
> The provider requests that patient days pertaining to additional patient stays that were not paid by Medicaid but related to patients who were eligible for medical assistance under a Medicaid-approved state plan during their stay ("Medicaid Eligible Days") be included in the Medicaid fraction of the Calculations. Based on prior experience with the Medicaid eligibility data compiled by state Medicaid agencies, the provider believes that the number of Medicaid Eligible Days in its Calculations may be materially understated. Among other causes, delays or errors in initial applications for Medicaid recipients can cause the eligibility data utilized in the Calculations to be inaccurate at the time the cost report is filed. The provider seeks to ensure a more accurate count of Medicaid Eligible Days is used to determine the proper amount of DSH reimbursement due to the provider. Based on historical industry experience the provider has estimated the amount of appealed reimbursement to be 2% of eligible DSH days, the reimbursement impact is detailed in the attached calculations.

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days that affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii), which places the burden of production on the provider states in pertinent part:

> The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the

> data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Furthermore, 42 C.F.R. § 405.1853(b) addresses position papers and specifies in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[7]

Similarly, with regard to position papers,[8] Board Rule 25.2.1 (Nov. 2021) requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[9] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, ***promptly*** forward them to the Board and the opposing party.[10]

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

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[7] (Emphasis added).
[8] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[9] (Emphasis added).
[10] (Emphasis added).

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
- upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868);
- if the Board is unable to contact the provider or representative at the last known address; or
- upon failure to appear for a scheduled hearing.

Relative to a Medicaid Eligible Days determination, it is well-established that adequate data to prove eligibility for each Medicaid patient day claimed is a complete and accurate (i.e., auditable) Medicaid eligible days listing, which upon timely submission by a provider, a MAC can examine to make applicable adjustments.

This appeal was initiated on October 24, 2019 (over 5 years ago), and at that time, the Providers did not include a list of additional Medicaid eligible days they expect to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Group's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[11] ***To-date, no listing has been provided—even after the MAC requested the listing on two (2) occasions***. Accordingly, the Provider has abandoned the issue by failing to properly develop its arguments and provide supporting documents, and by failing to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[12] Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.

* * * * *

Based on the foregoing, the Board has dismissed the group appeal. The Board hereby closes Case No. 20-0219GC and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

[11] Group's Preliminary Position Paper, Exhibit List.
[12] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

4/16/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Pamela VanArsdale, National Government Services, Inc. (J-6)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
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RE: ***Notice of Dismissal***
Baylor University Medical Center, Prov. No. 45-0021, FYE 06/30/2015
Case No. 20-0224

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 20-0224. Set forth below is the decision of the Board to dismiss the 2 remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) and Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 20-0224*

On **April 4, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2015. The Provider is commonly owned by Baylor Scott & White Health ("BS&W Health").

On **October 4, 2019**, BS&W Health filed the Provider's individual appeal request. The initial Individual Appeal Request contained ten (10) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – SSI Fraction/Medicare Managed Care Part C Days[2]
4. DSH Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[3]
5. DSH Payment – Medicaid Eligible Days
6. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days[4]

[1] On April 23, 2020, this issue was transferred to Case No. 18-1276GC.
[2] On April 23, 2020, this issue was transferred to Case No. 18-1279GC.
[3] On April 23, 2020, this issue was transferred to Case No. 18-1281GC.
[4] On April 23, 2020, this issue was transferred to Case No. 18-1277GC.

7. DSH Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[5]
8. Uncompensated Care ("UCC") Distribution Pool[6]
9. 2 Midnight Census IPPS Payment Reduction[7]
10. Standardized Payment Amount[8]

As the Provider is commonly owned/controlled by BS&W Health, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **April 23, 2020**, the Provider transferred Issues 2, 3, 4, 6, 7, 8, 9 and 10 to BS&W Health CIRP groups.

As a result of the case transfers, there are two (2) remaining issues in this appeal: Issue 1 (the DSH Payment/SSI Percentage (Provider Specific)) and Issue 5 (the DSH Payment – Medicaid Eligible Days).

On **October 24, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[9]

On **May 27, 2020**, the Provider timely filed its preliminary position paper. With respect to Issue 5, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2015 cost report does not reflect an accurate number of Medicaid eligible days." As a result, the

[5] On April 23, 2020, this issue was transferred to Case No. 18-1280GC.
[6] On April 23, 2020, this issue was transferred to Case No. 18-1282GC.
[7] On April 23, 2020, this issue was transferred to Case No. 18-1275GC.
[8] On April 23, 2020, this issue was transferred to Case No. 19-1717GC.
[9] (Emphasis added.)

Provider included, as an Exhibit, the original "estimated impact" for this issue of $67,598 based on an *estimated* 150 days.

On **September 24, 2020**, the Medicare Contractor timely filed its preliminary position paper.

On **March 22, 2021**, the Medicare Contractor filed a Jurisdictional Challenge[10] with the Board over Issue 1 requesting that the Board dismiss this issue. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **May 9, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **September 6, 2024**, the Board issued the Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

> Provider's Final Position Paper – *For each remaining issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *also include* ***any exhibits*** *the Provider will use to support to support its position*. *See* Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.[11]

On **December 5, 2024**, QRS filed a "Redacted Medicaid Eligible Days Listing Submission". The Listing was 82 pages with roughly 15,389 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 15,389 days) was being submitted at this late date, ***more than 9 years after the fiscal year at issue had closed***. NOTE—the roughly 15,389 days included in this belated listing is *exponentially* larger than the original *estimated* impact of 150

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[10] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

[11] (Emphasis added.)

days included with the appeal request. In addition, for the first time in the appeal, the Provider addresses section 1115 waiver days.

On **January 31, 2024**, the MAC filed its second Jurisdictional Challenge in this case requesting the dismissal of Issue 1 and 5 (superseding the Mar. 2021 request to dismiss Issue 1). Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **February 17, 2025**, the Provider timely filed its final position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-1276GC – QRS BSWH 2015 DSH SSI Percentage CIRP Group

In their Individual Appeal Request, the Provider summarizes its DSH Payment/SSI Percentage (Provider Specific) issue, in part, as follows:

> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).[12]

The Group issue Statement in Case No. 18-1276GC, to which the Provider transferred Issue No. 2, reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

[12] Issue Statement at 1 (Oct. 4, 2019).

Statement of the Legal Basis

The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

The Providers challenge their SSI percentages based on the following reasons:

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.[13]

On May 27, 2020, the Board received the Provider's preliminary position paper in 20-0224. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Provider Specific

The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation based on the Provider's Fiscal Year End (June 30).

The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.

Similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services,* No. CV-94-0055 (C.D. Cal June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS. *See* 65 Fed. Reg.

[13] Group Appeal Issue Statement in Case No. 18-1276GC.

> 50,548 (2000). Upon release of the completed MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008).[14]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $271,000.

MAC's Contentions

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2. The portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[15]

The MAC also argues that Issue 1 should be dismissed because the Provider failed brief the realignment sub-issue in their position and paper and failed to file a complete preliminary position paper.[16]

Issue 5 – DSH Payment – Medicaid Eligible Days

The MAC contends that the Provider failed to properly develop its arguments within its preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rule 25. The MAC argues the Provider's redacted listing, submitted on December 4, 2024, was deficient in submitting accurate and sufficient data.[17]

Additionally, the MAC contends the Provider is attempting to add the Section 1115 Waiver days issue improperly and untimely. The Section 1115 Waiver days were not part of the initial appeal request and untimely added via its December 4, 2024 redacted listing.

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[14] Provider's Preliminary Position Paper at 8-9 (May 27, 2020).
[15] Medicare Contractor's Jurisdictional Challenge at 7 (Jan. 31, 2025).
[16] *Id*. at 6-10.
[17] *Id*. at 15.

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[18] The Provider did not *timely* respond to the Jurisdictional Challenge, therefore the Board will not consider the response in this decision.

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's two (2) remaining issues.

A. DSH Payment/SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage; and (2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Case No. 18-1276GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[19] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[20] The Provider argues in its issue statement, which was included in the appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[21]

[18] Board Rule 44.4.3, v. 3.2 (Dec. 2023).
[19] Issue Statement at 1.
[20] *Id.*
[21] *Id.*

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 18-1276GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 20-0224 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 18-1276GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[22], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[23] Accordingly, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 18-1276GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 18-1276GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records" but fails to explain how it can, explain how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2.[24] Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Aug. 29, 2018), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

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[22] PRRB Rules v. 2.0 (Aug. 2018).

[23] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

[24] It is also not clear whether this is a systemic issue for BS&W Health providers in the same state subject to the CIRP rules or something that is provider specific because, if it was a common systemic issue, it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[25]

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[26]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[27]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not

[25] (Empasis added).
[26] Last accessed April 15, 2025.
[27] (Emphasis added).

explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 18-1276GC.

Accordingly, *based on the record before it*,[28] the Board finds that the SSI Provider Specific issue in Case No. 20-0224 and the group issue from the CHS CIRP group under Case No. 18-1276GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

Additionally, in its Final Position Paper, the Provider states, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra [sic] (Appellants' reply brief included as Exhibit P-3)."[29] The Board finds that this incorporation by reference does not comply with the regulatory and Board rule requirements to *fully* develop the Provider's position in the Final Position Paper. Particularly, 42 C.F.R. § 405.1853 provides in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[30]

An incorporation of arguments by reference from a different case simply fails to do so. Accordingly, the Board dismisses that portion of the issue as well.

2. *Second Aspect of Issue 1*

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue - the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Moreover, without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for Board appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI

[28] Again, the Board notes that the Provider failed to respond to the Jurisdictional Challenge and the Board must make its determination based on the record before it.
[29] Provider's Final Position Paper at 8-9 (Feb. 17, 2025).
[30] (Emphasis added).

Percentage realignment. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal in either the initial appeal or the position papers.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Aug. 2018) states:

> **No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[31]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Aug. 2018) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

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[31] (Bold emphasis added.)

Rule 25 Preliminary Position Papers[32]

> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 The Provider's Position Paper

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

[32] (Emphasis added).

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on October 24, 2019 included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 5, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this

> paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[33]

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On May 27, 2020, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[34] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $67,598 based on an estimated 150 days). The Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.

[33] (Emphasis added.)
[34] Provider's Preliminary Position Paper at 8.

> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2015 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

On December 4, 2024, QRS filed a "Redacted Medicaid Eligible Days Listing Submission". The Listing was 82 pages with roughly 15,389 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 15,389 days) was being submitted at this late date, ***more than 9 years after the fiscal year at issue had closed***. NOTE—the roughly 15,389 included in this belated listing is *exponentially* larger than the original estimate of 150 days included with the appeal request. Regardless, this filing was ***was roughly 4.5 years past the deadline for including it with its preliminary position paper*** since the position paper deadline was May 31, 2020.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e*., the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R.

§ 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[35] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provider the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[36]

C. 1115 Waiver Days

The Board finds that the section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. The Provider failed to include section 1115 Waiver days as a cost issue in its appeal request and failed to timely and properly add this additional issue to the appeal. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the section 1115 Waiver days.

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[35] (Emphasis added.)

[36] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

The appeal was filed with the Board in October of 2019 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[37]

Board Rule 7.2.1 (2018) elaborated on this regulatory requirement, instructing providers:

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>   - the adjustment, including the adjustment number,
>   - the controlling authority,
>   - why the adjustment is incorrect,
>   - how the payment should be determined differently,
>   - the reimbursement effect, and
>   - the basis for jurisdiction before the [Board].

Board Rule 8 (2018) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**

[37] 42 C.F.R. § 405.1835(b).

> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[38]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[39]

42 C.F.R. § 405.1835(e) provides in relevant part:

> (e) Adding issues to the hearing request. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
> . . .
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider added the section 1115 Waiver days to the case properly or timely.

In this regard, the Board notes that section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[40] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program and not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2019) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

[38] (Bold and italic emphasis added).
[39] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[40] 65 FR 47054, 47087 (Aug. 1, 2000).

> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the Section 1115 Waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The DSH Medicaid Eligible Days issue as stated in the original appeal request cannot be construed to include Section 1115 Waiver days. Additionally, there is no indication that any 1115 waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Based on the foregoing, the Board has dismissed the two (2) remaining issues in this case – (Issues 1 and 5). As no issues remain, the Board hereby closes Case No. 20-0224 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

4/16/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

Mr. Raymond Esteves
Executive Director
Saint Joseph of the Pines
103 Gossman Drive
Southern Pines, NC 28387

RE: **Determination re: Timely Filing of Appeal**
Saint Joseph of the Pines (34-5044)
Appealed Period: FFY 2025
PRRB Case No.: 25-4305

Dear Mr. Esteves:

The above-captioned appeal was filed with the Provider Reimbursement Review Board ("Board") via the Office of Hearings Case and Document Management System ("OH CDMS"). After review of the facts outlined below, the Board has determined that the appeal request was not filed in accordance with the Board Rules and regulations. The Board's review and determination is set forth below.

BACKGROUND:

On April 16, 2025, the Provider filed an appeal request for Federal Fiscal Year End ("FFY") 2025. The proceedings for the appeal indicate that the Provider is filing the appeal based on a **Notice of Quality Reporting Program Noncompliance Decision Upheld** dated October 4, 2024. There is only one (1) issue being disputed, 2% Reduction of the annual payment.

As set forth below, the Board has determined that the subject appeal request was untimely filed since it was filed on the 194th day past the final determination date of October 4, 2024.

RULES/REGULATIONS:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the contractor's final determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and ***the request for a hearing is filed within 180 days of receipt of the final determination***.

Board Rule 4.4.1. states: **Due Dates for New Appeals** New appeals must be received by the Board *no later than 180 days* from the commencement of the appeal period as specified in Rule 4.3. See Rule 2.1.4 for instructions on requesting an extension under 42 C.F.R. § 405.1836 "due to extraordinary circumstance beyond [the party's] control."

Board Rule 4.4.3 states: **Due Date Exceptions** If the due date falls on a Saturday, a Sunday, a federal legal holiday, (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the Board is unable to conduct business in the usual manner (e.g., "if OH CDMS were down for the entire last day of a deadline" (85 Fed. Reg. 58432, 58987 (Sept. 18, 2020))), the deadline becomes the next day that is not one of the aforementioned days. See 42 C.F.R. § 405.1801(d)(3).

Board Rule 4.5 states: **Date of Receipt by the Board** The timeliness of a filing is determined based on the date of receipt by the Board. The date of receipt is presumed to be: A. The date of filing in OH CDMS as evidenced by the Confirmation of Correspondence generated by the system; or B. If the filing is permitted pursuant to an exemption under Rule 2.1.2, the date of receipt is: • The date of delivery to the Board as evidenced by the courier's tracking bill for documents transmitted by a nationally recognized next-day courier. It is the responsibility of the provider to maintain a record of the delivery. See 42 C.F.R. § 405.1801(a)(2)(i). • The date stamped "received" by the Board on documents submitted by regular mail, hand delivery, or couriers not recognized as a national next-day courier. This provision also applies if the party is unable to supply the next-day courier's tracking bill as noted above. See 42 C.F.R. § 405.1801(a)(2)(ii).

Per PRRB Rule 6.1, the Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b). (Emphasis added.)

BOARD DETERMINATION:

As noted in the facts above, the final determination support document states that the subject appeal is based on a **Notice of Quality Reporting Program Noncompliance Decision Upheld** dated October 4, 2024. Allowing for the 180-day appeal period and a five-day presumption for mailing, the 185th day fell on Monday, April 7, 2025. The date of delivery to the Board, as evidenced by the Confirmation of Correspondence generated by OH CDMS, is April 16, 2025. The subject appeal request was filed 194 days past the final determination date of October 4, 2024 and was, therefore, untimely filed.

As a result, the Board hereby dismisses case number 25-4305, in its entirety, since it failed to meet the minimum filing requirements pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 and Board Rules 4.4.1, 4.4.3 and 4.4.5.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

FOR THE BOARD:

4/18/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Federal Specialized Services
Dana Johnson, National Government Services, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Blvd.
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Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Notice of Dismissal***
Bayfront Health Punta Gorda, Prov. No. 10-0047, FYE 09/30/2018
Case No. 22-1470

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-1470. Set forth below is the decision of the Board to dismiss the 2 remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) and Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 22-1470*

On **March 31, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2018. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **September 20, 2022**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained seven (7) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Unduly Narrow Definition of SSI Entitlement[1]
3. DSH Payment – Medicaid Eligible Days
4. DSH Payment – Dual Eligible Days (DE) – SSI Fraction[2]
5. DSH Payment – SSI Fraction/Medicare Managed Care Part C Days[3]
6. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days[4]
7. DSH Payment – SSI/Medicaid Fraction – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[5]

[1] On April 26, 2023, this issue was transferred to Case No. 21-1206GC.
[2] On April 26, 2023, this issue was transferred to Case No. 21-0066GC.
[3] On April 26, 2023, this issue was transferred to Case No. 20-2149GC.
[4] On April 26, 2023, this issue was transferred to Case No. 20-2149GC.
[5] On April 26, 2023, this issue was transferred to Case No. 21-0066GC.

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **April 26, 2023**, the Provider transferred Issues 2, 4, 5, 6 and 7 to CHS CIRP groups.

As a result of the case transfers, there are two (2) remaining issues in this appeal: Issue 1 (the DSH – SSI Percentage Provider Specific) and Issue 3 (the DSH – Medicaid Eligible Days).

On **September 20, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates,[6] providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[7]

On **May 10, 2023**, the Provider timely filed its preliminary position paper. With respect to Issue 3, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2018 cost report does not reflect an accurate number of Medicaid eligible days." As a result, the Provider included, as an Exhibit, the original "estimated impact" for this issue of $36,503 based on an *estimated* 50 days.

On **July 3, 2023**, the Medicare Contractor filed a Request for Medicaid Eligible Day Listing in connection with Issue 3. The Medicare Contractor made the filing to formally request that a listing of the Medicaid eligible days at issue plus supporting documentation be provided to the Medicare Contractor within 45 days. Notwithstanding the formal request, the Provider failed to file any response to the Medicare Contractor.

On **August 14, 2023**, the Medicare Contractor timely filed a Jurisdictional Challenge[8] with the Board over Issues 1 and 3 requesting that the Board dismiss these issues. Pursuant to Board Rule

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[6] An updated Critical Due Dates notice was sent on Mar. 9, 2023.
[7] (Emphasis added.)
[8] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in

44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, a response was not received until **June 6, 2024**, well beyond the deadline for a response.

On **August 16, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **August 24, 2023**, the Medicare Contractor timely filed its preliminary position paper. With regard to Issue 3, the Medicare Contractor's position paper noted that: (1) the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position; and (2) the Provider had failed to respond to the Medicare Contractor's request for their Medicaid eligible days listing.

On **November 20, 2023**, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the *caveat* that the "Listing [is] *pending finalization* upon receipt of State eligibility data."[9] The Listing was over 6 pages with roughly 846 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 846 days) was being submitted at this late date or why it was not final (*i.e*., why it was "pending finalization") at this late date, ***more than 5 years after the fiscal year at issue had closed***. NOTE—the roughly 846 included in this belated listing is *exponentially* larger than the original *estimated* impact of 50 days included with the appeal request.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 21-1206GC - CHS CY 2018 DSH SSI Percentage CIRP Group

In their Individual Appeal Request, the Provider summarizes its DSH Payment/SSI Percentage (Provider Specific) issue as follows:

> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that

Sebelius v. Auburn Reg. Med. Ctr., 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

[9] (Emphasis added.)

> CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).[10]

The Group issue Statement in Case No. 21-1206GC, to which the Provider transferred Issue No. 2, reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[11]

On May 10, 2023, the Board received the Provider's preliminary position paper in 22-1470. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its SSI percentage published by [CMS} was incorrectly computed because CMS failed to include all

[10] Issue Statement at 1 (Sept. 20, 2022).
[11] Group Appeal Issue Statement in Case No. 21-1206GC.

> patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[12]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $30,977.

MAC's Contentions

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2. The portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment, the appeal is premature as the Provider has not exhausted all available remedies, and the fiscal year end is already in alignment with the Federal Fiscal Year.[13]

Finally, the MAC asserts that the Provider did not file a complete preliminary position paper, and therefore violated Board Rule 25 and 42 C.F.R. § 405.1853.

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC contends that the Provider failed to properly develop its arguments within its preliminary position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25.

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[12] Provider's Preliminary Position Paper at 10 (May 10, 2023).
[13] Medicare Contractor's Jurisdictional Challenge at 7 (Aug. 14, 2023)

The MAC argues the Provider has not submitted a Medicaid eligible days listing and therefore, requests the Board dismiss the issue.

Additionally, the MAC contends the Provider is attempting to add the Section 1115 Waiver days issue improperly and untimely. The Section 1115 Waiver days were not part of the initial appeal request and untimely added via its Preliminary Position Paper.

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[14] The Provider failed to file a timely response, submitting their response nearly nine (9) months after the deadline to respond. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's two (2) remaining issues.

A. DSH Payment/SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage; and (2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Case No. 21-1206GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[15] Per

[14] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[15] Issue Statement at 1.

the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[16] The Provider argues in its issue statement, which was included in the appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[17]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 21-1206GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 22-1470 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 21-1206GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[18], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[19] Accordingly, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 21-1206GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 21-1206GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records" but fails to explain how it can, explain how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2.[20] Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (Nov.

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[16] *Id.*
[17] *Id.*
[18] PRRB Rules v. 3.1 (Nov. 2021).
[19] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[20] It is also not clear whether this is a systemic issue for CHS providers in the same state subject to the CIRP rules or something that is provider specific because, if it was a common systemic issue, it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

1, 2021) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Nov. 1, 2021), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents (Nov. 1, 2021)**
>
> If documents necessary to support your position are still unavailable, then provider the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.[21]

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[22]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[23]

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[21] (Italics and underline emphasis added.)
[22] Last accessed Oct. 15, 2024.
[23] (Emphasis added).

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 21-1206GC.

Accordingly, *based on the record before it*,[24] the Board finds that the SSI Provider Specific issue in Case No. 22-1470 and the group issue from the CHS CIRP group under Case No. 21-1206GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

Additionally, in its Preliminary Position Paper, the Provider states, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra [sic] (Appellants' reply brief included as Exhibit P-3)." The Board finds that this incorporation by reference does not comply with the regulatory and Board rule requirements to *fully* develop the Provider's position in the Preliminary Position Paper. Particularly, 42 C.F.R. § 405.1853 provides in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[25]

An incorporation of arguments by reference from a different case simply fails to do so. Accordingly, the Board dismisses that portion of the issue as well.

2. *Second Aspect of Issue 1*

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue - the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Moreover, the Provider's cost reporting period is already aligned with the Federal fiscal year end. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

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[24] Again, the Board notes that the Provider failed to respond to the Jurisdictional Challenge and the Board must make its determination based on the record before it.
[25] (Emphasis added).

B. DSH Payment – Medicaid Eligible Days

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal in either the initial appeal or the position paper.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Nov. 2021) states:

> **No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[26]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Nov. 2021) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

[26] (Bold emphasis added.)

Rule 25 Preliminary Position Papers[27]

> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will issue a notice setting deadlines for the first position paper generally at eight months after filing the appeal request for the provider, and twelve months for the Medicare contractor. Even though it will not be addressed in the Board's notice, the provider may file an *optional* response no later than ninety days following the due date for the Medicare contractor's preliminary position paper. Therefore, the Board requires preliminary position papers to present the ***fully*** developed positions of the parties and expects that parties will be diligent in planning and conducting any required investigation, discovery, and analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the applicable sub-section.

25.1.1 Provider's Position Paper

The provider's preliminary position paper must:

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
B. For ***each*** issue that has not been fully resolved, provide a ***fully*** developed narrative that:
    - States the material facts that support the provider's claim.
    - Identifies the controlling authority (*e.g.*, statutes, regulations, policy, or case law) supporting the provider's position.
    - Provides a conclusion applying the material facts to the controlling authorities.
C. Comply with Rule 25.2 addressing Exhibits.

. . .

[27] (Underline emphasis added to these excerpts and all other emphasis in original.)

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, then provider the following information in the position papers:

1. Identify the missing documents;
2. Explain why the documents remain unavailable;
3. State the efforts made to obtain the documents; and
4. Explain when the documents will be available.

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

The Board requires the parties file a ***complete*** preliminary position paper that includes a fully developed narrative (Rule 25.1), all exhibits (Rule 25.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn.

> **COMMENTARY**: Note that the change to require filing of the ***complete*** preliminary position paper was effective on August 29, 2018. Accordingly, failure to file a ***complete*** preliminary position paper with the Board will result in the Board dismissing your appeal or taking other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on September 20, 2022 included instructions on the content of the Provider's preliminary position

paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[28]

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On May 10, 2023, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[29] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $36,503 based

[28] (Emphasis added.)
[29] Provider's Preliminary Position Paper at 9.

on an estimated 50 days). The Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's [or Providers'] Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's [or Providers'] Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).

> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its 2018 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Jurisdictional Challenge, the Medicare Contractor asserts that the Provider has failed to submit a list of additional Medicaid eligible days and neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Medicare Contractor sent a request for the Provider's list of Medicaid Eligible days (and also discussed the lack of the listing in the Medicare Contractor's own position paper filing). The notice was sent to the Provider on July 3, 2023, nearly *five years after the end of the Provider's cost reporting period*. The Medicare Contractor also informed the Provider in its request that gave a deadline to respond of 45 days from the date of the letter. The Provider failed to file any response.

However, on November 20, 2023 (more than 4 months after the deadline to respond to the Motion), QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the caveat that the "Listing [is] pending finalization upon receipt of State eligibility data." The Listing was over 6 pages with roughly 846 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 846 days) was being submitted at this late date or why it was not final (*i.e.*, why it was "pending finalization") at this late date, ***more than 5 years after the fiscal year at issue had closed***. NOTE—the roughly 846 days included in this belated listing is *exponentially* larger than the original estimate of 50 days included with the appeal request. Regardless, this filing was more than 4 months past the deadline for responding to the Jurisdictional Challenge *and, more importantly,* ***was roughly 6 months past the deadline for including it with its preliminary position paper*** since the position paper deadline was May 18, 2023.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

The fact that the Listing was filed roughly 3 months after the Provider changed its designated representative to QRS does not excuse the Provider for its failure to include the information with its preliminary position paper or its failure to timely respond to the Jurisdictional Challenge. Board Rule 5.2 makes clear that "the recent appointment of a new representative will also not be

considered cause for delay of any deadlines or proceedings." Moreover, the Board rejects the Provider's attempt to label the November 20, 2023 filing as a "Supplement to Position Paper" and does not accept that filing because:

1. The alleged "Supplement" was filed ***more than 6 months*** *after the deadline* for that exhibit to be included with its preliminary position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)). Indeed, the Provider failed to timely reply to the Medicare Contractor's Jurisdictional Challenge and the alleged "Supplement" was filed ***more than 2 months*** *after the deadline* for filing a response to the Jurisdictional Challenge requesting the dismissal of Issue 3.

2. The alleged "Supplement" fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the roughly 846 days was not previously available, *in whole or in part* (*i.e*., it is not clear why the Provider failed to identify a single day at issue until more than a year after this appeal was filed and more than 5 years after the fiscal year at issue had closed); and (c) why the listing still was ***not*** a "*final*" listing at this late date.

3. Neither the Board Rules nor the September 20, 2022 Case Acknowledgment and Critical Due Dates permit the Provider to file a "Supplement" to its preliminary position paper (nor did the Provider allege in the "Supplement" filing that they do).

4. Given the fact that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the position paper filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its preliminary position paper or a supplement of documents that were identified in the preliminary position paper as being unavailable consistent with Board Rule 25.2.2. However, neither the preliminary position paper nor the alleged "Supplement" identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the alleged "Supplement" cannot be considered a refinement of the position paper since no specific days or listing were included with the preliminary position paper (indeed the *tentative* 846 days listed in the alleged "Supplement" is, without explanation, *exponentially* larger than the original estimated 50 days included with the appeal request).[30]

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[31] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provider the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

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[30] *See, e.g.,* Board Rule 27.3 (Nov. 2021) stating: "A party may also file a revise or supplemental position paper; however, this filing should not present new positions, arguments or evidence except on written agreement between the parties."

[31] (Emphasis added.)

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[32]

C. 1115 Waiver Days

The Board finds that the section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. The Provider failed to include section 1115 Waiver days as a cost issue in its appeal request and failed to timely and properly add this additional issue to the appeal. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the section 1115 Waiver days.

The appeal was filed with the Board in September of 2022 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[33]

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[32] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022): The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

[33] 42 C.F.R. § 405.1835(b).

Board Rule 7.2.1 (2021) elaborated on this regulatory requirement, instructing providers:

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>   - the relevant adjustment(s), including the adjustment number(s),
>   - the controlling authority (*e.g.*, specific regulation, Federal Register issuance, manual provision, or Ruling),
>   - why the adjustment(s) is incorrect,
>   - how the payment should be determined differently,
>   - the reimbursement effect, and
>   - the basis for jurisdiction before the Board.

Board Rule 8 (2021) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include, but are not limited to:
>
> - ***Section 1115 waiver days (program/waiver specific) . . .***[34]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[35]

42 C.F.R. § 405.1835(e) provides in relevant part:

> (e) Adding issues to the hearing request. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
> . . .
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

[34] (Bold and italic emphasis added).
[35] *See* 73 Fed. Reg. 30190 (May 23, 2008).

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider added the section 1115 Waiver days to the case properly or timely.

In this regard, the Board notes that section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[36] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program and not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2022) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the Section 1115 Waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely

[36] 65 FR 47054, 47087 (Aug. 1, 2000).

appealed. The DSH Medicaid Eligible Days issue as stated in the original appeal request cannot be construed to include Section 1115 Waiver days. Additionally, there is no indication that any 1115 waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Regardless, even if the Provider had included in its appeal request (which it did not), the Provider failed to properly develop the issue in its position paper filings. First, the Provider's preliminary position paper does not even mention § 1115 waiver days (much less even identify the specific 1115 waiver day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (2015). As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* § 1115 waiver days sub-issue.

Finally, even in the Provider's preliminary position paper, the Provider fails to identify what § 1115 waiver program(s) are involved and whether or not the § 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(4)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the preliminary position paper is perfunctory in that it only makes perfunctory conclusions. Again, the Provider failed to so develop its position paper notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Nov. 2021) as applied via Board Rule 27.2.

The Board's finding that neither the appeal request nor final position paper met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[37] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[38] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[39] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[40] Here, the Board makes the same finding based on similarly *overly generalized language*.

[37] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[38] *Id*. at *11.
[39] *Id.*
[40] *Id.*

Based on the above, the Board finds that the appeal did not include the *alleged* § 1115 waiver days sub-issue consistent with 42 C.F.R. §§ 405.1835(b)(2)-(3), 412.106(b)(4)(iii), and 405.1871(a)(3) and Board Rules 7.1, 8, 25, and 27.2.[41] In the alternative, the Board finds that, even if it had been included as part of the appeal, the Board would find that the issue was not properly developed in the position paper process.

* * * * *

Based on the foregoing, the Board has dismissed the two (2) remaining issues in this case – (Issues 1 and 3). As no issues remain, the Board hereby closes Case No. 22-1470 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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For the Board:

4/18/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson Leong, FSS

[41] If § 1115 waiver days were found to be part of the appeal request and had been properly briefed, the Board would still need to address an additional jurisdictional issue – review whether it had jurisdiction over the 1115 waiver days. For example, the Board has found that when a class of days (*e.g.*, 1115 waiver days) is excluded due to choice, error, and/or advertence from the as-filed cost report, then that class of days is an unclaimed cost for which the Board would lack jurisdiction under 42 U.S.C. § 1395oo(a). *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 061852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days from the appeal because no days were claimed with the as-filed cost report due to choice, error and/or inadvertence and, as such, the practical impediment standard or futility concept in the *Norwalk* and *Danbury* Board decisions is not applicable) (available at: https://www.cms.gov/regulations-and-guidance/review-boards/prrbreview/list-of-prrb-jurisdiction-decisions-items/2017-11 (last accessed Mar. 26, 2025)).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: **EJR Determination and Notice of Dismissal**

PRRB Case Number: 16-0992GC - *QRS UMC 2013 SSI Systemic CIRP Group*

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Request for Expedited Judicial Review ("EJR") filed on March 25, 2025 in the above-referenced appeal. The Board's decision with respect to EJR and its decision to dismiss the appeal are set forth below.

I. Issue in Dispute – EJR Requests

The Board received a Request for Expedited Judicial Review in this case on **March 25, 2025**. The request states:

> The Issue for purposes of this EJR request is whether regulation 42 C.F.R. 412.106(b)(1) is invalid by requiring a patient to be due a payment for Supplemental Security Income (SSI) for the month(s) he or she has an inpatient stay in order for the days of such stay to be included in the numerator of the Medicare Fraction for purposes of the Disproportionate Payment Percentage of the Disproportionate Share Hospital (DSH) add-on component of Medicare Inpatient Prospective Payment System (IPPS).[1]
>
> . . . .
>
> For purposes of EJR, the Providers take the same position as the petitioner in *Advocate Christ*, namely, that the inpatient days associated with individuals who were found eligible for SSI prior to, or for, the month(s) of their inpatient stay, and who have not

[1] Request for Expedited Judicial Review at 1-2 (Mar. 25, 2025).

> been *terminated* from the SSI program by SSA with respect to such month(s) should be included in the numerator of the Medicare Fraction.[2]
>
> . . . .
>
> Note that the Providers are not seeking EJR at this time on the question of whether CMS properly implements its policy by requesting only records of those individuals who are assigned one of only three SSI payment status codes (i.e., C01, M01, and M02) by the Social Security Administration (SSA) for purposes of the annual data match between CMS and SSA. However, the Providers challenge CMS's practice or policy of requesting from SSA only the three codes mentioned above, and assert that additional payment status codes should be requested by CMS and used to determine which inpatient stays, or portion of such stays, should be included in the numerator of the Medicare Fraction.[3]

The group case was established on **February 12, 2016**, with the following issue statement:

> **Statement of the Issue**
>
> Whether HMO / Medicare Plus Choice / Medicare Managed Care / Medicare Part C / Medicare Advantage ("MA") Days were properly accounted for in the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC's treatment of the MA days is not in accordance with the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). The MAC failed to include patient days applicable to MA patients who were also eligible for Medicaid in the Medicaid fraction of the Medicare DSH payment adjustment, but instead included those days in the SSI or Medicare fraction.
>
> The key legal issue to be determined is whether dual eligible MA patients are "entitled to benefits under Part A." If the answer to this question is in the affirmative, then these patient days should be included in both the numerator and the denominator of the SSI or Medicare fraction. On the other hand, if these patients are not entitled to benefits under Part A, then these patients should be excluded from both the numerator and denominator of the SSI or Medicare fraction.

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[2] *Id.* at 2.
[3] *Id.* at 2-3.

It is clear from the statute that MA patients are not "entitled to benefits under Part A." Under the Medicare statute, "entitlement of an individual to [Medicare part A] benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, [Medicare] part A . . . on his behalf for [certain] services." See 42 U.S.C. § 426(c)(1). A person may only enroll in a MA plan if he is entitled to benefits under Medicare Part A. See 42 U.S.C. § 1395w-21(a)(3)(A). However, upon enrollment in a MA plan, an individual is no longer "entitle[d] to have payments made under, and subject to the limitations in, [Medicare] part A." Rather, "payments under a contract with a Medicare+Choice organization….with respect to an individual electing a Medicare+Choice plan offered by the organization shall be ***instead*** of the amounts which (in the absence of the contract) would otherwise be payable under [Medicare] parts A and B." See 42 U.S.C. § 1395w-21(i)(I) (emphasis added). See also 42 U.S.C. § 1395w-21(a)(1) ("Each [MA] eligible individual . . . is entitled to receive benefits . . . (A) through the original Medicare fee-for-service program under parts A and B . . . , **or** (B) through enrollment in a Medicare+Choice plan under [MA]." (Emphasis added)).

The use of the language "**instead**" and "**or**" in the statute clearly indicates that a patient is entitled to benefits under a MA plan or Part A, but not both. Thus, a patient receiving benefits under an MA plan is not also entitled to benefits under Part A. Accordingly, the plain language of the statute requires that MA patients be excluded from the Medicare fraction and included in the Medicaid fraction.

Moreover, applying the interpretation reached in *Jewish Hospital*, the term "entitled to benefits under Part A" would refer to the right to a payment under Part A. However, the statutory language states that MA patients are paid under Part C instead of Part A. *See e.g.* 42 U.S.C. § 1395w 23(a)(1)(A) ("[T]he Secretary shall make monthly payments under this section in advance to each Medicare+Choice organization, *with respect to coverage of an individual under this part* [*i.e.*, part C] . . . ." (Emphasis added)).

