



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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Danelle Decker
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RE: ***Board Decision – DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues***
Danbury Hospital (Provider No. 07-0033)
FYE 09/30/2017
Case No. 22-0036

Dear Mr. Ravindran and Ms. Decker,

The Provider Reimbursement Review Board (“Board”) has reviewed the documentation in the above referenced appeal. The decision of the Board is set forth below.

Background:

A. Procedural History for Case No. 22-0036

On **April 13, 2021**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end September 30, 2017.

On **October 4, 2021**, the Board received the Provider’s individual appeal request. The initial Individual Appeal Request contained six (6) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)¹
3. DSH Payment – Medicaid Eligible Days
4. DSH Payment – Medicare Managed Care Part C Days (SSI Fraction & Medicaid Fraction)²
5. DSH Payment – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days) – (SSI Fraction & Medicaid Fraction)³
6. Standardized Payment Amount⁴

The Provider is commonly owned/controlled by Nuance Health and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **May 9 and 10, 2022**, the Provider transferred Issues 2, 4, 5, 6 and 7 to Nuance Health groups. As a result,

¹ On May 9, 2022, this issue was transferred to PRRB Case No. 21-1276GC.

² On May 9, 2022, this issue was transferred to PRRB Case No. 21-1277GC.

³ On May 9, 2022, this issue was transferred to PRRB Case No. 21-1280GC. The SSI Fraction portion was bifurcated into Issue #7 and transferred to PRRB Case No. 21-1278GC on May 10, 2022.

⁴ On May 9, 2022, this issue was transferred to PRRB Case No. 21-1281GC.

there are two (2) remaining issues in this appeal: Issue 1 (DSH Payment/SSI Percentage (Provider Specific)) and Issue 3 (DSH Payment – Medicaid Eligible Days).

On **October 14, 2021**, 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 25.⁵*

On **May 9, 2022**, the Provider changed its designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. (“QRS”).

On **May 31, 2022**, the Provider timely filed its preliminary position paper.

On **September 20, 2022**, the Medicare Administrative Contractor (“MAC”) timely filed its preliminary position paper.

On **December 5, 2022**, the MAC filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 3. 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.

B. Description of Issue 1 in the Appeal Request and the Provider’s Participation in Case No. 21-1276GC

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

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 their calculation.

...

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

⁵ (Emphasis added).

also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.⁶

Here, it is important to note that the amount in controversy listed for both Issue 1 (Provider Specific) and Issue 2 (Systemic Errors) in the Provider's individual appeal request is \$172,000.

The DSH/SSI Systemic Errors Group Issue Statement in Case No. 21-1276GC, Nuvance Health CY 2017 DSH SSI Percentage CIRP Group (Systemic Errors), to which the Provider transferred Issue 2 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,
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.⁷

⁶ Issue Statement at 1 (Oct. 4, 2021).

⁷ Group Issue Statement, Case No. 21-1276GC.

On May 31, 2022, the Provider filed its preliminary position paper. The following is the entirety of Provider's 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. This is based on certain data from the State of Connecticut and the Provider that does not support the SSI percentage issued by CMS.

The Provider has worked with the State of Connecticut and has learned that 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.

The Provider is seeking 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 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). 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.⁸

C. Description of Issue 3 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 3 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

⁸ Provider's Preliminary Position Paper at 8-9 (May 31, 2022).

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): 2,14,17,S-D

Estimated Reimbursement Amount: \$80,000⁹

Regarding the Medicaid eligible days issue, in its Preliminary Position Paper, the Provider argues that pursuant to the *Jewish Hospital* case¹⁰ 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.¹¹

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 for three reasons. First, the MAC argues that the SSI realignment portion of the issue has been abandoned by the Provider:

The Provider fails to note that its cost reporting year end is identical to the federal fiscal year end. This oversight leaves the MAC questioning the right the Provider is attempting to preserve.

The MAC contends that the Provider has abandoned the issue of SSI realignment and, therefore, it should be considered withdrawn. The Provider did not brief this issue within its preliminary position paper. PRRB Rule 25.3 addresses issues that are not briefed in a provider's position paper. In relevant part, this rule states:

Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.¹²

⁹ Appeal Request at Issue 3.

¹⁰ *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994).

¹¹ Provider's Preliminary Position Paper at 7-8.

¹² Jurisdictional Challenge at 6 (Dec. 5, 2022).

Failing that, the MAC argues the realignment sub-issue is premature:

The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.

...

The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for resolve this issue. The MAC requests that the PRRB dismiss this issue consistent with recent jurisdictional decisions.¹³

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.¹⁴

Finally, the MAC argues “the Provider did not file a **complete** preliminary and final¹⁵ position papers in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3.”¹⁶ The MAC posits that the Provider “failed to sufficiently develop and set forth the relevant facts and regarding the merits of its claim in its preliminary position paper.”¹⁷ Specifically the MAC avers:

Within its Provider's preliminary [position] paper, the Provider makes the broad allegation that “The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation” yet offers no evidence or analysis to demonstrate that CMS calculated its SSI percentage inaccurately. The Providers failed to include any evidence to establish the material facts in this case relating to inaccuracies in the SSI Percentage calculation at issue or any evidence pertaining to the alleged systemic SSI ratio data match errors like those referenced in the *Baystate* case. The Provider merely repeats their appeal request which itself is a verbatim recitation of the deficiencies that the Board found in the *Baystate* case.¹⁸

¹³ *Id.* at 7.

¹⁴ *Id.* at 4-6.

¹⁵ Note: Final position papers have not been filed in this case, so this was included in error.

¹⁶ *Id.* at 7.

¹⁷ *Id.* at 9.

¹⁸ *Id.* at 9-10.

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC requests that the Board find the Provider abandoned the DSH – Medicaid Eligible Days issue arguing:

The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider 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. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.

Within its preliminary position paper, the Provider makes the broad allegation, “. . . the Provider contends that the total number of days reflected in its’ [sic] 2017 cost report does not reflect an accurate number of Medicaid eligible days. . .” The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats their appeal request.¹⁹

Provider’s Jurisdictional Response

Board Rule 44.4.3 specifies: “Providers must file a response within thirty (30) days of the MAC’s jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination based upon the information contained in the record.” The MAC filed its Jurisdictional Challenge on December 5, 2022. The Provider failed to file any response.

Board 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 MAC, 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 Issue No. 1 & 3.

A. DSH Payment/SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider’s disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH

¹⁹ *Id.* at 11-12.

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 MAC 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. 21-1276GC.

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.”²⁰ Per the appeal request, the Provider’s legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts 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).”²¹ The Provider argues that “its’ [sic] SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . .” and 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.”²²

The Provider’s DSH/SSI Percentage (Systemic Errors) issue in group Case No. 21-1276GC also alleges that the MAC 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).

The Board has previously noted that CMS’ regulation interpretation for the SSI percentage is clearly not “specific” to a single provider.²³ Rather, it applies to all SSI calculations. To this end, the Board also reviewed the Provider’s Preliminary Position Paper to see if it further clarified Issue 1. However, Provider’s PPP does not explain how this argument is *specific to this provider*. Instead, the PPP refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Furthermore, the Provider cites *Loma Linda Community Hospital* and alleges that “SSI entitlement of individuals can be ascertained from State records.”²⁴ But the Provider fails to explain its alleged similarities to *Loma Linda Community Hospital* or how it can ascertain SSI entitlement from the state records.

In accordance with 42 C.F.R. § 405.1853(b), the commentary to Rule 23.3 (Aug. 29, 2018) explains that preliminary position papers must “be **fully** developed and include **all available** documentation necessary to provide a *thorough understanding* of the parties’ positions.” The commentary to Rule 25 also explicitly states, “preliminary position papers are expected to present

²⁰ Issue Statement at 1.