In addition, just as the D.C. Court of Appeals ruled in *Northeast Hospital Corporation v. Sebelius* (D.C. Cir. September 13, 2011) ("*Northeast*") MA days must be included in the Medicaid fraction for periods prior to October 1, 2004. The D.C. District Court ruled in *Allina Health Services, et al. v. Sebelius* (Case No. 1:10-cv-01463 (RMC)) ("*Allina*") that MA days should be included in the Medicaid fraction for periods after October 1, 2004. The D.C. District Court in *Allina* also found that the 2004 Final Rule, et. al., which applies to the fiscal year under appeal, were

> procedurally defective and, therefore, infirm *ab initio*. The Providers request the Board incorporate the entire administrative and judicial records of *Northeast* and *Allina* into the record of this appeal.
>
> Accordingly, MA days are not days for which patients are "entitled to benefits under Part A." As a result, these days should be excluded from the numerator and denominator of the Providers' SSI or Medicare fractions.[4]

II. Providers' Preliminary Position Paper

This group appeal was filed in 2016. The Providers filed a Preliminary Position Paper ("PPP") in 2023, more than seven years later. It acknowledges that the Board "began bifurcating DSH related group appeals into five separate group appeals as follows: 1) SSI Fraction Systemic, 2) SSI Fraction Part C, 3) SSI Fraction Dual Eligible, 4) Medicaid Fraction Part C Days, and 5) Medicaid Fraction Dual Eligible Days."[5] They claim the issue in the instant position paper "addresses what a proper and consistent definition of the term 'entitled' will have on all five of these related issues."[6]

The PPP begins by explaining that, in the FY 2005 IPPS Final Rule, CMS adopted a policy of including dual-eligible days in the SSI Fraction, "whether or not the beneficiary had exhausted Medicare Part A coverage."[7] This was a change from including only covered/paid days, and now including total days.[8] The Providers also discuss CMS Ruling 1498-R and the treatment of Part C Days, including the litigation from *Allina Health*.[9] The Providers seek to either restrict the denominator of the SSI/Medicare fraction to include only "covered" days as "entitled to Medicare Part A" or to include "paid" and "unpaid" SSI Days in the SSI Fraction Numerator.[10] They summarize that these appeals challenge the inconsistent use of "entitled" and the limited number of SSA Payment Status Codes used in determining the SSI Fraction numerator.[11] The PPPs expand on these points, with a large discussion on Part C Days, covered vs. total days, exhausted benefit days, and Medicare Secondary Payor days, as they all relate to "entitled to Medicare Part A" for dual eligible days in the SSI Fraction.[12]

The discussion then shifts to CMS Ruling 1498-R and the interpretation of "entitled to SSI" for the SSI Fraction. The Providers argue that "entitled" should be treated the same in both contexts, and that the post-*Baystate* data matching process is deficient for only including three SSA Status Codes to check for SSI entitlement.[13] They also briefly note that the identified errors in the data

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[4] Statement of the Group Issue at 1-2 (Feb. 12, 2016).
[5] Providers' Preliminary Position Paper, at 2 (Sept. 28, 2023).
[6] *Id.* at 3.
[7] *Id.* at 5.
[8] *Id.* at 5-6.
[9] *Id.* at 6-8.
[10] *Id.* at 8.
[11] *Id*. at 8-9.
[12] *Id.* at 18-50.
[13] *Id.* at 50-92.

matching process are sufficient to prove the fact of injury, even if not the specific amount of injury, since CMS withholds the data necessary to verify the SSI Fractions. They argue that this should shift the burden to the Secretary to prove why the Providers' allegations should not be accepted.[14]

III. Relevant Law

A. Authorities Raised in the Providers' Position Papers and EJR Requests

The authorities cited in the Providers' PPP include several court decisions, including *Baystate* and *Allina (*both *v. Price* and *v. Sebelius)*, several statutory provisions within the Medicare Act, 42 C.F.R. § 412.106(d) and two publications within the Federal Register from 2005 and 2010.[15] Importantly, *Advocate Christ* is not mentioned in the PPPs. The Request for EJR, however, focuses on some of those items and then addresses *Advocate Christ*, in depth. There are several authorities relevant to legal issues distinct from those raised in the Providers' PPP. The Board briefly discusses each of these authorities below.

1. The Baystate Litigation[16]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[17] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[18] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[19] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[20] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[21]

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[14] *Id.* at 77-78.
[15] *Id.* at 4-5, 6-7, 9-10, 19, 41-42, and 50-51.
[16] *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008), *amended in part*, 587 F. Supp. 2d 37 (D.D.C. Nov. 07, 2008), *judgment entered*, 587 F. Supp. 2d 44 (D.D.C. Dec. 8, 2008), *dismissing appeal*, 2009 WL 604186 (D.C. Cir. 2009).
[17] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[18] *Id.*
[19] *Id.*
[20] *Id.* at 31459-31460; 42 C.F.R. § 412.106(b).
[21] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.

In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[22]

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to SSNs as well as HICANs and Title II numbers."[23] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[24] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[25]

Consistent with Ruling 1498-R, CMS published the new data matching process in the FY 2011 proposed rule published on May 4, 2010.[26] The proposed rule includes references to the

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[22] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there were actual SSI cash benefits. *See id*. at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.

[23] CMS-1498-R at 5.

[24] *Id.*

[25] *Id.* at 5-6.

[26] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).

Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[27]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 Final Rule").[28] Significantly, in the preamble to the FY 2011 Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[29] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[30] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[31] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[32]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare Contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[33] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and

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[27] *See, e.g.*, 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the Baystate decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement").

[28] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).

[29] *Id.* at 50280.

[30] *Id.* at 50280-50281.

[31] *Id.* This included all codes with the "S" prefix indicating suspended payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.

[32] *Id.* at 50285.

[33] CMS-1498-R at 6-7, 31.

other agency rules and guidelines.[34] In the FY 2011 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[35]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[36]

However, neither Ruling 1498-R nor Ruling 1498-R2 divest the Board of jurisdiction in these appeals since the NPRs at issue were issued after Ruling 1498-R and since the fiscal years at issue are not covered by Ruling 1498-R2. As a result of the new regulation and new data match process, CMS calculated SSI percentages for the Providers for the fiscal years at issue.[37]

2. MMA § 951

MMA § 951, which was enacted in 2003, directed the Secretary to "arrange to furnish to subsection (d) hospitals . . . the data necessary for such hospitals to compute the number of patient days used in computing the disproportionate patient percentage . . . for that hospital for the current cost reporting year."[38] CMS implemented MMA § 951 as part of the FY 2006 IPPS Final Rule and stated the policy to make available the MedPAR LDS data used to calculate providers' DSH Medicare/SSI fractions:

> In accordance with section 951 of Pub. L. 108-173, as we proposed in the FY 2006 IPPS proposed rule, we are changing the process that we use to make Medicare data used in the DSH calculation available to hospitals. Currently, as stated above, CMS calculates the Medicare fraction for each section 1886(d) hospital using data from the MedPAR LDS (as established in a notice published in the August 18, 2000 Federal Register (65 FR 50548)). The MedPAR LDS contains a summary of all services furnished to a Medicare beneficiary, from the time of admission through discharge, for a stay in an inpatient hospital or skilled nursing facility, or both; SSI eligibility information; and enrollment data on Medicare beneficiaries. The MedPAR LDS is protected by the Privacy Act of 1974 (5 U.S.C. 552a) and the Privacy Rule of the Health Insurance

[34] *Id.* at 28, 31.
[35] 75 Fed. Reg. at 24006.
[36] CMS-1498-R2 at 2, 6.
[37] SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.
[38] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173, § 951, 117 Stat. 2066, 2427 (2003).

> Portability and Accountability Act of 1996 (Pub. L. 104-191). The Privacy Act allows us to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such compatible use of data is known as a "routine use." In order to obtain this privacy-protected data, the hospital must qualify under the routine use that was described in the August 18, 2000 Federal Register. Currently, a hospital qualifies under the routine use if it has an appeal properly pending before the Provider Reimbursement Review Board (PRRB) or before an intermediary on the issue of whether it is entitled to DSH payments, or the amount of such payments. Once determined eligible to receive the data under the routine use, the hospital is then required to sign a data use agreement with CMS to ensure that the data are appropriately used and protected, and pay the requisite fee.
>
> Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108-173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period. Under this provision, the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year. The data set made available to hospitals will be the same data set CMS uses to calculate the Medicare fractions for the Federal fiscal year.
>
> Because we interpret section 951 to require the Secretary to arrange to furnish these data, we do not believe that it will continue to be appropriate to charge hospitals to access the data. These changes will require CMS to modify the current routine use for the MedPAR LDS to reflect changes in the data provided and the circumstances under which they are made available to hospitals. In a future Federal Register document, we will publish the details of any necessary modifications to the current routine use to implement section 951 of Pub. L. 108-173.[39]

[39] 70 Fed. Reg. 47278, 47439-40 (Aug. 12, 2005).

Further, CMS has stated that it is prohibited by Federal law and regulations from releasing the data files of SSI eligibility information provided to CMS by SSA:

> In accordance with the published routine use for the SSI system of records maintained by the SSA, CMS signs a data use agreement with SSA to receive the SSI data file for the sole purpose of administering the Medicare and Medicaid programs. While we understand the commenters' concern, CMS is strictly prohibited from disclosing SSI eligibility information. In addition, SSA is prohibited from disclosing this information by Federal law and regulations. While we cannot release the SSI eligibility information provided by SSA, we are permitted to disclose the results of the data match of SSI eligibility information with the Medicare inpatient hospital billing data as a routine use for the MedPAR LDS system of records. The routine use allows us to release the information to hospitals that sign a data use agreement that limits the uses and protects the privacy of the SSI/MedPAR LDS match information.[40]

3. Pomona Valley Litigation[41]

The D.C. Circuit Court found that the hospital in the *Pomona Valley* case had made a *prima facie* showing that the CMS data matching process missed a number of Medicare patient days attributable to patients who qualified for SSI benefits.[42] The D.C. Circuit Court found that, "[g]iven the strength of the hospital's showing, and the absence of any countervailing evidence, the Board's conclusion that Pomona had failed to prove an undercount was unreasonable."[43] The D.C. Circuit Court then remanded the case back to CMS and ultimately to the Board based on its finding:

> Although Pomona's case compels a ruling in its favor "if undisputed," *we do not foreclose the possibility that CMS may be able to dispute it successfully*. ***And if CMS does introduce evidence to dispute it***, *the burden of proof will remain with Pomona*. . . . All we hold today is that Pomona's showing was robust enough to require some response from the agency.[44]

4. The Empire Health Litigation

In *Empire Health Found. v. Price* ("*Empire*"),[45] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the

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[40] *Id.* at 47440.
[41] *Pomona Valley Hosp. Med. Ctr. v. Becerra*, 82 F.4th 1252 (D.C. Cir. 2023), *aff'g*, 2020 WL 5816486 (D.D.C. 2020).
[42] *Pomona Valley*, 82 F.4th at 1259.
[43] *Id.* at 1260.
[44] *Id.* at 1262 (emphasis added and citation omitted).
[45] 334 F. Supp. 3d 1134 (E.D. Wash. 2018).

Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[46] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[47] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate context in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[48] and that the regulation is procedurally invalid.[49]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[50] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[51] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[52] However, the Ninth Circuit then reviewed the substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[53] wherein the Ninth Circuit considered the meaning of the words "entitled" and "eligible" in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[54] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[55] According, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[56] Accordingly, the Ninth Circuit took the following actions to implement its holding:

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[46] *Id.* at 1141.
[47] *Id.*
[48] *Id*. at 1162.
[49] *Id*. at 1163.
[50] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[51] *Id.* at 884.
[52] *Id.*
[53] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[54] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[55] *Id.* at 886.
[56] *Id.*

1. It affirmed the Washington District Court's order vacating the FY 2005 IPPS Final Rule as it relates to the deletion of the word "covered" from 42 C.F.R. § 412.106(b)(2)(i); and

2. It "reinstat[ed] the version of 42 C.F.R. § 412.106(b)(2)(i) which embraced only 'covered' patient days" (*i.e.*, reinstated the rule previously in force).

The Secretary appealed the Ninth Circuit decision and the U.S. Supreme Court subsequently issued its decision in *Empire Health*[57] finding that the Secretary "correctly construes the statutory language at issue."[58] The Court found that the structure of the DSH provisions supported the Secretary, summarizing that "Counting everyone who qualifies for Medicare benefits in the Medicare fraction—and no one who qualifies for those benefits in the Medicaid fraction—accords with the statute's attempt to capture, through two separate measurements, two different segments of a hospital's low-income patient population."[59] It found that being "entitled" to Medicare benefits means meeting the basic statutory criteria, not actually receiving payment for a given day's treatment.[60] Nor did the Court find any credence in the argument that "entitled" was modified by the statute by adding "(for such days)". Though this parenthetical does direct the Secretary to evaluate a patient's status on a given day, it does not invite an evaluation of whether a patient *received* Part A payments, but rather whether it is qualified to receive part A payments.[61] Based on the foregoing, the Court reversed the Ninth Circuit's *Empire* decision and remanded the case for further proceedings.[62]

On remand, the Ninth Circuit addressed the appellant's "remaining challenge."[63] Specifically, it noted that neither the Ninth Circuit or the Supreme Court addressed the appellant's alternative argument concerning the Secretary's calculation of patient days for those patients "entitled to supplemental security income [SSI] benefits," which also factors into the Medicare fraction.[64] The argument claims that there is an inconsistency in between "entitled to Medicare" and "entitled to SSI." As discussed above, "entitled to Medicare" Part A has been deemed to mean legally entitled to benefits, regardless of whether payment was actually made, but the Secretary's policy for SSI benefits includes those patient days only when SSI benefits are paid to an individual on a given month, not merely when they are eligible for benefits.[65] Consideration of this issue is now pending before the District Court for the Eastern District of Washington.[66]

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[57] 142 S. Ct. 2354 (2022).
[58] *Id.* at 2362.
[59] *Id.*
[60] *Id.*
[61] *Id.* at 2365.
[62] *Id.* at 2368.
[63] *Empire Health Found. v. Azar*, 2022 WL 17411382, *1 (9th Cir. 2022).
[64] *Id.*
[65] *Id.*
[66] *Id.* at *2. Following the Supreme Court's remand in *Empire*, the district court initially dismissed this alternative argument for lack of subject matter jurisdiction. The Ninth Circuit reversed that decision and ordered the district court "to consider the argument in the first instance and to obtain supplemental briefing on the impact of the Supreme Court's ruling . . . ." *Id.*

Notwithstanding the ongoing proceedings, as of the date of the instant decision, the Secretary's position with respect to the validity of the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

5. The Advocate Christ[67] Litigation

The issue in *Advocate Christ* involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

The Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[68] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[69]

In contrast, the SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[70] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[71] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[72]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[73] and may terminate,[74] suspend[75] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[76] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

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[67] *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346, 349, 350 (D.C. Cir. 2023), *cert. granted*, No. 23-715 (U.S. June 10, 2024).
[68] 42 U.S.C. § 426.
[69] 42 U.S.C. § 426-1.
[70] 42 U.S.C. § 1382.
[71] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[72] 20 C.F.R. § 416.202.
[73] 20 C.F.R. § 416.204.
[74] 20 C.F.R. §§ 416.1331-1335.
[75] 20 C.F.R. §§ 416.1320-1330.
[76] 20 C.F.R. § 1320.

1. The individual fails to give the SSA permission to contact financial institutions;[77]
2. The individual fails to apply for other benefits to which the individual may be entitled;[78]
3. The individual fails to participate in drug or alcohol addiction treatment;[79]
4. The individual is absent from the United States for more than 30 days;[80] or
5. The individual becomes a resident of a public institution or prison.[81]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[82]

While *Empire Health*, discussed *supra*, dealt with the interpretation of "entitled" to Medicare benefits as described in the FY 2005 Final Rule, *Advocate Christ Med. Ctr. v. Becerra*[83] concerns a challenge to the substantive and procedural validity of the FY 2011 IPPS Final Rule, specifically the interpretation of "entitled" to SSI benefits as described therein.[84] Both the D.C. District Court and D.C. Circuit Court have found that CMS's interpretation of "entitled" to SSI benefits is valid, and *certiorari* has been granted by the Supreme Court, where the case is still pending.[85]

~ ~ ~

In summary:

- *Baystate* found that the data matching process from the FY 2005 Final Rule, which implemented MMA § 951, did not use the best available data, and resulted in the modified data matching process published in the FY 2011 Final Rule.
- MMA § 951 mandates that CMS must give hospitals the information necessary to compute the number of patient days used in computing their DPPs.
- *Pomona Valley* found that the Provider in that case had shown discrepancies between the number of days in their DPP and California Medicaid data. The case has been remanded to the Board to determine whether CMS can refute the evidence showing these discrepancies.

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[77] 20 C.F.R. § 416.207.
[78] 20 C.F.R. § 416.210.
[79] 20 C.F.R. § 416.214.
[80] 20 C.F.R. § 416.215.
[81] 20 C.F.R. § 416.211.
[82] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[83] 80 F.4th 346, 349, 350 (D.C. Cir. 2023), *cert. granted*, No. 23- 715 (U.S. June 10, 2024).
[84] 80 F.4th at 350-351.
[85] 144 S. Ct. 2629 (2024).

- *Empire Health* concerned the substantive and procedural validity of the FY 2005 IPPS Final Rule and its interpretation of "entitled" to Medicare benefits. The Supreme Court has found the interpretation was valid.
- *Advocate Christ* concerned the substantive and procedural validity of the FY 2011 IPPS Final Rule and its interpretation of "entitled" to SSI benefits. The D.C. Circuit has affirmed the validity of that interpretation, and the case is pending before the Supreme Court.

B. A Group May Contain Only One Issue

The regulations governing group appeals are located at 42 C.F.R. § 405.1837. In subsection (a), the regulation makes clear that a group may only have one issue:

> (a) *Right to Board hearing as part of a group appeal: Criteria*. A provider (but no other individual, entity, or party) has a right to a Board hearing, as part of a group appeal with other providers, with respect to a final contractor or Secretary argue determination for the provider's cost reporting period, **only if**—
>
> (1) The provider satisfies individually the requirements for a Board hearing under § 405.1835(a) or § 405.1835(c), except for the $10,000 amount in controversy requirement in § 405.1835(a)(2) or § 405.1835(c)(3).
>
> (2) **The matter at issue in the group appeal involves a <u>single</u>** question of fact or **interpretation of law**, regulations, or CMS Rulings that is common to each provider in the group; and
>
> (3) The amount in controversy is, in the aggregate, $50,000 or more, as determined in accordance with § 405.1839 of this subpart.[86]

To this end, the group appeal content requirements in subsection (c)(3) specify that a group appeal request "must include . . . a precise description of the ***one*** question of fact or ***interpretation of law***, regulations, or CMS Rulings *that is common to the particular matter at issue* in the group appeal."[87] Consistent with this requirement that a group ***contain only one issue***, subsection (f) clearly sets forth the "Limitations on group appeals" as follows:

> (1) <u>After the date of receipt</u> by the Board of a group appeal hearing request under paragraph (c) of this section, ***a provider may not add other questions of fact or law to the appeal***, <u>regardless</u> of whether the

[86] (Bold and underline emphasis added and italics in original.)
[87] (Bold and underline emphasis added and italics in original.)

> question is common to other members of the appeal (as described in § 405.1837(a)(2) and (g) of this subpart).
>
> (2) The Board may not consider, in one group appeal, more than one question of fact, interpretation of law, regulations, or CMS Rulings that is common to each provider in the appeal. If the Board finds jurisdiction over a group appeal hearing request under § 405.1840 of this subpart-
>
> (i) The Board must determine whether the appeal involves specific matters at issue that raise more than one factual or legal question common to each provider; and
>
> (ii) When the appeal is found to involve more than one factual or legal question common to each provider, the Board must assign a separate case number to the appeal of each common factual or legal question and conduct further proceedings in the various appeals separately for each case.[88]

Pursuant to its rulemaking authority under 42 U.S.C. § 1395oo(e), and in accordance with 42 C.F.R. § 405.1837, the Board adopted Rule 8 regarding the framing of issues for adjustments involving multiple components and Rule 13 regarding common group issues. Board Rule 8 states in pertinent part:

> 8.1 – General
>
> Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, ***each contested component must be appealed as a separate issue and described as narrowly as possible*** using the applicable format outlined in Rule 7. See common examples below.
>
> 8.2 – Disproportionate Share Cases (e.g., dual eligible, general assistance, charity care, HMO days, etc.)[89]

Board Rule 13 (Common Group Issue) states in pertinent part:

> The matter at issue ***must involve a <u>single</u>*** common question of fact or interpretation of law, regulation or CMS policy or ruling.[90]

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[88] (Emphasis added.)
[89] (Emphasis added).
[90] *See also* PRRB Board Rule 15.2 (where the Lead Intermediary must advise the Board of its position as to "whether the group appeal establishes a single common issue"); Model Form B – Group Appeal Request (Section 9, where the form reminds the filer that the appeal must only involve "one issue per group"; Model Form D and Model Form E (Certification B, where the Group Representative must attest that they have reviewed 42 C.F.R. § 405.1837

Accordingly, the governing regulation (42 C.F.R. § 405.1837) and Board Rules 8 and 13 regarding the scope of group appeals are clear: A group appeal is limited to one specific issue that is established upon the initiation of the appeal.

C. Expedited Judicial Review ("EJR") Requests May Not Expand Issues

The regulations governing requests for expedited judicial review are located at 42 C.F.R. § 405.1842. In subsection (b), the regulation makes clear that a group of providers may seek EJR of a legal question or a specific matter that has been properly appealed to the Board. Specifically, 405.1842(b)(2) states in pertinent part:

> (2) ***Initiating EJR procedures.*** A provider or group of providers may request the Board to grant EJR of a specific matter or matters ***under appeal***, or the Board on its own motion may consider whether to grant EJR of a specific matter or matters ***under appeal***.

Accordingly, where a matter has not been properly filed "under appeal" before the Board, it may not be considered for expedited judicial review.

IV. Decision of the Board

The Board is required to grant an EJR request if the Board determines the following conditions are satisfied:

> (i) [t]he Board has jurisdiction to conduct a hearing on the specific matter at issue in accordance with § 405.1840 of this subpart.
> (ii) The Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.[91]

A group of Providers generally have a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if:

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely

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and that they have a good faith belief that addition request meets the single common issue requirement for a group appeal).

[91] 42 C.F.R.§ 405.1842(f)(1). *See also*, 42 U.S.C. § 1395oo(f)(1).

issue a final determination; [92]

- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[93]

A. Scope of the Issue in the EJR Requests and Appealed Issues from Issue Statements

Based on its review of the EJR Request, the Board finds that, by their own admission, the Providers have requested EJR over the "*Advocate Christ*" issue:

> For purposes of EJR, the Providers take the same position as the petitioner in *Advocate Christ*, namely, that the inpatient days associated with individuals who were found eligible for SSI prior to, or for, the month(s) of their inpatient stay, and who have not been terminated from the SSI program by SSA with respect to such month(s) should be included in the numerator of the Medicare Fraction.[94]

However, the Board finds that the initial appeal request ***did not*** appeal the *Advocate Christ* issue – it specifically appealed the treatment of Medicare Part C Days in the DSH calculation.

The Board notes that 42 C.F.R. § 405.1853(b)(1) addresses position paper filings and states: "[a]fter any preliminary narrowing of the issues, the parties must file position papers *in order to narrow the issues further*." In accordance with this regulation, preliminary position papers are limited to the issues originally appealed and cannot be expanded outside of the scope of the initial appeal. The development of subsequent or new case law should only be included in position papers if it is specific to the originally appealed issue and does not expand the scope of that issue.

Accordingly, the Board **denies** the Request for EJR in its entirety as the issue in the request for EJR is not the issue in the group appeal.

V. Dismissal of Duplicate Appeal

As previously discussed, the issue statement in the instant case (16-0992GC) concerns the treatment of Part C Days in the DSH calculation. The group is fully formed with the following two Providers:

1. Banner - University Medical Center South Campus (Provider Number 03-0111, FYE 6/30/2013) appealing from an NPR dated 8/11/2015

[92] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[93] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[94] Request for Expedited Judicial Review at 2.

2. Banner University Medical Center - Tucson (Provider Number 03-0064, FYE 6/30/2013) appealing from an NPR dated 8/27/2015

These same two Providers were the two sole providers in the following groups, which were appealing from the same NPRs and FYEs:

1. Case 16-0990GC: *QRS UMC 2013 SSI Fraction Part C Days CIRP Group*
2. Case 16-0991GC: *QRS UMC 2013 Medicaid Fraction Part C Days CIRP Group*

On **April 15, 2019**, QRS, as the Providers' representative, filed Requests for EJR in Cases 16-0990GC and 16-0991GC concerning "whether Medicare Advantage Days ('Part C Days') should be removed from the disproportionate share hospital adjustment ('DSH Adjustment') Medicare fraction and added to the Medicaid Fraction."[95]

On **May 8, 2019**, the Board granted EJR in both cases for the Part C Days issue, specifically "the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011)."[96]

The Board finds that the Providers in the instant case are appealing the treatment of Part C Days for their FYE June 30, 2013, but were already granted EJR for the exact same issue and FYE on May 8, 2019. Board Bule 4.5 (2015) specially prohibits duplicate appeals: "A Provider may not appeal an issue from a final determination in more than one appeal." Based on the foregoing, the Board hereby ***dismisses*** Case 16-0992GC in its entirety.

VI. Conclusion

The Providers have requested EJR based on the issue in *Advocate Christ,* however, the initial appeal requests *did not* appeal this issue. Therefore, the Board ***denies*** the EJR request in their entirety for the reasons stated herein. The Board also finds that Case 16-0992GC is a duplicate appeal and dismisses it in its entirety and removes it from its docket.

Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

[95] Case Nos. 16-0990GC and 16-0991GC Request for Expedited Judicial Review at 1 (Apr. 15, 2019).
[96] Case Nos. 16-0990GC and 16-0991GC EJR Determination at 8 (May 8, 2019).

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicola E. Musgrave, Esq.
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FOR THE BOARD:

4/21/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: Kevin D. Smith -A

cc: Dean Wolfe, Noridian Healthcare Solutions (J-F)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran, President
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RE: ***Dismissal of Medicare Fraction (SSI) – Statutory & Systemic Errors – GCE CIRP Group***
25-3081GC *et al.* (*See* Attached Listing of 62 Cases)

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the "Board") has reviewed the appeal requests in the 62 above-referenced cases. Set forth below is the decision of the Board to dismiss the above-captioned optional and common issue related party ("CIRP") group appeals. The pertinent facts and the Board's determination are set forth below.

Introduction:

Between February 21 and 28, 2025, Quality Reimbursement Services, Inc. ("QRS") filed the above-referenced 62 optional and CIRP group appeals in the Office of Hearings Case & Document Management System ("OH CDMS"). The issue statements in these groups are materially identical. The Providers contend that the Medicare/SSI Fractions published on CMS' website on August 13, 2024, pursuant to CMS Transmittal 12785, were determined incorrectly due to the "inclusion of Medicare Part C days in the denominator of the Fraction . . . and . . . exclusion of days from the numerator of the Medicare Fraction associated with individuals who were entitled to Supplemental Security Income ("SSI") during their hospital stay but who were not in SSI pay status during such stays, or were in SSI pay status during their hospital stay but were not assigned payment status code C01, M01 or M02."[1]

Within their Issue Statements, the Providers also request a good cause extension to file these appeals, alleging that the operations of their Provider Representative, Quality Reimbursement Services ("QRS"), faced disruption due to wildfires that occurred in January 2025, in the vicinity of its Arcadia, California location.[2] The group appeals were filed between 192 and 199 days after the date of the issuance of the Transmittal which the Providers allege forms the basis for their appeals, thus, twelve to nineteen days after the expiration of the 180-day time limit for filing such an appeal.

[1] *See e.g.*, Case No. 25-3081GC, Providers' Issue Statement at 1 (Feb. 21, 2025).
[2] *Id.*

Background:

A. Medicare DSH Payment and Realignment

Part A of the Medicare statute covers inpatient hospital services. Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system ("PPS").[3] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4]

The PPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[5] This case involves the hospital-specific disproportionate share hospital ("DSH") adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[6]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and the amount of the DSH payment to be paid to a qualifying hospital.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction."

This matter concerns the Medicare/SSI fraction.[10] The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), defines the Medicare/SSI fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter . . . .

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's

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[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*
[5] *See* 42 U.S.C. § 1395ww(d)(5).
[6] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[10] The other component of the DPP not at issue in this matter is the "Medicaid Fraction" which is the number of hospital patient days for patients eligible for medical assistance under a State Medicaid plan (*i.e.* a plan approved by the Secretary under 42 U.S.C. § 1396 *et* seq.) but who were not entitled to Medicare Part A, divided by the total number of hospital patient days. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). *See also* 42 C.F.R. § 412.106(b)(4).

eligibility for and, if eligible, the amount of any DSH payment adjustment.[11] CMS calculates the Medicare/SSI Fractions used to calculate Medicare DSH payments based on discharges in the respective federal fiscal year, but hospitals are permitted under 42 C.F.R. § 412.106(b)(3) to request that CMS recalculate, or "realign," their Medicare/SSI Fractions based on discharges in the hospital's cost reporting period.

B. Appeal of Publication of Medicare/SSI Fraction Data Pursuant to CMS Transmittal 12785

The Providers in these groups state that they are appealing from the publication of Medicare/SSI Fractions on CMS' website on August 13, 2024, that was done pursuant to CMS Transmittal 12785, "Instructions for Processing Requests for SSI Realignment for Cost Reporting Periods Starting Before October 1, 2013." Transmittal 12785 replaced and updated Transmittal 12747 that was originally issued on July 26, 2024. The original Transmittal 12747 announced that CMS was resuming the processing of realignment requests for cost reporting periods starting before October 1, 2013. With realignment, hospitals are permitted under 42 C.F.R. § 412.106(b)(3) to request that CMS recalculate, or "realign," their Medicare/SSI Fractions based on discharges in the hospital's cost reporting period, rather than CMS' calculated Medicare/SSI Fractions based on discharges in the respective federal fiscal year.

The original Transmittal 12747 which Transmittal 12785 updates describes how CMS temporarily halted the processing of realignment requests for cost reporting periods starting before October 1, 2013, "due to a lack of policy established through notice-and-comment rulemaking regarding the treatment of Part C days for that period of time."[12] However, on June 9, 2023, CMS issued Final Rule CMS-1739-F, finalizing the treatment of Medicare Part C days in determining a hospital's DPP, whereby such days are to be included in the Medicare/SSI Fraction and excluded from the numerator of the Medicaid fraction. Both transmittals announce that with the issuance of final rule CMS-1739-F, and the publication of provider Medicare/SSI Fractions on the CMS website, the agency was resuming the processing of realignment requests for such cost reporting periods.

The original Transmittal 12747 states that the Medicare/SSI Fractions available on the CMS website for cost reporting periods starting before October 1, 2013, like the federal fiscal year Medicare/SSI Fractions for the same period, were determined pursuant to final rule CMS-1739-F. The transmittal directs MACs to use such fractions to determine DSH payments for realignment requests in appropriate cases. The Transmittal explains that for realignment requests for such cost reporting periods, "CMS will calculate cost reporting period SSI ratios for all periods, for all hospitals, and post those ratios to the CMS DSH website . . . ."[13] Both Transmittal 12785 and the earlier Transmittal 12747 which it updates are nearly identical and focused on the realignment process. The ***only*** change in Transmittal 12785 from the earlier Transmittal 12747 is addressing a formatting change "to update the DSH Adjustment and

[11] 42 C.F.R. § 412.106(b)(2)-(3).
[12] CMS Transmittal 12747 at 3 (July 26, 2024).
[13] *Id.*

Realignment files years 1988-2013, so that the SSI Ratio column is consistently rounded to four (4) decimals in all files. All other information remains the same."[14]

Board Determination:

In these cases, the Providers maintain that CMS' publication of Medicare Fraction data on its website pursuant to Transmittal 12785 on August 13, 2024, "'constitutes a final determination of the Secretary as to the amount of the payment under subsection . . . (d) of section 1886' of the Social Security Act (the Act)" and because the Groups "[are] dissatisfied with this determination . . . the PRRB should accept jurisdiction"[15] over the appeals. However, the publication of Medicare/SSI Fractions in conjunction with Transmittal 12785, which merely requires a formatting change to the Medicare/SSI Fraction data posted on CMS' website so that the "SSI Ratio column is consistently rounded to four (4) decimals in all files" is not a "final determination" from which a provider may appeal. As explained below, the Board dismisses this matter for lack of jurisdiction over the Providers' appeals in these 62 groups.

The Medicare statute authorizes providers to seek hearings before the PRRB in two sets of circumstances: First, where the provider is dissatisfied with "the amount of total program reimbursement" as set forth in a Notice of Program Reimbursement ("NPR");[16] and second, where the provider is dissatisfied with a "final determination" "as to the amount of the payment" under the prospective payment system.[17] In this case, the Providers in these groups have not yet received NPRs and have based their appeals, pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(ii), on their dissatisfaction with Medicare/SSI Fraction data that was published on the CMS website in conjunction with Transmittal 12785.

The Providers, in their Issue Statements, acknowledge that the Board "has taken the position that publication of [Medicare/SSI Fraction data on CMS' website] is not a final determination."[18] But the Providers also note disagreement with the Board's position, citing *Battle Creek Health Sys. v. Becerra*,[19] and *Baylor All Saints Med. Ctr. v. Becerra*,[20] decisions where courts held that providers met the requirements for a Board appeal before receiving a final appealable determination as to the amount of DSH payment.[21]

For the Board, the court's decision in *Battle Creek* is inapposite because, unlike in the instant case, the challenged Transmittal and publication of data in that case was described by the court as being a "*fait accompli*."[22] The court in *Battle Creek* observed that the challenged Transmittal and publication of data there "provided, with some finality, 'advance knowledge of the amount of [the DSH] payment.'"[23] Yet, in the instant cases, the publication of the challenged

[14] CMS Transmittal 12785 at 1 (Aug. 13, 2024).
[15] *See e.g.* Case No. 25-3081GC, Providers' Issue Statement at 1.
[16] 42 U.S.C. § 1395oo(a)(1)(A)(i).
[17] *Id*. § 1395oo(a)(1)(A)(ii).
[18] Providers' Issue Statement at 1.
[19] 2023 WL 7156125 (D.D.C. Oct. 31, 2023), *appeal docketed*, No. 23-5310 (D.C. Cir. Dec. 29, 2023).
[20] 2024 WL 3833278 (N.D. Tex. Aug. 15, 2024), *appeal docketed*, No. 24-10934 (5th Cir. Oct. 17, 2024).
[21] Providers' Issue Statement at 1-2.
[22] *Battle Creek,* 2023 WL 7156125 at *5.
[23] *Id.*

Transmittal and accompanying Medicare/SSI Fraction data, provided by CMS for the purpose of informing provider choice as to whether to request realignment of the Medicare/SSI Fraction, does not definitively inform whether a provider qualifies for the DSH adjustment, much less the amount of DSH reimbursement that a provider could receive.

In recent Board decisions, the Board has continued to notice its disagreement with *Battle Creek* and by extension, other court decisions like *Baylor All Saints*.[24] The Board has maintained that *Memorial Hospital v. Becerra*[25] is a better-reasoned decision and provides a more thoughtful analysis. In *Memorial Hospital*, a group of providers filed an appeal similar to the Providers' appeals in these 62 groups. The *Memorial Hospital* providers challenged CMS' publication of Medicare/SSI Fraction data, arguing that there are certain instances where a provider can file a Board appeal prior to receiving an NPR. The court in *Memorial Hospital* ultimately agreed with the Board that CMS' publication of Medicare/SSI Fractions was not an appealable final determination.

The court distilled the parties' positions as "boil[ing] down to a dispute about whether Plaintiffs have conflated a determination by the Secretary about one of several undetermined elements that eventually flows into the amount of payment and 'a final determination of the Secretary as to the amount of payment.'"[26] The court held that CMS' publication of Medicare/SSI Fractions, even if the publication of such fractions had been issued as "final," could and would not be a final determination "as to the amount of payment" because the Medicare/SSI Fractions are "just one of the variables that determines whether hospitals receive a DSH payment and, if so, for how much."[27] For the court, a challenge to an element of payment under 42 U.S.C. § 1395oo(a)(1)(A)(ii) is only appropriate if, as the D.C. Circuit has explained, "the Secretary ha[s] firmly established 'the only variable factor in the final determination as to the amount of payment under § 1395ww(d).'"[28]

Using the reasoning in *Memorial Hospital*, given the nature of the DSH adjustment, the publication of hospitals' Medicare/SSI Fractions on CMS' website is not a final determination as to the amount of payment due to any provider because the Medicare/SSI Fraction alone does not determine the amounts hospitals will be paid under the adjustment. Instead, the Medicare/SSI Fraction is incorporated, along with the Medicaid Fraction, into the DPP, which is ultimately the calculation that determines eligibility for and the amount of any DSH adjustment. The DPP must also exceed certain thresholds to qualify for any DSH adjustment.[29] Thus, although CMS calculates and publishes the Medicare/SSI Fraction for every hospital that receives Medicare reimbursement, the determination of whether a hospital receives reimbursement is made only after the hospital submits its year-end cost report.

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[24] *See, e.g.*, Board decisions in PRRB Case Nos. 24-0491, 24-1531GC, and 24-0413GC.
[25] 2022 WL 888190 (D.D.C. Mar. 25, 2022).
[26] *Id*. at *8.
[27] *Id*. at *9
[28] *Id*. at *8 (quoting *Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807, 811 (D.C. Cir. 2001) (quoting *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 147 (D.C. Cir. 1986)) (emphasis added); *see also Samaritan Health Serv. v. Sullivan*, 1990 WL 33141 at *3 (9th Cir. 1990) (unpublished table decision) ("We have held that if the Secretary's classification of a hospital effectively fixes the hospital's reimbursement rate, then that decision is a 'final determination' as referred to 42 U.S.C. § 1395oo(a)(1)(A)(ii).").
[29] 42 C.F.R. § 412.106(d)(2)(i)-(ii).

In this matter, the Providers contend that the Medicare/SSI Fractions published on CMS' website on August 13, 2024, pursuant to CMS transmittal 12785, were determined incorrectly due to the "inclusion of Medicare Part C days in the denominator of the Fraction" and . . . "exclusion of days from the numerator of the Medicare Fraction associated with individuals who were entitled to [SSI] during their hospital stay but who were not in SSI pay status during such stays, or were in SSI pay status during their hospital stay but were not assigned payment status code C01, M01 or M02."[30] Transmittal 12785 bears no connection to the issue under appeal as the Transmittal merely implements a formatting change to the SSI Fraction data that was previously made available through the earlier Transmittal 12747 in order to ensure that the SSI Ratio column is consistently rounded to four decimals in all files. This information is published so that providers have sufficient information available to inform whether they want to request realignment. Providers cannot claim that with publication of Medicare/SSI Fraction data on CMS' website in a new decimal format pursuant to Transmittal 12785, they are somehow "dissatisfied with a final determination of Secretary as to the amount of payment."[31]

Neither the publication of the Medicare/SSI Fraction data, nor the decimal formatting change described in Transmittal 12785 informs whether a provider qualifies for the DSH adjustment, much less the amount of DSH reimbursement that a provider could receive. The Providers here have included no proof that they have requested realignment, nor even that with realignment they would be eligible for DSH reimbursement (changes in either the Medicare/SSI or Medicaid fractions could potentially result in a DPP below that required to qualify for the DSH adjustment). Moreover, appeal of Transmittal 12785, which only rounded the published Medicare/SSI Fraction data to four decimal places, concerns only one factor of the DPP and is almost certainly unlikely to result in a change in DSH reimbursement sufficient to meet the amount in controversy required for a group appeal ($50,000 or more).[32] That CMS is providing such information to inform a provider's choice as to whether to request realignment of the Medicare/SSI Fraction that will be calculated for use in determining the DPP that ultimately determines whether a provider qualifies for DSH and how much they could receive, clearly indicates that the publication of SSI Fraction data is not a final determination as to the amount of payment.