²¹ *Id.*

²² *Id.*

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 See Provider’s PPP at 9.

fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.” Moreover, 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 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.²⁵

In its PPP (filed on May 31, 2022), the Provider only cites to the 2000 Federal Register as the source for the MEDPAR data it claims it has yet to receive. But additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have since occurred. For example, as noted in the FY 2006 IPPS Final Rule:

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.

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:

²⁵ (Emphasis added).

<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 2023* and instructs providers to send a request via email to access their DSH data.²⁷ The Provider’s appeal is relative to FYE 2017.

Based on the foregoing, the Board finds that the Provider’s *Preliminary Position Paper* failed to comply with Board Rules 23 and 25 (November 1, 2021) governing the content of position papers. The Board also finds that the Provider’s *Preliminary Position Paper* failed to comply with Board Rule 25.2.2 by not addressing why the MEDPAR data for FYE 2017 was allegedly unavailable. Thus, 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. 21-1276GC.

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 21-1276GC 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, 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.

Pursuant to 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[.]” In this case, there is nothing in the record indicating that a proper written realignment request was made by the Provider and that the MAC made a final determination regarding DSH SSI Percentage realignment from which the Provider can appeal. Moreover, an appeal before the Board may not be used as a conduit for the MAC (the intermediary) nor for CMS. 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

²⁶ Last accessed August 14, 2024.

²⁷ Emphasis added.

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 Nuvance Health CIRP group per 42 C.F.R. § 405.1837(b)(1).

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation.

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), 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) states:

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.

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

The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.

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.

Furthermore, 42 C.F.R. § 405.1853 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.*²⁹

Similarly, with regard to position papers,³⁰ Board Rule 25.2.1 requires that “the parties must exchange *all available* documentation as exhibits to fully support your position.”³¹ 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.³²

Finally, Board Rule 41.2 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 (*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 4, 2021 (nearly 4 years ago), and at that time, the Provider 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 Provider’s preliminary position paper indicated that it would be sending the eligibility listing under

²⁹ (Emphasis added).

³⁰ The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.

³¹ (Emphasis added).

³² (Emphasis added).

separate cover.³³ ***To-date, no listing has been provided.*** 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.³⁴ 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.

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 21-1276GC and because the purported realignment portion of the issue is premature in absence of a properly submitted written realignment request subject to a final determination from which the Provider can appeal. The Board also dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for submitting fully developed and complete position papers in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 22-0036 and removes it from the Board's docket.

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:

8/1/2025

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

cc: Wilson C. Leong, Esq., Federal Specialized Services

³³ Provider's Preliminary Position Paper at 8.

³⁴ 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.



DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Juan Morado
Benesch Friedlander Coplan & Aronoff LLP
71 South Wacker Suite 1600
Chicago, IL 60606-4637

RE: ***Notice of Dismissal***

Pipeline West Suburban Hospital Medical Center (Provider Number 14-0049)
FFY 2024
Case Number: 24-0710

Dear Mr. Morado:

The Provider Reimbursement Review Board (“Board” or “PRRB”) received Pipeline West Suburban Hospital Medical Center’s Individual Appeal Request in Case No. 24-0710 on January 19, 2024. On February 4, 2025, a Notice of Hearing was issued to the parties which set a hearing for August 7, 2025.

The Board staff attempted to contact the Provider’s Representative via email on July 1, 2025, July 16, 2025 and July 24, 2025, to inquire as to whether the Provider was still pursuing the appeal. To date, the Provider has not responded to any of the Board staff’s inquiries.¹ The Board therefore sent a Notice of Potential Dismissal on July 28, 2025, requiring a response by Friday, August 1, 2025, notifying the Provider that failure to respond would result in dismissal of the appeal.

Board Rule 41.2 (Dec. 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 (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.***²

Regulations dealing with the failure to follow Board rules, or to comply with the Board’s deadlines can be found at 42 C.F.R. § 405.1868:

¹ Provider’s last filing in this case occurred on July 8, 2025 with the filing of the Provider’s Witness List.

² (Emphasis added.)

(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.

The Provider failed to respond to the Board's July 28, 2025 Notice of Potential Dismissal. Accordingly, the Board hereby dismisses Case No. 24-0710 with prejudice 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
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For the Board:

8/4/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq. Federal Specialized Services
Pamela VanArsdale, National Government Services, Inc. (J-6)



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***
Brandywine Hospital, Prov. No. 39-0076, FYE 09/30/2017
Case No. 22-0430

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 22-0430. 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. 22-0430

On **August 3, 2021**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end September 30, 2017. The Provider is commonly owned by Community Health Systems, Inc. (“CHS”).

On **January 14, 2022**, CHS filed the Provider’s individual appeal request. The initial 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
4. DSH Payment – Medicare Managed Care Part C Days (SSI Fraction & Medicaid Fraction)²
5. DSH Payment – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days) – (SSI Fraction & Medicaid Fraction)³

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 **August 15, 2022**, the Provider transferred Issues 2, 4, and 5 to CHS CIRP groups.

¹ On August 15, 2022, this issue was transferred to Case No. 20-0997GC.

² On August 15, 2022, this issue was transferred to Case No. 19-2620GC.

³ On August 15, 2022, this issue was transferred to Case No. 20-1383GC.

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 **January 18, 2022**, 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 25.⁴*

On **September 7, 2022**, 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’ 2017 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 \$39,166 based on an *estimated* 100 days.

On **October 31, 2022**, the Medicare Contractor filed a Request for DSH Medicaid Eligible Days listing in connection with Issue 3.

On **November 28, 2022**, the Medicare Contractor 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 that Medicaid eligible days listing.

On **December 16, 2022**, the Medicare Contractor timely filed a Jurisdictional Challenge⁵ with the Board over Issues 1 and 3 requesting that the Board dismiss these issues. Pursuant to Board

⁴ (Emphasis added).

⁵ 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

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 **November 9, 2023**, the Provider changed its designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. (“QRS”).

On **November 9, 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.”⁶ The Listing was 1 page with 87 Medicaid eligible days. QRS’ filing did not explain why the listing 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***. NOTE—the roughly 87 days included in this belated listing is *less than* the original *estimated* impact of 100 days included with the appeal request.

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.

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).⁷

The Group issue Statement in Case No. 20-0997GC, to which the Provider transferred Issue No. 2, reads, in part:

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).

⁶ (Emphasis added).

⁷ Issue Statement at 1 (Jan. 14, 2022).

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.⁸

On September 7, 2022, the Board received the Provider's preliminary position paper in 22-0430. 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. This is based on certain data from the State of Pennsylvania and the Provider that does not support the SSI percentage issued by CMS.

⁸ Group Appeal Issue Statement in Case No. 20-0997GC.

The Provider has worked with the State of Pennsylvania and has learned that 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.

The Provider is seeking 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 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). 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.⁹

The amount in controversy listed for both Issues 1 and 2 in the Provider’s individual appeal request is \$7,733.

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.¹⁰

In addition, “the MAC asserts that the Provider did not file a complete preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3.”¹¹

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. The MAC argues the Provider has not submitted a Medicaid eligible days listing and therefore, requests the Board dismiss the issue.

⁹ Provider’s Preliminary Position Paper at 8-9 (Sept. 7, 2022).

¹⁰ Medicare Contractor’s Jurisdictional Challenge at 7 (Dec. 16, 2022).

¹¹ *Id.* at 8.

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.¹² 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."

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. 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."¹³ 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)."¹⁴ The Provider argues in its issue statement, which was included in the

¹² Board Rule 44.4.3, v. 3.1 (Nov. 2021).

¹³ Issue Statement at 1.

¹⁴ *Id.*

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.”¹⁵

The Provider’s DSH/SSI Percentage (Systemic Errors) 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 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. 22-0430 is duplicative of the DSH/SSI Percentage (Systemic Errors) 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.¹⁶ 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. 20-0997GC.