As the Medicare/SSI Fraction data published pursuant to Transmittal 12785 is not an appropriately appealable final determination, the untimeliness of the Provider's filings is not an issue. Although there is no need to address the Providers' request for a good cause extension, assuming *arguendo* that the Providers could persuade the Board that Transmittal 12785, and accompanying Medicare/SSI Fraction data, is a final appealable determination, the Board would have nevertheless denied the Providers' request for a good cause extension. In these cases, the

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[30] *See e.g.* Case No. 25-3081GC, Providers' Issue Statement at 1. Although the Providers characterizes this as the "sole issue" under appeal, the issue statement appears to encompass two separate and distinct issues: 1) the inclusion of Medicare Part C days in the denominator of the Medicare/SSI Fraction; and 2) the exclusion of patient days for individuals eligible for both Medicare and SSI from the numerator of the Medicare/SSI Fraction. This conflation of issues is contrary to 42 C.F.R. § 405.1837(a)(2) which restricts a group appeal to a "single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." *See also* PRRB Rule 13.

[31] *See* 42 U.S.C. § 1395oo(a)(1)(A)(ii).

[32] *See* 42 U.S.C. § 1395oo(b); 42 C.F.R. § 405.1837(a)(3).

Providers' appeals were filed between 192 and 199 days after the date of the issuance of the Transmittal and accompanying Medicare/SSI Fraction data which the Providers allege forms the basis for the appeal. The filings were twelve to nineteen days past the expiration of the 180-day statutory time limit to file an appeal.

In the filing of the appeals for the Providers, QRS embeds in the issue statements a request for good cause extension of the filing deadline. This request argues that the Board's grant of an extension is warranted given the challenges that the Provider Representative, QRS, experienced because of wildfires that occurred in the vicinity of QRS' Arcadia, California location in January 2025. Specifically, the issue statement states, under the heading of "Jurisdiction":

> The operations of Quality Reimbursement Services (QRS) have faced significant disruption due to the recent California wildfires which have directly impacting QRS' ability to meet the appeal deadline. As a California-based firm tasked with filing appeals on behalf of hospitals, QRS experienced substantial operational challenges, including office closures, communication failures, and staff displacement, all of which were entirely beyond QRS' control. The main office of QRS is located in Arcadia, which was one of the areas most put in danger from the fires. Staff in the Arcadia office, as well as the President of QRS, were forced to evacuate both from the QRS office and their homes. QRS was able to complete some of its work and file some appeals timely, but was unable to file all appeals timely. Given the severe impact of the wildfires on QRS's ability to prepare and finalize all of appeal(s) timely, we respectfully request a good cause extension of the filing deadline under this regulation. Granting this exception would acknowledge the significant challenges caused by these natural disasters and uphold the principles of fairness inherent in the PRRB's Rules and the regulations.[33]

Regarding a good cause extension, the regulation at 42 C.F.R. § 405.1836(b) states in pertinent part:

> The Board may find good cause to extend the time limit **only if the provider demonstrates in writing it [could] not reasonably be expected to file timely due to extraordinary circumstances beyond its control** (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180-day limit specified in § 405.1835(a)(3). . . .[34]

In the present cases, while the requests for good cause extension refer generally to the California wildfires, the requests fail to provide any specific "relevant information and documents

[33] *See e.g.* Case No. 25-3081GC, Providers' Issue Statement at 1.
[34] (Bold Emphasis added).

'demonstrat[ing] . . . [the provider] could not be expected to file timely due to extraordinary circumstances beyond its control.'"[35] There is a dearth of "relevant information" or "documents" accompanying the requests; in fact, there are no documents accompanying the requests, not even an official emergency declaration, news report, or map.

The Board notes that while QRS indicates that it "experienced substantial operational challenges, including office closures, communication failures, and staff displacement,"[36] it has provided no detail regarding the alleged operational challenges. The request, which is the same in each of the 62 cases, is devoid of any information regarding how the QRS office was affected by the wildfires (e.g., building damage, power outages, access to the site). According to QRS' website, QRS' Arcadia, California location is only one of the company's seven offices, with six offices located in other states.[37] The request does not give the Board any information with regard to which employees – especially, the named case representative – were involved in the filing of this appeal, or in which locations they work or how the company's work was distributed among the company's offices. Through its silence, QRS asks the Board to assume that the employees involved in the filing of this appeal work at the Arcadia site but does not inform the Board how and when they were impacted (e.g., access to files, access to systems (internal or to the Board's OH CDMS), personal injury). QRS asks the Board to simply accept that all 7 offices and all employees across the country were equally affected by the wildfires in California and unable to timely file these appeals. QRS does not explain why no one in an office other than Arcadia could have filed the appeal or requested an extension while California-based employees were unavailable. Nor does QRS explain why it "was able to complete some of its work and file some appeals timely, but was unable to file all appeals timely."[38] The Board notes that the wildfires started January 7, 2025, a month before the ostensible deadline that is the subject of this decision (i.e., 180 days from the Aug. 13, 2024 date of Transmittal 12785). QRS should have been aware of this deadline.

In addition to the fact that the Board does not consider the transmittal to be an appealable final determination, the Board finds that QRS has not shown good cause for a filing extension. QRS has not provided sufficient information on which the Board can base a decision. Failure of the case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines.

Conclusion:

As the Medicare/SSI Fraction data published pursuant to Transmittal 12785 is not an appropriately appealable final determination, the Providers have failed to meet the jurisdictional requirements for a hearing and the Board dismisses the 62 group appeals and removes them from the Board's docket.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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[35] Board Rule 2.1.4 v. 3.2 (Dec. 15, 2023), *see also*, 42 C.F.R. § 405.1836(b).
[36] Providers' Issue Statement at 1.
[37] *See* https://qualityreimbursement.com/contact (last visited April 14, 2025).
[38] Providers' Issue Statement at 1.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

FOR THE BOARD:

4/21/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: Kevin D. Smith -A

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Cecille Huggins, Palmetto GBA
Geoff Pike, First Coast Service Options, Inc. c/o Guidewell Source
Michael Redmond, Novitas Solutions, Inc. c/o Guidewell Source
Danelle Decker, National Government Services, Inc.
Byron Lamprecht, WPS Government Health Administrators

Listing of 62 Cases

25-3081GC	WellStar Health CY 1989 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3086GC	WellStar Health CY 1990 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3090GC	WellStar Health CY 1991 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3104GC	Baptist Health System CY 2003 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3105GC	Baptist Health System CY 2004 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3107GC	Baptist Health System CY 2005 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3109GC	Baptist Health System CY 2006 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3114GC	Baptist Health System CY 2007 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3118GC	Baptist Health System CY 2008 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3120GC	Baptist Health System CY 2009 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3122GC	Baptist Health System CY 2010 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3126GC	Baptist Health System CY 2012 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3132GC	WellStar Health CY 1992 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3135GC	WellStar Health CY 1993 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3136GC	WellStar Health CY 1994 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3137GC	WellStar Health CY 1995 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3138GC	WellStar Health CY 1996 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3139GC	WellStar Health CY 1997 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3147G	QRS CY 1989 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3150G	QRS CY 1990 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3152G	QRS CY 1991 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3153G	QRS CY 1992 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3155G	QRS CY 1993 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3156G	QRS CY 1994 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group

25-3157G	QRS CY 1995 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3174G	QRS CY 1996 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3176G	QRS CY 1997 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3180G	QRS CY 1998 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3210G	QRS CY 1999 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3214G	QRS CY 2000 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3216G	QRS CY 2001 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3218G	QRS CY 2002 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3222G	QRS CY 2003 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3227G	QRS CY 2004 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3232G	QRS CY 2005 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3233G	QRS CY 2006 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3236G	QRS CY 2007 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3238GC	WellStar Health CY 1998 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3239GC	WellStar Health CY 1999 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3240GC	WellStar Health CY 2000 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3241GC	WellStar Health CY 2001 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3242GC	WellStar Health CY 2002 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3244GC	WellStar Health CY 2003 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3247G	QRS CY 2008 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3248G	QRS CY 2009 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3249G	QRS CY 2010 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3250G	QRS CY 2011 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3251G	QRS CY 2012 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3252G	QRS CY 2013 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3253G	QRS CY 1988 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE Group
25-3254GC	Baptist Health System CY 2013 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3271GC	WellStar Health CY 2004 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3275GC	WellStar Health CY 2005 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3282GC	WellStar Health CY 2006 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3290GC	WellStar Health CY 2007 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group

25-3292GC	WellStar Health CY 2008 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3294GC	WellStar Health CY 2009 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3298GC	WellStar Health CY 2010 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3310GC	WellStar Health CY 2011 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3312GC	WellStar Health CY 2012 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3317GC	WellStar Health CY 2013 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group
25-3458GC	St. Luke's Health CY 1988 Medicare Fraction (SSI) - Statutory & Systemic Errors - GCE CIRP Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Notice of Dismissal***
Stringfellow Memorial Hospital, Prov. No. 01-0038, FYE 04/30/2017
Case No. 20-0063

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 20-0063. Set forth below is the decision of the Board to dismiss the 3 remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific), Medicaid Eligible Days, and Uncompensated Care ("UCC") payments.

Background

A. *Procedural History for Case No. 20-0063*

On **April 2, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end April 30, 2017.

On **September 30, 2019**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH SSI Percentage (Systemic Errors)[1]
3. DSH SSI Fraction / Medicare Managed Care Part C Days[2]
4. DSH SSI Fraction / Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[3]
5. DSH – Medicaid Eligible Days
6. DSH Medicaid Fraction / Medicare Managed Care Part C Days[4]
7. DSH Medicaid Fraction / Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[5]
8. Uncompensated Care ("UCC") Distribution Pool
9. 2 Midnight Census IPPS Payment Reduction[6]

[1] On April 21, 2020, the Provider transferred the issue to PRRB Case No. 20-1332GC.
[2] On April 21, 2020, the Provider transferred the issue to PRRB Case No. 20-1333GC.
[3] On April 21, 2020, the Provider transferred the issue to PRRB Case No. 20-1334GC.
[4] On April 21, 2020, the Provider transferred the issue to PRRB Case No. 20-1335GC.
[5] On April 21, 2020, the Provider transferred the issue to PRRB Case No. 20-1336GC.
[6] On April 21, 2020, the Provider transferred the issue to PRRB Case No. 20-1337GC.

As a result of the case transfers, there are three (3) remaining issues in this appeal: Issue 1 (the DSH – SSI Percentage Provider Specific), Issue 5 (the DSH – Medicaid Eligible Days), and Issue 8 (UCC Distribution Pool).

On **October 9, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[7]

On **May 22, 2020**, the Provider timely filed its preliminary position paper. With respect to Issue 5, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2017 cost report does not reflect an accurate number of Medicaid eligible days."

On **July 22, 2020**, the Medicare Contractor timely filed a Jurisdictional Challenge[8] with the Board over Issues 1, 5, and 8 requesting that the Board dismiss these issues. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **September 10, 2020**, the Medicare Contractor filed its preliminary position paper. With regard to Issue 5, the Medicare Contractor's position paper noted that: (1) the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available

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[7] (Emphasis added.)

[8] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

documentation necessary to support its position; and (2) the Provider had failed to respond to any of the Medicare Contractor's requests for that Medicaid eligible days listing.

On **January 18, 2023**, the Medicare Contractor filed a Final Request for DSH Package in connection with Issue 5.The Medicare Contractor formally requested that a listing of the Medicaid eligible days at issue plus supporting documentation be provided to the Medicare Contractor within 30 days. Notwithstanding the formal request, the Provider failed to file any response to the Medicare Contractor.

As no response was received from the Provider, on **December 17, 2024**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to furnish documentation in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); (2) the Provider failed to furnish the Medicaid eligible days listing with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2; and (3) the Provider has effectively abandoned Issue 5. Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** timely respond to that Motion.

On **November 27, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **November 28, 2023**, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the *caveat* that the "Listing [is] *pending finalization* upon receipt of State eligibility data."[9] The Listing was 5 pages with roughly 167 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 167 days) was being submitted at this late date or why it was not final (*i.e.*, why it was "pending finalization") at this late date, ***more than 6 years after the fiscal year at issue had closed***.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20-1332GC - CHS CY 2017 HMA DSH SSI Percentage CIRP Group

In their Individual Appeal Request, the Provider summarizes its DSH Payment/SSI Percentage (Provider Specific) issue as follows:

> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that

[9] (Emphasis added.)

> CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).[10]

The Group issue Statement in Case No. 20-1332GC, to which the Provider transferred Issue No. 2, reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[11]

On May 22, 2020, the Board received the Provider's preliminary position paper in 20-0063. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include

[10] Issue Statement at 1 (Sept. 11, 2019).
[11] Group Appeal Issue Statement in Case No. 20-1332GC.

> all patients that were entitled to SSI benefits in the Provider's DSH calculation based on the Provider's Fiscal Year End (June 30).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services,* No. CV-94-0055 (C.D. Cal June 2, 1995), the SSI entitlement of individuals can be ascertained from [s]tate records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the completed MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008).[12]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $14,000.

MAC's Contentions

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)
The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2. The portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[13]

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC contends that the Provider failed to properly develop its arguments within its preliminary position paper in accordance with 42 C.F.R. § 405.1853(b) and Board Rule 25.2.1 and 25.2.2. The MAC argues the Provider has not submitted a Medicaid eligible days listing and therefore, requests the Board dismiss the issue.

Issue 8 – UCC Distribution Pool

[12] Provider's Preliminary Position Paper at 8-9.
[13] Medicare Contractor's Jurisdictional Challenge at 2.

The MAC argues "that the Board does not have jurisdiction over the UCC DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2)."[14] The MAC also contends that this issue is a duplicate of PRRB Case No. 16-0769GC and should therefore be dismissed.[15]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[16] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Similarly, the Provider's response to the Motion to Dismiss was due within 30 days but the Provider failed to timely file a response. In this regard, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's three (3) remaining issues.

A. DSH Payment/SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage; and (2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Case No. 20-1332GC.

[14] *Id.* at 10.
[15] *Id*. at 12.
[16] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[17] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. 1395ww(d)(5)(F)(i)."[18] The Provider argues in its issue statement, which was included in the appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[19]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-1332GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 20-0063 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-1332GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[20], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[21] Accordingly, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 20-1332GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-1332GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records" but fails to explain how it can, explain how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2.[22] Moreover, the Board

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[17] Issue Statement at 1.
[18] *Id.*
[19] *Id.*
[20] PRRB Rules v. 2.0 (Aug. 2018).
[21] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[22] It is also not clear whether this is a systemic issue for providers in the same state subject to the CIRP rules or something that is provider specific because, if it was a common systemic issue, it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The

finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Aug. 29, 2018), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[23]

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[24]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[25]

Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

[23] (Italics and underline emphasis added.)

[24] Last accessed Oct. 15, 2024.

[25] (Emphasis added).

Accordingly, *based on the record before it*,[26] the Board finds that the SSI Provider Specific issue in Case No. 19-2704 and the group issue from the CHS CIRP group under Case No. 20-1332GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue - the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Moreover, without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for Board appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal in either the initial appeal or the position papers.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Aug. 2018) states:

> **No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits**

[26] Again, the Board notes that the Provider failed to respond to the Jurisdictional Challenge and the Board must make its determination based on the record before it.

> **of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[27]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Aug. 2018) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

> **Rule 25 Preliminary Position Papers**[28]
>
> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the following sub-sections.
>
> **25.1.1 The Provider's Position Paper**
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
> B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.

[27] (Bold emphasis added.)
[28] (Underline emphasis added to these excerpts and all other emphasis in original.)

C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on October 9, 2019 included instructions on the content of the Provider's preliminary position paper

consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 5, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[29]

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On May 22, 2020, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[30] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case. The Provider's complete briefing of this issue in its position paper is as follows:

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[29] (Emphasis added.)
[30] Provider's Preliminary Position Paper at 7-8.

Calculation of Medicaid Eligible Days

Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.

The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).

The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:

> [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.

Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2017 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Motion to Dismiss, the Medicare Contractor asserts that the Provider has failed to submit a list of additional Medicaid eligible days and neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Medicare Contractor sent a request for the Provider's list of Medicaid Eligible days (and also discussed the lack of the listing in the Medicare Contractor's own position paper filing). A request was filed formally with the Board in OH CMDS on January 18, 2023, *seven years after the end of the Provider's cost reporting period*. The Medicare Contractor also

informed the Provider in its final request for information that the deadline to respond was within 30 days. The Provider failed to file a response.

Due to the non-responsiveness of the Provider, on **December 17, 2024**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish the list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2. The Medicare Contractor thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the regulations and the Board Rules.[31]

Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** timely respond to that Motion by the January 17, 2025 deadline (*i.e.*, 30 days after December 17, 2024).

On November 28, 2023, QRS did however file a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the caveat that the "Listing [is] pending finalization upon receipt of State eligibility data." The Listing was 5 pages with roughly 167 Medicaid eligible days. QRS' filing did not explain why the listing of so many days was being submitted at this late date or why it was not final (*i.e.*, why it was "pending finalization") at this late date, ***more than 7 years after the fiscal year at issue had closed***. Regardless, this filing ***was roughly 4½ year past the deadline for including it with its preliminary position paper*** since the position paper deadline was May 27, 2020.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

The fact that the Listing was filed merely 1 day after the Provider changed its designated representative to QRS does not excuse the Provider for its failure to include the information with its preliminary position paper or its failure to timely respond to the Motion to Dismiss. Board Rule 5.2 makes clear that "the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings." Moreover, the Board rejects the

[31] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

Provider's attempt to label the November 28, 2023 filing as a "Supplement to Position Paper" and does not accept that filing because:

1. The alleged "Supplement" was filed ***more than 4½ years*** *after the deadline* for that exhibit to be included with its preliminary position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)). Indeed, the Provider failed to timely reply to the Medicare Contractor's Motion to Dismiss Issue 5.

2. The alleged "Supplement" fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the roughly 167 days was not previously available, *in whole or in part* (*i.e*., it is not clear why the Provider failed to identify a single day at issue until more than 4 years after this appeal was filed and more than 7 years after the fiscal year at issue had closed); and (c) why the listing still was ***not*** a "*final*" listing at this late date.

3. Neither the Board Rules nor the October 9, 2019 Case Acknowledgment and Critical Due Dates permit the Provider to file a "Supplement" to its preliminary position paper (nor did the Provider allege in the "Supplement" filing that they do).

4. Given the fact that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the position paper filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its preliminary position paper or a supplement of documents that were identified in the preliminary position paper as being unavailable consistent with Board Rule 25.2.2. However, neither the preliminary position paper nor the alleged "Supplement" identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the alleged "Supplement" cannot be considered a refinement of the position paper since no specific days or listing were included with the preliminary position paper.[32]

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[33] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provider the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary

[32] *See, e.g.,* Board Rule 27.3 (Aug. 2018) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."
[33] (Emphasis added.)

evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[34]

C. UCC Distribution Pool

Last, the Board finds that it does not have jurisdiction over the DSH UCC payment issue in the above-referenced appeal because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).

1. Bar on Administrative Review

The Board does not generally have jurisdiction over Uncompensated Care DSH payment issues because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation. Based on these provisions, judicial and administrative review is precluded under 42 U.S.C. §§ 1395ff and 1395oo for:

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[35]
>
> (B) Any period selected by the Secretary for such purposes.

2. Interpretation of Bar on Administrative Review

a. Tampa General v. Sec'y of HHS

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs*. ("*Tampa General*"),[36] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[37] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost

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[34] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

[35] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.

[36] 830 F.3d 515 (D.C. Cir. 2016).

[37] 89 F. Supp. 3d 121 (D.D.C. 2015).

data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[38] The D.C Circuit also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[39]

The D.C. Circuit went on to address the provider's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[40]

b. DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[41] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[42] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that it had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, the D.C. Circuit found the same relationship existed with regard to the methodology used to generate the estimates.[43]

[38] 830 F.3d 515, 517.
[39] *Id.* at 519.
[40] *Id.* at 521-22. *See also Yale New Haven Hosp. v. Becerra*, 56 F.4th 9 (2nd Cir. 2022) (citing to *Tampa General*"); *Ascension Providence v. Becerra*, No. 21-cv-369, 2023 WL 2042176 (N.D. Ind. 2023) (citing to *Tampa General*").
[41] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[42] *Id.* at 506.
[43] *Id.* at 507.

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[44] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[45] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[46] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[47] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[48]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[49]

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[50] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.[51] For review to be available in these circumstances, the following criteria must satisfied:

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[44] 514 F. Supp. 249 (D.D.C. 2021).
[45] *Id.* at 255-56.
[46] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[47] *Id.* One provider had a cost report for the 6-month period from July 1, 2011 to December 31, 2011 and another for the 12-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the 9-month period from October 1, 2011 to June 30, 2012 and another for the 12-month period from July 1, 2012 to June 30, 2013.
[48] *Id.*
[49] *Id.* at 262-64.
[50] *Id.* at 265.
[51] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[52]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[53] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

d. Ascension Borgess Hospital v. Becerra

Even more recently, the D.C. Circuit revisited, once again, the judicial and administrative bar on review of uncompensated care DSH payments again in *Ascension Borgess Hospital v. Becerra* ("*Ascension*").[54] In *Ascension*, the providers sought an order declaring the Worksheet S-10 audit protocol was unlawful, vacating the payments based on the Worksheet S-10 audit, requiring the Secretary to recalculate those payments, and setting aside the Board decisions refusing to exercise jurisdiction over their appeals.[55] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the providers claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."[56] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[57] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[58]

The Board concludes that the same findings are applicable to the Provider's challenge to their FFY 2017 UCC payments. The Provider is challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2017. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that

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[52] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[53] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[54] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[55] *Id*. at *4.
[56] *Id.* at *9.
[57] 139 S. Ct. 1804 (2019).
[58] *Ascension* at *8 (bold italics emphasis added).

the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review.

* * * * *

Based on the foregoing, the Board has dismissed the three (3) remaining issues in this case – (Issues 1, 5 and 8). As no issues remain, the Board hereby closes Case No. 20-0063 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

4/22/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
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RE: ***Notice of Dismissal***
Bayfront Health – St. Petersburg, Prov. No. 10-0032, FYE 09/30/2017
Case No. 23-0012

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0012. Set forth below is the decision of the Board to dismiss the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) issue.

Background

A. *Procedural History for Case No. 23-0012*

On **April 11, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2017.

On **October 4, 2022**, the Provider filed this individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Unduly Narrow Definition of SSI Entitlement[1]
3. DSH Payment – Medicaid Eligible Days[2]
4. DSH Payment – Medicare/SSI and Medicaid Fractions – Medicare Managed Care Part C Days[3]
5. DSH Payment – SSI/Medicare and Medicaid Fractions – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[4]

On **October 12, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates,[5] providing among other things, the filing deadlines for the parties' preliminary position

[1] On May 30, 2023, this issue was transferred to Case No. 20-0997GC.
[2] This issue was withdrawn on June 10, 2024.
[3] On May 30, 2023, this issue was transferred to Case No. 19-2620GC.
[4] On May 30, 2023, this issue was transferred to Case No. 20-1383GC.
[5] An updated Critical Due Dates notice was sent on Mar. 16, 2023.

papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[6]

On **May 30, 2023**, the Provider filed its preliminary position paper.

On **August 22, 2023**, the Medicare Contractor filed a Jurisdictional Challenge[7] with the Board over Issue 1[8] requesting that the Board dismiss this issue. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **August 23, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **September 5, 2023**, the Medicare Contractor timely filed its preliminary position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20-0997GC – CHS CY 2017 DSH SSI Percentage CIRP Group

In their Individual Appeal Request, the Provider summarizes its DSH Payment/SSI Percentage (Provider Specific) issue as follows:

> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.

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[6] (Emphasis added.)

[7] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

[8] The motion also challenged Issue 3, but that was subsequently withdrawn.

> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).[9]

The Group Issue Statement in Case No. 20-0997GC, to which the Provider transferred Issue No. 2, reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis:**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA Records
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking[10]

[9] Issue Statement at 1 (Oct. 4, 2022).
[10] Group Issue Statement for PRRB Case No. 20-0997GC.

On May 30, 2023, the Board received the Provider's preliminary position paper in 23-0012. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its SSI percentage published by [CMS} was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[11]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $64,147.

MAC's Contentions

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. The MAC contends that Issue 1 should be dismissed because it is duplicative of Issue 2, which was transferred to PRRB Case No. 20-0997GC. The portion of Issue 1 related to SSI realignment should be dismissed because it was not addressed in its preliminary position paper, there was no final determination over SSI realignment, and the appeal is premature as the Provider has not exhausted all available remedies.[12]

[11] Provider's Preliminary Position Paper at 9 (May 30, 2023).
[12] Medicare Contractor's Jurisdictional Challenge at 5-6 (Aug. 22, 2023).

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[13] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage; and (2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage issue that was appealed in Case No. 20-0997GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[14] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[15] The Provider argues in its issue statement, which was included in the appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[16]

The Provider's DSH SSI Percentage issue in Group Case No. 20-0997GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not

[13] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[14] Issue Statement at 1.
[15] *Id.*
[16] *Id.*

consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 23-0012 is duplicative of the DSH SSI Percentage issue in Case No. 20-0997GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6, the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[17] Accordingly, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue No. 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 20-0997GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-0997GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records" but fails to explain how it can, explain how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2.[18] Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (Nov. 1, 2021) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

25.2.2 Unavailable and Omitted Documents (Nov. 1, 2021)

[17] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

[18] It is also not clear whether this is a systemic issue for CHS providers in the same state subject to the CIRP rules or something that is provider specific because, if it was a common systemic issue, it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

> If documents necessary to support your position are still unavailable, then provider the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.[19]

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[20]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[21]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 20-0997GC.

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[19] (Italics and underline emphasis added.)
[20] Last accessed Oct. 15, 2024.
[21] (Emphasis added).

Accordingly, *based on the record before it*,[22] the Board finds that the SSI Provider Specific issue in Case No. 23-0012 and the group issue from the CHS CIRP group under Case No. 20-0997GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

Additionally, in its Preliminary Position Paper, the Provider states, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra [sic] (Appellants' reply brief included as Exhibit P-3)." The Board finds that this incorporation by reference does not comply with the regulatory and Board rule requirements to *fully* develop the Provider's position in the Preliminary Position Paper. Particularly, 42 C.F.R. § 405.1853 provides in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[23]

An incorporation of arguments by reference from a different case simply fails to do so. Accordingly, the Board dismisses that portion of the issue as well.

2. *Second Aspect of Issue 1*

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue - the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Moreover, the Provider's cost reporting period is already aligned with the Federal fiscal year end. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

* * * * *

Based on the foregoing, the Board has dismissed Issue 1. As there are no other issues remaining, the case will close and be removed from the Board's docket.

---

[22] Again, the Board notes that the Provider failed to respond to the Jurisdictional Challenge and the Board must make its determination based on the record before it.
[23] (Emphasis added).

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

4/22/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Request for Reinstatement***
Custom Hospice, LLC (Provider Number 23-1638)
Appeal Period:12/31/2023
Case Number: 25-4148

Dear Mr. Estep and Ms. Van Arsdale:

The Provider Reimbursement Review Board ("Board") has reviewed the subject appeal in response to the Representative's April 18, 2025 request for reinstatement. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

On March 26, 2025, Calhoun Bhella and Sechrest LLP ("Calhoun Bhella"/ "Representative") filed the above-referenced individual appeal request on behalf of Custom Hospice, LLC ("Custom"/"Provider"). The appeal request involved the Hospice Quality Reporting Program ("HQRP") and the sole issue in dispute was listed as the 4% APU Reduction.

Although the Provider's final determination date was entered in the Office of Hearing Case and Document Management System ("OH CDMS") as September 30, 2024, the final determination support uploaded was a copy of an October 13, 2023 "*Notice of Quality Reporting Program Decision Overturned*." Additional support filed with the appeal included a copy of a July 1, 2024 "*Non-Compliance Notification that May Result in a 4% Reduction to Your FY 2025 Annual Payment Update for CCN 231638*." A copy of the September 30, 2024 final determination, on which the Provider indicated the appeal was based, was not included.

Consequently, on April 14, 2025, the Board dismissed Case No. 25-4148 because the appeal failed to meet the minimum filing requirements, one of which requires that a copy of the final determination be included.[1]

[1] The Board's letter also pointed out that FY under appeal appears to be 2025; not 2023, as the Provider indicated.

On April 18, 2025, Calhoun Bhella filed a request for reinstatement of the case and included a copy of the previously omitted September 30, 2024 final determination under appeal. According to Calhoun Bhella, when the individual appeal was filed, they inadvertently submitted a copy of the favorable reconsideration decision for the previous calendar year rather than the September 30, 2024 determination.

In support of reinstatement, Calhoun Bhella asserted the following:

1) The Provider's original appeal was filed timely and, although it did not include a copy of the September 30, 2024 determination, it did include a detailed discussion of, and reference to, the date of that determination three times in its issue statement. The issue statement met the three aspects of the statutory filing requirements because it 1) explained its dissatisfaction with a determination 2) it met the $10,000 reimbursement threshold; and 3) it referred to the date of the determination (three different times) which was enough to establish that the appeal was filed within 180 days;
2) The Courts and Board Rules allow the Board to dismiss appeals, only if the provider lacks a justifiable excuse for any claimed oversight. Therefore, the inadvertent omission of the 2024 Reconsideration determination in this case qualifies as excusable neglect;
3) The correct Reconsideration determination has now been submitted, which cures the defect identified in the Board's dismissal satisfying the requirements in 42 C.F.R. § 405.1835(b)(3) and Board Rule 7.1.2.4;
4) The Provider's appeal was timely filed within 180 days of the September 30, 2024 final determination. Omitting a copy of the September 30, 2024 determination was a technical deficiency which was rectified without delay;
5) Reinstatement of the appeal does not prejudice the Medicare Contractor and supports procedural fairness whereas denial would result in significant prejudice, depriving the Provider of its statutory right to a fair hearing;
6) Reinstatement is consistent with Regulations and Board Rules. Specifically, the Representative cites 42 C.F.R.§ 405.1885 (a)(1)-(2) which gives the Board the authority to reopen the matter and Board Rule 47.3, which grants the Board discretion to reinstate a case upon a demonstration of good cause; and
7) The Board's dismissal of the appeal for failure to provide a copy of the final determination goes against the Provider's statutory right to a hearing as cited in 42 U.S.C. § 1395oo(a).

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

Calhoun Bhella has filed a motion requesting that the Board reinstate Custom's Quality Reporting appeal under Case No. 25-4148. Board Rule 47.1 governs motions for reinstatement of an issue or case:

> **47.1 Motion for Reinstatement**
>
> A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s) (*see* 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (*see* Rule 44 governing motions). **The Board will not reinstate an issue(s)/case if the provider was at fault. . . .**
> . . . .
>
> **47.3 Dismissals for Failure to Comply with Board Procedures**
>
> **Upon written motion demonstrating good cause**, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, **administrative oversight**, settlement negotiations or a change in representative **will not be considered good cause to reinstate**. . . .[2]

Board Rule 47.1 makes it clear that the Board will not reinstate a case or issue **if the provider was at fault.** Additionally, the Board refers the Representative to Board Rule 47.3, which is specific to dismissals due to failure to comply with Board procedures, which details what the Board **does not consider to be good cause for reinstatement**, specifically, *administrative oversight*. In this case, the Board finds that the Representative was at fault for omitting the final determination from the original filing due to a self-admitted administrative error.

The Board agrees that the Representative has cured the defect in this case by belatedly filing a copy of the correct final determination with its motion for reinstatement. In addition, the Board has considered Calhoun Bhella's assertion that, ". . . reinstatement is the default when the missing filing is supplied,"[3] and that a "[d]enial after the cure would render the second sentence of Rule 47.3 meaningless, violating the canon that agency rules must be read to give effect to every clause." However, the Board disagrees with the Representative's assertion that simply providing the missing document ***guarantees*** reinstatement. Instead, it is the Board's position that curing the defect simply meets the "*prerequisite*" for Board ***consideration*** of a Motion for Reinstatement under Board Rule 47.3.

The Board points to Calhoun Bhella's concession that it "***inadvertently*** included a copy of a favorable Reconsideration Decision rendered by CMS the previous calendar year."[4] Despite the Representative's rationalization that the Reconsideration Determination submitted was relevant even though it was not the determination being appealed, the fact is the Provider failed to comply with 42 C.F.R. § 405.1835(b)(3) which mandates that an appeal include "A copy of the final contractor or Secretary determination under appeal[.]".

---

[2] (Italics emphasis in original, and bold emphasis added except the titles had bold emphasis in original.)
[3] April 18, 2025 Reinstatement Request at 4.
[4] *Id.* at 1 (Emphasis added).

With regard to the Representative's claim that its reference to the correct final determination in the issue statement was enough for the Board to determine it had jurisdiction, that does not change the fact that the Provider was required to ***submit*** a copy of the determination *by the filing deadline*. Further, the Representative describes its failure to provide the September 30, 2024 determination as an "oversight [*that*] was unintentional and harmless . . .,"[5] and "purely technical"[6] which reinforces the Board's conclusion that the omission was an administrative oversight.

Finally, the Board finds the Representative's motion for reinstatement to be deficient. Although Calhoun Bhella asserts reinstatement would not prejudice the Medicare Contractor, the motion for reinstatement does not include a statement, as required by Board Rule 44.2, confirming it had actually contacted the Medicare Contractor prior to filing the motion to determine whether the Medicare Contractor concurred.[7]

Therefore, the Board finds it properly exercised its authority under 42 C.F.R. § 405.1868(b) to dismiss the case and declines to exercise its discretion to reinstate Case No. 25-4148. The Board finds that the Representative was at fault and failed to establish good cause under Board Rules 47.1 and 47.3 as it admitted fault for not including a copy of the correct final determination. In addition, the Representative failed to confer with the Medicare Contractor prior to filing the motion, as required by Board Rules 47.1 and 44. Accordingly, this case remains closed and off the Board's docket.

Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

FOR THE BOARD:

4/25/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: Kevin D. Smith -A

cc: Wilson C. Leong, Federal Specialized Services

[5] April 18, 2025 Reinstatement Request at 2.
[6] *Id.* at 3.
[7] Board Rule 44.2 Duty to Confer (v. 3.2, Dec. 15, 2023).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Leslie Goldsmith, Esq.
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RE: ***Expedited Judicial Review Decision***
24-1722GC: *New York-Presbyterian CY 2019 Capital DSH CIRP Group*
24-1878GC: *Penn State Health CY 2020 Capital DSH CIRP Group*
25-1180GC: *UPMC CY 2021 NPR Capital DSH CIRP Group*

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the April 1, 2025 consolidated request for expedited judicial review[1] ("EJR") for the above-referenced common issue related party ("CIRP") group appeals. The decision with respect to EJR is set forth below.[2]

Issue under Dispute

In these group cases, the Providers are challenging:

> [t]he validity of the regulation at 42 C.F.R. § 412.320(a)(1)(iii), which bars hospitals that are geographically urban and reclassify as rural under 42 C.F.R. § 412.103 from receiving a capital disproportionate share hospital ("DSH") add-on payment, known as the capital DSH adjustment. The Providers challenge the validity of 42 C.F.R. § 412.320(a)(1)(iii) on a number of grounds including that the regulation (a) is inconsistent with the controlling Medicare statute, (b) was adopted in violation of the Administrative Procedure Act, and (c) is arbitrary and capricious.[3]

Background:

Under the inpatient prospective payment system ("IPPS"), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for operating costs ("operating IPPS") as set forth at § 1395ww(d); and one for capital costs ("capital IPPS") as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to

[1] Providers' Petition for Expedited Judicial Review at 1 (Apr. 1, 2025) ("Request for EJR").
[2] The Request for EJR encompasses ten (10) group cases. On April 7, 2024, pursuant to Board Rule 44.6 (2023), the Medicare Contractor's representative made a filing which indicated it would be submitting substantive claim challenges "as to many of the providers." Substantive Claim Challenges were timely filed in seven (7) of the cases, which will be addressed by the Board under separate cover.
[3] Request for EJR at 1.

create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.[4] This case focuses on the capital IPPS.

1. Geographic Reclassification

In 1989, Congress created the Medicare Geographic Classification Review Board ("MGCRB") which implemented a geographic reclassification system in which IPPS hospitals can be reclassified to a different wage index area[5] for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.[6] This includes an IPPS hospital reclassifying from a rural to an urban labor market, or vice versa.

2. Operating DSH Adjustment Under Operating IPPS

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under operating IPPS.[7] Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[8]

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.[9] One of the adjustments is the hospital-specific Disproportionate Share Hospital ("DSH") adjustment as set forth at 42 U.S.C. § 1395ww(d)(5)(F), which requires the Secretary to provide an adjustment (*i.e.*, an increase in the operating IPPS payment) to hospitals that "serve [] a significantly disproportionate number of low-income patients."[10]

A hospital may qualify for a DSH adjustment to its operating IPPS payments based on its disproportionate patient percentage ("DPP").[11] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[12]

---

[4] Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), *available at* https://oig.hhs.gov/oas/reports/region1/11700500.pdf (last visited Oct. 20, 2022) ("*Significant Vulnerabilities*").
[5] *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).
[6] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). *See also Significant Vulnerabilities* at 4-5.
[7] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[8] *Id.*
[9] *See* 42 U.S.C. § 1395ww(d)(5).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[12] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

The DSH adjustment provided under operating IPPS is ***not*** at issue in this case. The DSH adjustment is relevant because certain standards set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment that the Secretary adopted for purposes of capital IPPS.

3. Capital DSH Adjustment Under Capital IPPS

A hospital's *capital* costs are paid separately under capital IPPS (*i.e.*, separate and apart from payment for a hospital's *operating* costs under the operating IPPS). Specifically, on December 22,1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987 ("OBRA-87") and OBRA-87 § 4006(b) required the Secretary to establish the capital IPPS for cost reporting periods beginning in FY 1992.[13] OBRA-87 § 4006(b) was codified at 42 U.S.C. § 1395ww(g) which states, in pertinent part:

> **(g) Prospective payment for capital-related costs; return on equity capital for hospitals**
>
> (1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall,* for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .
>
> (B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;
>
> (ii) *may provide for <u>an adjustment</u> to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located*;
>
> (iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and
>
> (iv) may provide for suitable adjustment to reflect hospital occupancy rate.
>
> (C) In this paragraph, the term ''capital-related costs'' has the meaning given such term by the Secretary under subsection (a)(4)

[13] Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).