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 25.2.¹⁷ Moreover, the Board finds that the Provider’s Preliminary Position Paper failed to comply with Board Rule 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 the merits of its position on Issue 1 of its issue and explain the nature of the any alleged “errors” and include *all* exhibits.

¹⁵ *Id.*

¹⁶ 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).

¹⁷ 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.

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 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.¹⁸

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”) 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>.¹⁹

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.”²⁰

¹⁸ (Italics and underline emphasis added).

¹⁹ Last accessed Oct. 15, 2024.

²⁰ (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. 20-0997GC.

Accordingly, *based on the record before it*,²¹ the Board finds that the SSI Provider Specific issue in Case No. 22-0430 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.

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) 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**

²¹ 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.

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.²²

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:

Rule 25 Preliminary Position Papers²³

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.

²² (Bold emphasis added.)

²³ (Underline emphasis added to these excerpts and all other emphasis in original).

25.1.1 The 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.

...

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 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.

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 January 18, 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)(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.²⁴

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."

²⁴ (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 September 7, 2022, 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.²⁵ 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 \$39,166 based on an estimated 100 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*

²⁵ Provider's Preliminary Position Paper at 8.

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 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.

On November 9, 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.” The Listing was 1 page with 87 Medicaid eligible days. QRS’ filing did not explain why the listing 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***. NOTE—the 87 days included in this belated listing is *less than* than the original estimate of 100 days included with the appeal request. Regardless, this filing was roughly 10 months past the deadline for responding to the Jurisdictional Challenge *and, more importantly, was roughly 14 months past the deadline for including it with its preliminary position paper* since the position paper deadline was September 11, 2022.

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).

The fact that the Listing was filed the same day 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 9, 2023 filing as a “Supplement to Position Paper” and does not accept that filing because:

1. The alleged “Supplement” was filed *roughly 14 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 requesting to dismiss Issue 3 and the alleged “Supplement” was filed *roughly 10 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 87 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 roughly 22 months after this appeal was filed and more than 6 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 January 18, 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* 87 days listed in the alleged “Supplement” is, without explanation, less than the original estimated 100 days included with the appeal request).²⁶

²⁶ See, *e.g.*, Board Rule 27.3 stating: “Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence.”

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 provider 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 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.²⁸

* * * * *

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. 22-0430 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:

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

8/4/2025

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 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.

Notice of Dismissal for Brandywine Hospital

Case No. 22-0430

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

RE: ***Notice of Dismissal***

Martin General Hospital (Prov. No. 34-0133), FYE 04/30/2017, Case No. 20-0389

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 20-0389. Set forth below is the decision of the Board to dismiss the two (2) issues in this appeal challenging the Provider’s Disproportionate Share Hospital (“DSH”) SSI Provider Specific and DSH Medicaid Eligible Days issues.

Background:

A. Procedural History for Case No. 20-0389

On **May 9, 2019**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end April 30, 2017. The Provider is commonly owned by Quorum Health (“Quorum”).

On **November 5, 2019**, Quorum filed the Provider’s individual appeal request. The initial Individual Appeal Request included five (5) issues:

1. DSH SSI Provider Specific
2. DSH SSI Percentage¹
3. DSH Medicaid Eligible Days
4. Uncompensated Care (UCC) Distribution Pool
5. 2 Midnight Census IPPS Payment Reduction²

As the Provider is commonly owned/controlled by Quorum, 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 June 18, 2020, Quorum transferred two of the issues to CIRP groups.

On **November 23, 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 June 18, 2020, this issue was transferred to Case No. 20-1339GC.

² On June 18, 2020, this issue was transferred to Case No. 20-1340GC.

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.*³

On **June 30, 2020**, the Provider timely filed its Preliminary Position Paper (hereinafter, "Provider's PPP"). In the PPP cover letter, the Provider withdrew the UCC Distribution Pool issue from the case.⁴

On **July 6, 2020**, the Medicare Contractor ("MAC") filed a copy of its request to the Provider for the Medicaid Eligible Days listing in the Office of Hearings Case & Document Management System ("OH CDMS").