> as of September 30, 1987, and does not include a return on equity capital.[14]

Significantly, the statute governing capital IPPS does not specifically mandate or address the use of a capital DSH adjustment. Rather, it specifies generally that the Secretary "may provide for an adjustment to take into account variations in relative costs." As described below, the Secretary exercised his discretion to establish the c*apital* DSH adjustment at issue in this case which is limited in that it ***only*** applies to *urban* hospitals with 100 or more beds and that serve low-income patients.[15]

1. Initial Implementation of Capital IPPS and the Capital DSH Adjustment

To the end, the Secretary published a final rule on August 30, 1991 to establish the capital IPPS.[16] In implementing the capital IPPS, the Secretary recognized that he had discretion on whether to apply many of the adjustments statutorily required under operating IPPS to capital IPPS:

> We are persuaded by the argument advanced by some commenters, including ProPAC, that in the long run the ***same*** adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. *While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process),* ***we have the latitude to develop adjustments based on combined costs for the capital prospective payment system***.
>
> We do not believe that it would be appropriate to use the current operating payment adjustments in the capital prospective payment system either permanently or on an interim basis until legislation is enacted changing the operating adjustments to the level appropriate for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME) exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should

[14] (Underline and italics emphasis added.)
[15] 42 C.F.R. § 412.320(a)(1). *See also* MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 2 (rev. Nov. 2021), *available at* https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Apr. 29, 2025).
[16] 56 Fed. Reg. 43358 (Aug. 30, 1991).

> reflect only the higher Medicare costs associated with teaching activity and treating low income patients.[17]

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more than 100 beds. The proposal was described as follows:

> In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to ({1 +DSHP)$^{0\text{-}4176}$ - 1)), where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.
>
> Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.[18]

In adopting his proposal, the Secretary gave the following justification:

> *Comment*: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.
>
> *Response*: In the final rule, we are providing that urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level than other hospitals. For FY 1992, the minimum payment level is 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also

[17] *Id.* at 43369-70 (emphasis added).
[18] *Id* at 43377.

> be eligible for the higher minimum payment level. We are not extending the special protection to other hospitals that receive disproportionate share payments under the operating prospective payment system. In urban areas, we believe that our criteria properly focuses on those hospitals that serve a large disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries**.[19]

In response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to rural hospitals with 500 or more beds:

> As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1,1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(l)(ii) of the regulations.[20]

[19] *Id.* at 43409-10 (bold and underline emphasis added).
[20] *Id.* at 43377.

Similarly, in response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to other classes of hospitals such as "[a]ll small urban hospitals, hospitals with high Medicare usage, rural hospitals, rural hospitals with at least 100 beds, rural referral centers, or those hospitals with high 'total government' usage":

> In developing the capital disproportionate share adjustment for this final rule, we examined the relationship between the disproportionate share patient percentage and total costs per case for each class of hospital that is currently receiving an operating payment adjustment. We believe that only those hospitals that merit the adjustment according to our regression analysis should receive additional capital payments for serving low income patients. The regression results did not indicate any significant relationship between total costs per case and disproportionate share patient percentage for any of the special groups mentioned above.[21]

In response to comments, the Secretary also looked at setting a threshold DSH percentage to qualify for a capital DSH adjustment but rejected that alternative approached based upon the following explanation:

> We examined closely the possibility of using a disproportionate share patient percentage threshold in our total cost regression analysis. We were unable to find any threshold level of disproportionate share percentage below which no payment adjustment was merited, or a threshold above which a higher adjustment was merited. As a result, we believe that it is most equitable to make a capital disproportionate share payment to all qualifying hospitals with a positive patient percentage, rather than penalize some hospitals that have a higher cost of treating low income patients but whose patient percentage is below the artificial level we would set.[22]

Further, in response to comments, the Secretary rejected not providing *any* capital DSH adjustment based on the explanation:

> We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We believe that it is appropriate for Medicare's payment to recognize these higher Medicare patient care costs.[23]

---

[21] *Id.* at 43378.
[22] *Id.* at 43379.
[23] (Emphasis added.)

Finally, the Secretary addressed how MGCRB reclassifications, in certain circumstances, affect whether an IPPS hospital qualifies for the capital DSH adjustment:

> *Comment*: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.
>
> *Response*: Any hospital that is reclassified to an urban area by the MGCRB for purposes of its standardized amount is considered to be urban for all prospective payment purposes other than the wage index. As such, if any hospital reclassified by the MGCRB to an urban area for purposes of the standardized amount has at least 100 beds, it would be eligible for capital disproportionate share payments. We note that a rural hospital reclassified for purposes of the wage index only is still considered a rural hospital, and as such, will not be eligible for capital disproportionate share payments.[24]

The resulting regulations governing capital IPPS were codified at 42 C.F.R. Part 412, Subpart M (§§ 412.300 to 412.374). The regulation governing the capital DSH adjustment was codified at § 412.320 which, at initial implementation, stated:

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).
>
> (b) *Payment adjustment factor*. (1) <u>If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments</u>, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital's disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.
>
> (2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.[25]

[24] *Id.*
[25] *Id*. at 43452-53.

2. *Reclassification of Certain IPPS Urban Hospitals as Rural for Purposes of Operating IPPS Pursuant to BBRA § 401 and Impact on Capital IPPS Adjustments*

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA") and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.[26] IPPS hospitals are reclassified per BBRA § 401 are often referred to as "§ 401 hospitals."

On August 1, 2000, the Secretary published the interim final rule to, in part, implement BBRA § 401 and stated in the preamble that a hospital reclassified as rural pursuant to § 401 is treated as rural for ***all*** purposes under operating IPPS, including the DSH adjustment for operating IPPS:

> *A hospital that is reclassified as rural* under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, ***is treated as rural for all purposes*** *of payment under the Medicare inpatient hospital prospective payment system* (section 1886(d) of the Act), *including* standardized amount (§§ 412.60 et seq.), wage index (§ 412.63), and ***disproportionate share calculations*** (§ 412.106) as of the effective date of the reclassification.[27]

On August 1, 2000, the Secretary also published the FY 2001 IPPS Final Rule which included the following discussion on the effect of reclassification of a hospital from urban to rural pursuant to BBRA § 401:

> In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. ***That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes***. In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action

[26] BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).
[27] 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added.)

appears warranted. We also sought specific comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.

****

Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. *If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area. Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113*. In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106– 113, which authorizes a 30-percent expansion in a rural hospital's resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME, which are made under section 1886(h) of the Act.)

> Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.
>
> ****
>
> We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.
>
> ****
>
> *We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary*. ***Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify***. As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.[28]

Thus, both the August 1, 2000 interim final rule and the FY 2001 IPPS Final Rule confirmed that urban hospitals reclassified as rural pursuant to BBRA § 401 would be treated as rural for all purposes of operating IPPS, including DSH adjustments. The Secretary memorialized this policy in regulation at 42 C.F.R. § 412.103 (2000) which states in pertinent part:

> **§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural**.
>
> (a) *General criteria*. A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
>
> 1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and

[28] 65 Fed. Reg. 47054, 47087-89 (Aug. 1, 2000).

> Services Administration which is available via the ORHP website at http:// www.nal.usda.gov/orph or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857.
>
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
>
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.[29]

Neither the August 1, 2000 interim final rule nor the FY 2001 IPPS Final Rule explicitly discussed the impact on capital DSH adjustments under capital IPPS. However, through operation of the cross-reference in 42 C.F.R. § 412.320(a) to § 412.63(a) in the phrase "the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area",[30] it would appear that hospitals reclassified from urban to rural were ***not*** eligible for capital DSH adjustments under capital IPPS. In this regard, the Board notes that, following the 2000 rulemaking process, § 412.63(a)-(b) (2001) read, in pertinent part:

> (a) *General rule*. (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.
>
> (2) **Each such rate is determined for hospitals located in urban <u>or</u> rural areas** within the United States and within each such region respectively, **as described in paragraphs (b)** through (g) of this section.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, **except that**, effective January 1, 2000, **a hospital reclassified as rural may mean** a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or **a**

[29] 65 Fed. Reg. 47026, 47048.
[30] 56 Fed. Reg. at 43452.

> **reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103**.[31]

The specific reference in § 412.63(b) to urban to rural reclassifications made under § 412.103 makes clear that capital DSH adjustments would not apply to hospitals reclassified from urban to rural pursuant to BBRA § 401 which as noted above was implemented at § 412.103.

3. Changes to Operating IPPS Required by MMA § 401 and Their Effect on Capital IPPS

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") and MMA § 401 to equalize operating IPPS payments between urban and rural hospitals.[32] Specifically, § 401 specifies that, beginning with FY 2004, all IPPS hospitals are paid on the basis of the large urban standardized amount under operating IPPS.

The Office of Management and Budget publishes information on core-based statistical areas ("CBSAs") and the Secretary has used this information for purposes of defining labor market areas for use in the wage index for operating IPPS.[33] On June 6, 2003, OMB announced the new CBSAs, comprised of metropolitan statistical areas ("MSAs") and the new Micropolitan Areas based on Census 2000 data.[34]

On August 11, 2004, the Secretary published the FY 2005 IPPS Final Rule and this rule finalized revisions to the operating IPPS regulations to both implement MMA § 401 as well as adopt OMB's new CBSA designations.[35] With respect to implementing MMA § 401, the Secretary revised 42 C.F.R. § 412.63 to apply only to years through 2004 and added a new § 412.64 to implement MMA § 401 for federal rates for FYs 2005 forward. Specifically, § 412.64 reads in pertinent part:

> **§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.**
>
> (a) *General rule*. CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the following definitions apply:

[31] (Bold and underline emphasis added.)
[32] Pub. L. 108–173.
[33] 69 Fed. Reg. 48916, 49026 (Aug. 11, 2004).
[34] *Id.*
[35] 69 Fed. Reg. 48916 (Aug. 11, 2004).

(i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.

(ii) The term *urban area* means—

(A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(C) The term *rural area* means any area outside an urban area.

(D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

(2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.

(3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.

(4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the

> change. Such a change in MSA designation may occur as a result of redesignation of an MSA by the Executive Office of Management and Budget.[36]

Significantly, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: "A hospital is classified as a 'disproportionate share hospital' for the purposes of capital prospective payments if the hospital is located, *for purposes of receiving payment under § 412.63(a)*, in an urban area."[37] As a result of the FY 2005 IPPS Final Rule, § 412.320(a) was updated to reference § 412.64 as it relates to FYs 2005 forward:

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a ''disproportionate share hospital'' for the purposes of capital prospective payments <u>if either of the following conditions is met</u>:
>
> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) <u>For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64</u>.[38]

Again, as previously noted, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

Finally, in the preamble to the FY 2005 IPPS Final Rule, the Secretary included the following discussion on the impact of the new CBSAs on geographic reclassifications:

> Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB's new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to

[36] *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).
[37] (Emphasis added.)
[38] 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

> revise § 412.316(b) and § 412.320(a)(1) to specify that, for discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.
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> The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.
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> As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.[39]

[39] 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004).

4. August 18, 2006 Revisions to the Capital DSH Adjustment

In the FY 2007 Proposed IPPS Rule, the Secretary[40] announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.[41]

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and Budget's ("OBM's") new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005.[42]

In the FY 2007 IPPS Final Rule published on August 18, 2006, the Secretary finalized these technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment:

> These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.
>
> These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).
>
> We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital

[40] of the Department of Health and Human Services.
[41] 71 Fed. Reg. 23996, 24122 (Apr. 25, 2006).
[42] *Id.*

> reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.[43]

In adopting these changes, the Secretary noted that it did not receive any public comments on the proposed change as published in the proposed rule published on May 17, 2006.[44]

As a result of the FY 2007 IPPS Final Rule, the regulation, subparagraph (iii) was added to 42 C.F.R. § 412.320(a)(1) so that revised § 412.320(a) read, in pertinent part:

> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if either of the following conditions is met:
>
> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.
>
> **(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.[45]**

5. *Litigation Challenging the Validity of 42 C.F.R. § 412.320(a)(1)(iii) as added by the FY 2007 IPPS Final Rule*

The validity of 42 C.F.R. § 412.320(a)(1)(iii) was addressed in *Toledo Hosp. v. Becerra* ("*Toledo*"),[46] wherein the hospital made the following contentions:

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[43] 71 Fed. Reg. 47870, 48104-48105 (Aug. 18, 2006).
[44] *Id.*
[45] (Bold emphasis added.)
[46] 621 F.Supp.3d 13 (D.D.C. 2021).

> Toledo Hospital contends that the Secretary's 2006 rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to "take into account" relative costs of capital for various hospital types and areas of location, as subsection (g) requires.[47]

In *Toledo*, U.S. District Court for the District of Columbia ("D.C. District Court") outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.[48] The Court also noted how Congress enacted legislation in 1999[49] allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into an urban labor market area for the purposes of fixing its wage index.[50] The Court also noted the separate IPPS payment for a hospital's *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R. § 412.320 for large urban hospitals (the capital DSH payment).[51] The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.[52]

The appellants in *Toledo* were geographically located in an urban labor market area, but applied to the Secretary (and were approved) to reclassify as rural under § 401. The appellants thereafter applied to the MGCRB to reclassify their wage index to an urban labor market area. The appellants' Medicare Contractor later denied their requests for capital DSH adjustments due to their § 401 rural reclassifications. Before the D.C. District Court, the hospitals argued that 42 C.F.R. § 412.320(a)(1)(iii) violated the plain language of the Medicare Act and that it was promulgated in in an arbitrary and capricious manner.[53]

The D.C. District Court rejected the argument that the capital DSH policy in 42 C.F.R. § 412.320(a)(1)(iii) violated the Medicare Act on its face, finding that the Secretary was not prohibited from treating § 401 reclassified hospitals as rural for operating PPS purposes while denying urban status for the purposes of the capital DSH adjustment.[54] The Court next examined, however, whether the Secretary's decision to do so was reasonable. The D.C. District Court made the following findings:

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[47] *Id.* at *25 (citations omitted).
[48] *Id.* at *18-19.
[49] 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a "§ 401" hospital.
[50] *Toledo* at *19.
[51] *Id.* at *19-20.
[52] *Id.* at *21.
[53] *Id.* at *22.
[54] *Id.* at *23-25.

1. "if the Secretary had any policy concerning Section 401 reclassifications before 2006, he never announced such a policy, much less explained the basis for it."[55]

2. The Secretary's decision to not provide a capital DSH adjustment was arbitrary because:

   - "The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006."[56]

   - "[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements."[57]

   - "The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp*., 797 F.3d at 1161 (upholding Secretary's regulation where the Secretary explained why 'added precision' 'would not justify the added complication') (quotation omitted)."[58]

   - "The agency cannot 'entirely fail[ ] to consider' the "relevant data" and the factors that Congress directed it to review. *State Farm*, 63 U.S. at 43. 103 S.Ct. 2856. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did he take costs into account at all."[59]

Notwithstanding these findings, the D.C. District Court declined to vacate 42 C.F.R. § 412.320(a)(1)(iii) because "vacatur of a rule is not an appropriate remedy on review of an adjudication."[60] Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants' eligibility for a capital DSH adjustment.[61]

Providers' Request for EJR

As background, "[e]ach of the Providers is an acute care hospital paid by Medicare pursuant to the inpatient and capital [prospective payment systems]. During the years under appeal, the hospitals were all geographically located in urban areas, operated more than 100 beds, served low-income patients and, for all or part of the year, received [§] 401 rural reclassifications pursuant to 42 C.F.R. § 412.103."[62]

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[55] *Id.* at *29.
[56] *Id.*
[57] *Id.*
[58] *Id.*
[59] *Id.*
[60] *Id.* at *30.
[61] *Id.*
[62] Request for EJR at 7.

The Providers are challenging the validity of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent with the underlying operating PPS statute, in particular 42 U.S.C. § 1395ww(d)(8)(B), which states that hospitals that have undergone a rural reclassification are rural only for purposes of this subsection 1395ww(d). The Providers note that "[t]he capital PPS provisions are located in an entirely different section of the statute, in 42 U.S.C. § 1395ww(g), and therefore a rural reclassification under the subsection (d) operating PPS provisions does not apply for subsection (g) capital PPS purposes."[63]

The Providers believe that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(g), and the regulation must be found invalid.[64] The Providers assert that "the Secretary has implicitly acknowledged that he cannot apply rural status for hospitals that have undergone a rural reclassification to payment provisions outside of subsection (d)", and provides as an example, that "the Secretary has stated with respect to direct graduate medical education ("GME") that no adjustments to the direct GME cap are available for urban hospitals that have reclassified as rural because subsection (d) reclassification 'affects only payments under section 1886(d) of the Act,' and 'payments for direct GME are made under section 1886(h) of the Act.'"[65] Further, the regulation fails to take into account any variation in cost based on location, as the capital PPS statute permits at 42 U.S.C. § 1395ww(g)(1)(B)(ii).[66]

The Providers assert that "the Secretary's adoption of the regulation was arbitrary and capricious and violates the Administrative Procedure Act because he "failed to establish that the adoption of the exception to the capital DSH adjustment, for providers that reclassified as rural, took 'into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located.'"[67]

Though 42 C.F.R. § 412.320(a)(1)(iii) has not been vacated, the Providers argue that the merits of their position were adopted by the D.C. District Court in *Toledo*.[68] Further, the Providers contend that the Secretary adopted the FY 2024 hospital IPPS proposed rule in which the Secretary, in response to *Toledo*, proposed to amend 42 C.F.R. § 412.320(a)(1)(iii). Specifically, effective for discharges occurring on or after October 1, 2023, an urban hospital that is reclassified as rural under § 412.103 "will no longer be considered rural for purposes of determining capital DSH eligibility. Instead, for purposes of § 412.320, the geographic classifications specified under § 412.64 will apply."[69] However, the Providers explain that "for the periods under appeal, CMS and its contractors will continue to apply the 2006 regulation, denying capital DSH to the Providers for these periods."[70]

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[63] *Id.* at 1, 7.
[64] *See id.* at 7-8.
[65] *Id.* at 8 (citing 70 Fed. Reg. 47278, 47437 (Aug. 12, 2005)).
[66] *Id.*
[67] *Id.* at 8-9.
[68] *Id.* at 9-12.
[69] *Id.* at 10 (citing 88 Fed. Reg. 58640, 59117, 59334 (Aug. 28, 2023).
[70] *Id.*

The Providers further contend that since the Board is bound by the regulation being challenged,[71] namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), it lacks the authority to decide the legal question presented in the Providers' Request for EJR. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.[72]

Medicare Contractor's Response:

Following receipt of the Consolidated Request for EJR on April 1, 2025, the Medicare Contractor's representative, Federal Specialized Services ("FSS") filed a notice on April 7, 2025 certifying that that it would be filing Substantive Claim Challenges "as to many of the providers" encompassed in the Providers' consolidated Request for EJR. FSS, however, failed to file of challenges in cases 24-1722GC, 24-1878GC, and 25-1180GC within the time required by the Board's Rules.[73]

The Medicare Contractor did note in its response, however:

> The MAC also intends to file a jurisdictional challenge in 25-1180GC as the same issue was raised by the same providers for the same fiscal year in case number 24-0026GC.[74]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

1. *Jurisdiction – Appropriate Cost Report Claim (FYEs On or After December 31 ,2016)*

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[75] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[76] The Secretary revised the Medicare cost reporting regulations in

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[71] *See* 42 C.F.R. § 405.1867.
[72] Request for EJR at 10-12.
[73] Board Rule 44.5.2 (2023) typically requires a party questioning whether a participant included an appropriate claim on the cost report at issue to file its Substantive Claim Challenge within 60 days of the group filing its Final Schedule of Providers ("SOP"). When an EJR Request is filed within 60 days of the Final SOP, the moving party must certify that it will be filing a challenge within five business days and then must file the actual challenge within 20 days following the filing of the EJR Request. The Consolidated EJR Request in the case was filed on April 1, 2025. On April 7, 2025 (four business days after the EJR Request), FSS certified that it would be filing substantive claim challenges "as to many of the providers." Twenty days from the date the Consolidated EJR Request was filed was Monday, April 21, 2025. As of April 22, 2025, no substantive claim or jurisdictional challenges were filed in cases 24-1722GC, 24-1878GC, and 25-1180GC.
[74] Response to Provider's Request for Expedited Judicial Review at 1 (Apr. 7, 2025).
[75] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[76] *Id.* at 70555.