On **August 24, 2020**, the MAC filed a jurisdictional challenge over the SSI Provider Specific issue in the case. 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 **October 16, 2020**, the MAC timely filed its Preliminary Position Paper (hereinafter, "MAC's PPP.")⁵

On **January 10, 2023**, the MAC filed a copy of its Final Request to the Provider for DSH Medicaid Eligible Days Support in OH CDMS.

On **March 2, 2023**, the MAC filed a global jurisdictional challenge for Quorum appeals that included the Medicaid Eligible Days issue. Again, per Board Rule 44.4.3, the Provider had 30 days to file a response but did not file one.

On **August 18, 2023**, Quality Reimbursement Services, Inc. ("QRS") became the authorized Representative in Case No. 20-0389.

³ (Emphasis added).

⁴ On August 21, 2023, QRS effectuated the withdrawal of the UCC Distribution Pool issue in OH CDMS as the issue status had not been updated based on the earlier withdrawal.

⁵ In the MAC's PPP, the MAC advised that although the Provider stated a listing of additional eligible days was being submitted under separate cover, it was not. In addition, the MAC requested a listing on July 6, 2020 and January 10, 2023 but the Provider has failed to respond. (See, MAC's PPP at 20 and Exhibit C-6 as well as Exhibit C-1 of Medicare Contractor's Jurisdictional Challenge dated March 2, 2023.)

B. Description of Issue 1 in the Individual Appeal Request and the Provider's Participation in Case No. 20-1339GC

In its Individual Appeal Request, the Provider summarizes its DSH- SSI Provider Specific issue as follows:

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 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.⁶

The Group issue Statement in Case No. 20-1339GC, to which the Provider transferred Issue 2 (the DSH SSI Percentage), 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:

⁶ Issue Statement at 1 (Nov. 5, 2019).

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.⁷

On June 30, 2020, the Board received the Provider's Preliminary Position Paper in Case No. 20-0389. 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 the Centers for Medicare and Medicaid Services ("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 (April 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"), 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 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).⁸

The amount in controversy listed for both SSI Percentage Issues 1 and 2 in the Provider's individual appeal request is \$7,420.⁹

⁷ Group Issue Statement, Case No. 20-1339GC.

⁸ Provider's PPP at 8-9 (June 30, 2020).

⁹ The Provider rounded the reimbursement impact for Issues 1 and 2 to \$7K in OH CDMS.

C. Description of Issue 3 in the Individual 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 3 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.

Audit Adjustment Number(s): 9, 10, s-d

Estimated Reimbursement Amount: \$36,000¹⁰

Regarding the Medicaid eligible days issue, in its PPP the Provider argues that pursuant to the *Jewish Hospital* case¹¹ 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.¹²

¹⁰ Appeal Request at Issue 3. Calculation Support shows actual amount of \$36,840 which the Provider rounded to \$36K.

¹¹ *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994).

¹² Provider’s PPP at 7.

MAC's Contentions Issue 1 – DSH SSI Provider Specific

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Provider Specific issue. According to the Provider's PPP, this issue 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 two components related to SSI data accuracy should be dismissed because they are duplicative of the DSH SSI Percentage issue transferred to Case No. 20-1339GC. Additionally, 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

MAC's Contentions Issue 3 – DSH Medicaid Eligible Days

In its Jurisdictional Challenge, the MAC advised that the Provider failed to include a list of additional Medicaid eligible days it expected to be included (even though the Provider's PPP included a statement indicating a listing of additional Medicaid eligible days would be sent under separate cover.)¹⁴ In addition, the MAC contends that the Provider did not file complete PPPs in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2. and 25.3.¹⁵ Therefore, since the issue was not properly developed, the Provider did not provide a list of additional Medicaid days, nor did it explain why it could not produce the documentation, the MAC contends the Providers have abandoned the issue.¹⁶

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.¹⁷ The Provider has not filed a response to either 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 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.