42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement ("NPR") issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). Since all the participants in Cases 24-1722GC and 24-1878GC have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

The Providers have appealed from original NPRs.

Based on its review of the record, the Board finds that each of the participants in these group appeals filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835; that the providers in each case appealed the issue in their respective appeals' and that (except for Case 25-1180GC) the Board is not precluded by regulation or statute from reviewing the issue in these appeals. Finally, in each case, the amount in controversy meets the $50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3).

2. *Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873 (Cost Reports Beginning on or After January 1, 2016)*

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. The regulation, 413.24(j) requires that:

> (1) In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), must include an appropriate claim for the specific item, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the

> provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) Self-disallowance procedures. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.

In conjunction with the regulation above, 42 C.F.R. § 405.1873(a) states:

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider must include in its cost report an appropriate claim for the specific item (as prescribed in § 413.24(j) of this chapter). **If** the provider files an appeal to the Board seeking reimbursement for the specific item and **any party** to such appeal **questions whether the provider's cost report included an appropriate claim for the specific item**, the Board must address such question in accordance with the procedures set forth in this section.

These regulations are applicable to the cost reporting periods under appeal for all of the participants in these group appeals, which all have cost reporting periods ending on or after December 31, 2016. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[77] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[78] In these cases, 24-1722GC and 24-1878GC, the Medicare Contractor has failed to file a Substantive Claim Challenge[79] within the time frame specified by Board Rule 44.5.1 (2023) for any of the Providers with FYEs December 31, 2016 or later.

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[80] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

3. Jurisdiction – Case 25-1180GC – CIRP Group Requirements

a. Relevant Law

Providers under common ownership or control must appeal common issues for the same calendar year together in a group appeal.

42 U.S.C. § 1395oo(f)(1) states, in relevant part:

> Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

The regulations governing the mandatory use of group appeals is set forth at 42 C.F.R. § 405.1837(b)(1):

> (i) Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.

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[77] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[78] *See* 42 C.F.R. § 405.1873(a).
[79] Board Rule 44.5 states: "The Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."
[80] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."

Board Rule 12.3.1 (2023) reads:

> **Mandatory Common Issue Related Party ("CIRP") Group**
>
> Providers under common ownership or control that wish to appeal a specific matter that is common to the providers for fiscal years that end in the same calendar year ***must*** bring the appeal as a group appeal. *See* 42 C.F.R. § 405.1837(b).

In promulgating the relevant regulations, the Secretary considered the implementing statute. Some commenters urged the Secretary to revise the proposed regulations to allow a CIRP group to be closed when a substantial number of providers had been added to the group, and any remaining providers would simply be bound by any decision in the group. The Secretary made clear:

> We believe that we lack the authority to allow, for the same period, more than one group appeal per issue by commonly owned or controlled providers. We believe that our proposal that a group appeal involving commonly owned or controlled providers not close until the group notifies the Board that the group is complete would have adequately protected other such providers that would like to join the group appeal.
>
> . . . .
>
> **Once the Board has determined that a group appeal involving commonly owned providers is fully formed, no other provider under common ownership may appeal the issue (either by joining the group or by pursuing an individual appeal) that is the subject of the group appeal, with respect to a cost reporting period that falls within a calendar year covered by the group appeal**, unless the Board modifies its determination that the group is fully formed.[81]

One commenter also suggested an exception be included for commonly owned providers spread across different regions. It urged that these providers may operate independently and should be permitted to bring separate group appeals. The Secretary declined, stating:

> Our interpretation of the statute is that commonly owned or operated providers must bring "a" group appeal on the same issue. If the Congress had intended to permit separate group appeals, it could have said that the appeal must be brought by "one or more groups." Therefore, at this time, **we believe we are constrained to require that commonly owned or operated providers bring only one group appeal for the same issue (regarding cost reporting periods ending in the same calendar year)**.[82]

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[81] 73 Fed. Reg. 30190, 30212-30213 (May 23, 2008) (emphasis added).
[82] *Id.* at 30213 (emphasis added).

Finally, Board Rule 4.6.2 (2023) governs appeals covering the same issue from multiple determinations:

> Appeals of the same issue from distinct determinations covering the same time period must be pursued in a single appeal. For example, a provider may not appeal an issue from a Medicare contractor's failure to issue a timely Notice of Program Reimbursement ("NPR") and then appeal the same issue from the NPR covering the same time period in separate appeals.

b. Board Decision Regarding Case 25-1180GC

The Board granted EJR in Case 24-0026GC on January 12, 2024. The appeal was a CIRP group for CY 2021 for the same Capital DSH issue as Case 25-1180GC, which also involves CY 2021. Both involve the same parent organization, UPMC Health.

Case 24-0026GC contained four providers who all appealed from the failure to issue a timely determination. Two of those Providers were withdrawn and have now appealed from their NPRs in Case 25-1180GC (which has a pending EJR request).

The relevant regulations and Board Rules make clear that for each parent organization, there can only be one appeal for each issue and calendar year. It makes no difference that Case 24-0026GC was appealing the failure to issue timely NPRs and Case 25-1180GC is appealing from issued NPRs; Board Rule 4.6.2, when read in conjunction with the relevant CIRP group regulations and the discussion surrounding their implementation, specifically prohibits this type of bifurcation amongst commonly owned providers for appeals involving the same issue and CY. Any UMCP Health Providers wishing to appeal the Capital DSH issue for CY 2021 were *required* to pursue it in Case 24-0026GC. Based on the foregoing, the Board is dismissing Case 25-1180GC as a duplicate CIRP group.

4. Board's Decision Regarding the EJR Request

The Board finds that:

1) Case 25-1180GC is an improper CIRP group since it is an appeal from the same parent organization for the same issue and calendar year as a previously adjudicated case before the Board and, as such, Case 25-1180GC is hereby dismissed;

2) It has jurisdiction over the matter for the subject years and that the participants in cases 24-1722GC and 24-1878GC are entitled to a hearing before the Board;

3) Board review of whether the Providers' cost reports included an appropriate claim for a specific item as required by 42 C.F.R. § 405.1873(a) has not been triggered;

4) Based upon the participants' assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), there are no findings of fact for resolution by the Board;

5) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

6) It is without the authority to decide the legal question of whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' EJR Request for the issue and the subject years in Cases 24-1722GC and 24-1878GC. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes the cases. Additionally, Case 25-1180GC is hereby dismissed and will be removed from the Board's docket.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole A. Musgrave, Esq.
Shakeba DuBose, Esq.

FOR THE BOARD:

4/29/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Chair
Signed by: Kevin D. Smith -A

Enclosure: Schedules of Providers
cc: Danelle Decker, National Government Services, Inc. (J-K)
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-L)
Scott Berends, Esq., FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Notice of Dismissal***
Carlsbad Medical Center (Provider Number 32-0063)
FYE: 08/31/2016
Case Number: 20-0183

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 20-0183. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days payment.

Background

A. *Procedural History for Case No. 20-0183*

On **April 8, 2019**, the Provider, Carlsbad Medical Center ("Carlsbad") was issued a Notice of Program Reimbursement ("NPR") for the fiscal year ending August 31, 2016. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **October 3, 2019**, Carlsbad filed an Individual Appeal Request appealing the following (5) issues:

1. DSH Payment SSI Percentage ("Provider Specific")[1]
2. DSH SSI Percentage ("Systemic Errors")[2]
3. DSH Medicaid Eligible Days
4. Uncompensated Care ("UCC") Distribution Pool[3]
5. Two Midnight Census IPPS Payment Reduction[4]

[1] On March 31, 2025, this issue was withdrawn.
[2] On April 21, 2020, this issue was transferred to Case No. 19-1409GC.
[3] On December 17, 2024, this issue was withdrawn.
[4] On April 21, 2020, this issue was transferred to Case No. 19-0185GC.

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **April 21, 2020**, the Provider transferred Issues 2 and 5 to CHS CIRP groups.

After the transfers, three issues remained in the appeal: Issue 1, DSH – SSI Percentage ("Provider Specific"), Issue 3, DSH – Medicaid Eligible Days and Issue 4, UCC Distribution Pool.[5]

On **October 22, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[6]

On **May 27, 2020**, the Provider timely filed its preliminary position paper. With respect to Issue 3, Medicaid Eligible Days, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made, and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days. . . ."[7] As a result, the Provider included, as an Exhibit, the original "estimated impact" for this issue of $31,554 based on an *estimated* 50 days.[8]

On **August 26, 2020**, the Medicare Contractor timely filed a Jurisdictional Challenge[9] with the Board over Issue 1, DSH SSI Percentage ("Provider Specific") and Issue 4, UCC, requesting that

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[5] Issue 1 was withdrawn on March 31, 2025, and Issue 4 was withdrawn on December 17, 2024.
[6] (Emphasis added.)
[7] Provider's May 27, 2020 Preliminary Position Paper at 8.
[8] *Id.* Exhibit 2 at 2.
[9] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of

the Board dismiss these issues. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **September 24, 2020**, the Medicare Contractor filed its preliminary position paper. Regarding Issue 3, DSH Medicaid Eligible Days, the Medicare Contractor's position paper noted that the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position.[10]

On **January 30, 2025**, the Provider filed its Final Position Paper. With respect to Issue 3, DSH Medicaid Eligible Days, the Provider's position paper, for the first time, mentions section 1115 Waiver Days.[11]

On **February 20, 2025**, the Medicare Contractor filed its Final Position Paper. Regarding Issue 3, DSH Medicaid Eligible Days, The Medicare Contractor noted that the provider had consolidated "section 1115 waiver days" with its Medicaid Eligible Days. As the "section 1115 waiver days" are "not an issue in this appeal," the Medicare Contractor asserted that it would "only consider Medicaid Eligible Days for a possible administrative resolution."[12]

On **February 25, 2025**, the Provider changed its designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **February 27, 2025**, the Medicare Contractor filed a Jurisdictional Challenge with the Board over Issue 1, DSH SSI Percentage ("Provider Specific") and Issue 3, DSH Medicaid Eligible Days (in which the Provider was including section 1115 waiver days) requesting that the Board dismiss these issues.

On **March 25, 2025**, the Provider filed a response to the Medicare Contractor's Jurisdictional Challenge.

Auburn, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

[10] Medicare Contractor's September 24, 2020 Preliminary Position Paper at 15.

[11] Provider's January 30, 2025 Final Position Paper at 10.

[12] Medicare Contractor's February 20, 2025 Final Position Paper at 15-16.

B. Description of Issue 3 in the Appeal Request

In their Individual Appeal Request, the Provider summarizes its DSH Medicaid Eligible Days issue as follows:

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 5, 22, 23, 25, 45, S-D
>
> Estimated Reimbursement Amount: $31,000[13]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the *Jewish Hospital* case[14] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[15]

Medicare Contractor's Contentions

Issue 3 – DSH Payment – Medicaid Eligible Days

The Medicare Contractor contends that the Provider failed to properly develop its arguments within its preliminary position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25 and 27. The Medicare Contractor argues the Provider has not submitted a Medicaid eligible days listing and therefore, requests the Board dismiss the issue.

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[13] Provider's October 3, 2019 Individual Appeal Request, Tab 3 Appeal Issues, Issue 3.
[14] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[15] Provider's May 27, 2020 Preliminary Position Paper at 7.

Additionally, the Medicare Contractor contends the Provider is attempting to add the Section 1115 Waiver days issue improperly and untimely. The Section 1115 Waiver days were not part of the initial appeal request and untimely added via its Final Position Paper.[16]

Provider's Jurisdictional Response

The Provider contends that it "appealed all Medicaid eligible days" in its Appeal Request, "including section 1115 waiver days." The Provider asserts, "[b]y definition, section 1115 waiver days are Medicaid eligible days." The Provider maintains although the Medicare Contractor contends that it "is attempting to untimely add the 'issue' of section 1115 waiver days, . . . there exists no such issue." The Provider argues "[s]ection 1115 waiver days are part and parcel of Medicaid eligible days."[17]

The Provider maintains "the regulations at 42 C.F.R. § 405.1835 contain requirements for appealing an 'issue' and a time limit on adding an 'issue' – not on clarifying a 'sub-issues' or . . . 'components' of an issue." The Provider argues "[b]oth a June 25, 2004 proposed rule (69 Fed. Reg. 35716) and a May 23, 2008 final rule (73 Fed. Reg. 30190) indicate that an 'issue' is encapsulated by a specific cost report adjustment. They do not slice and dice an 'issue' into component parts, including the specific reason why Medicaid eligible days were not counted in the numerator of the Medicaid Fraction of the Disproportionate Payment Percentage."[18]

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's remaining issue.

A. DSH Payment – Medicaid Eligible Days

The Provider did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal in either the initial appeal or the Preliminary Position Paper.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Aug. 2018) states, at 7.3.1.2:

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[16] Medicare Contractor's February 27, 2025 Jurisidictional Challenge at 2.
[17] Provider's March 25, 2025 Jurisdictional Response at 1-2.
[18] *Id.* at 2.

> **No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) Position papers.
>
> * * *
>
> (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[19]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Aug. 2018) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

[19] (Bold emphasis added.)

Rule 25 Preliminary Position Papers[20]

> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 The Provider's Position Paper

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

* * *

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange *all* available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4.

[20] (Underline and italics emphasis added to these excerpts and all other emphasis in original.)

Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

Parties should file with the Board a **complete** preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

COMMENTARY: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on October 22, 2019, included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicaid Eligible Days, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[21]

Similarly, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On May 27, 2020, the Provider filed its preliminary position paper in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[22] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $31,554 based on an estimated 50 days). The Provider's complete briefing of this issue in its preliminary position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.

[21] (Emphasis added.)
[22] Provider's May 27. 2020 Preliminary Position Paper at 8.

> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[23]

In its Jurisdictional Challenge, the Medicare Contractor asserts that the Provider has failed to submit "a complete list of additional Medicaid eligible days with its preliminary or final position papers or submitted such list under separate cover to the MAC. . . . The Provider has yet to submit complete, unredacted listings to the MAC."[24] The Medicare Contractor maintains the Provider has neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with the regulations and Board Rules.[25]

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[23] *Id.* at 7-8.
[24] Medicare Contractor's February 27, 2025 Jurisdictional Challenge at 15.
[25] *Id.*

The Medicare Contractor asserts in the Provider's January 30, 2025 Final Position Paper, the Provider included "a redacted listing of 308 days identified as '1115 Waiver and Additional ME Days Consolidated.' As it relates to the Medicaid eligible days under appeal, the Provider's exhibits state 'A listing of the additional Medicaid Eligible days being claimed is being submitted directly to the MAC. A redacted version of this same list is being included with this position paper.'" The Medicare Contractor contends "[t]o date, the provider has not submitted the referenced listing. Additionally, the waiver day listing included as an exhibit states 'Listing pending finalization upon receipt of State eligibility data,' indicating that the list is incomplete and not suitable for audit, had an unredacted auditable version been submitted."[26]

The Board finds the Provider's filing does not explain why the listing of 308 days was being submitted at this late date or why it was not final (*i.e*., why it was "pending finalization") at this late date, *more than 9 years after the fiscal year at issue had closed*. NOTE—the roughly 308 days included in this belated listing is *exponentially* larger than the original estimate of 50 days included with the appeal request.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e*., the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

Pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[27] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provide the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rules 25.2.1 and 25.2.2 related to

[26] *Id*. at 12.
[27] (Emphasis added.)

identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable.[28]

A. 1115 Waiver Days

The Board finds that the section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. The Provider failed to include section 1115 Waiver days as a cost issue in its appeal request and failed to timely and properly add this additional issue to the appeal. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the section 1115 Waiver days.

The appeal was filed with the Board in October of 2019 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[29]

Board Rule 7.2.1 (2018) elaborated on this regulatory requirement, instructing providers:

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[28] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):
> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

[29] 42 C.F.R. § 405.1835(b).

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>   - the adjustment, including the adjustment number,
>   - the controlling authority,
>   - why the adjustment is incorrect,
>   - how the payment should be determined differently,
>   - the reimbursement effect, and
>   - the basis for jurisdiction before the [Board].

Board Rule 8.1 (2018) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "each contested component must be appealed as a separate issue and described as narrowly as possible." The Rule continues:

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[30]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[31]

42 C.F.R. § 405.1835(e) provides in relevant part:

> (e) Adding issues to the hearing request. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
>
> * * *
>
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2), of this section.

[30] (Bold/Italic emphasis added).
[31] *See* 73 Fed. Reg. 30190 (May 23, 2008).

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider added the section 1115 Waiver days to the case properly or timely.

In this regard, the Board notes that section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[32] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program and not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2019) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

[32] 65 FR 47054, 47087 (Aug. 1, 2000).

Because the Provider did not raise the Section 1115 Waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The DSH Medicaid Eligible Days issue as stated in the original appeal request cannot be construed to include Section 1115 Waiver days. Additionally, there is no indication that any 1115 waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal.

Regardless, even if the Provider had included in its appeal request (which it did not), the Provider failed to properly develop the issue in its position paper filings. First, the Provider's preliminary position paper does not even mention § 1115 waiver days (much less even identify the specific 1115 waiver day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (2015). As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* § 1115 waiver days sub-issue.

Finally, even in the Provider's final position paper, the Provider fails to identify what § 1115 waiver program(s) are involved and whether or not the § 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the final position paper is deficient in that it only makes perfunctory conclusions.[33] Again, the Provider failed to so develop its position paper notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Nov. 2021) as applied via Board Rule 27.2.

The Board's finding that neither the appeal request nor final position paper met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[34] In that case, the provider's issue was tied to improper calculation of DSH payment and read in part, "[t]he

[33] For example, QRS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that "the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." However, QRS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is QRS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? QRS fails to brief the merits of its claims and fails to establish the Board's jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the final position paper references "uncompensated care pool."

[34] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment."[35] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[36] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[37] Here, the Board makes the same finding based on similarly *overly generalized language.*

* * * * *

Based on the foregoing, the Board has dismissed the (1) remaining issue in this case – (Issue 3, Medicaid Eligible Days). As no issues remain, the Board hereby closes Case No. 20-0183 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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For the Board:

4/30/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: Kevin D. Smith -A

cc: Michael Redmond, Novitas Solutions, Inc. c/o Guidewell Source
Wilson Leong, FSS

[35] *Id*. at *5.
[36] *Id.*
[37] *Id.*