As set forth below, the Board hereby dismisses the Provider's Issue Nos. 1 and 3.

¹³ Medicare Contractor's Jurisdictional Challenge at 2 (Aug. 24, 2020).

¹⁴ MAC's jurisdictional challenge at 3. (March 2, 2023).

¹⁵ *Id.* at 2.

¹⁶ *Id.* at 6.

¹⁷ Board Rule 44.4.3, v. 2.0 (Aug. 2018).

A. DSH SSI Provider Specific

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider's disagreement 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 the Provider transferred to Case No. 20-1339GC.

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.”¹⁸ 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).”¹⁹ The Provider argues that “its'[sic] 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.”²⁰

The Provider's DSH/SSI Percentage (*Systemic Errors*) issue in group Case No. 20-1339GC 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 SSI Provider Specific issue in Case No. 20-0389 is duplicative of the DSH/SSI Percentage (*Systemic Errors*) issue in Case No. 20-1339GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6²¹, the Board dismisses this aspect of the DSH SSI 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.²² Accordingly, the Provider's reference

¹⁸ Issue Statement at 1.

¹⁹ *Id.*

²⁰ *Id.*

²¹ PRRB Rules v. 2.0 (Aug. 2018).

²² 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, the 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. 20-1339GC.

To this end, the Board also reviewed the Provider’s PPP 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. 20-1339GC 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 PPP failed to comply with the Board Rule 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 the merits of its position on Issue 1 and explain the nature of any alleged “errors” in its PPP 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 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

²³ (Italics and underline emphasis added.)

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>.²⁴

This CMS webpage describes access to DSH data *from 1998 to 2023* and instructs providers to send a request via email to access their DSH data.”²⁵

Accordingly, *based on the record before it*, the Board finds that DSH SSI Provider Specific issue in the instant appeal and the group issue in Case No. 20-1339GC are the same issue.²⁶ 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 SSI Provider Specific issue.

2. Second Aspect of Issue 1

The second aspect of the DSH - SSI 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 MAC 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 MAC 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

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’s issue statement for Issue 3 is stated, *supra*.

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

²⁴ Last accessed August 6, 2025.

²⁵ Emphasis added.

²⁶ 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 Health CIRP group per 42 C.F.R. § 405.1837(b)(1).

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.

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

The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.

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.

Furthermore, 42 C.F.R. § 405.1853 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.*²⁷

Similarly, with regard to position papers,²⁸ Board Rule 25.2.1 requires that “the parties must exchange ***all available*** documentation as exhibits to fully support your position.”²⁹ This

²⁷ (Emphasis added).

²⁸ The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.

²⁹ (Emphasis added).

requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides instruction on the content of position papers as it relates to unavailable documentation/exhibits, as discussed *supra*.

Finally, Board Rule 41.2 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 (*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 November 15, 2019 (more than 5.5 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expected to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's PPP indicated that it would be sending the eligibility listing under separate cover.³⁰ ***To date, there is no evidence that the listing has been provided—even after the MAC requested the listing on 2 separate occasions.***³¹ 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.³² 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 is dismissing the two (2) issues in this case: DSH – SSI Provider Specific (Issue 1) and DSH - Medicaid Eligible Days (Issue 3). As no issues remain, the Board hereby closes Case No. 20-0389 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.

³⁰ Provider's PPP at 8.

³¹ MAC PPP at 20 and March 2, 2023 Jurisdictional Challenge at Exhibit C-1.

³² *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:

8/6/2025

X Ratina Kelly

Ratina Kelly, CPA

Board Member

Signed by: PIV

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***

Northwest Medical Center (Prov. No. 03-0085), FYE 09/30/2016, Case No. 21-0088

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 21-0088. Set forth below is the decision of the Board to dismiss the two (2) issues in this appeal challenging the Provider’s Disproportionate Share Hospital (“DSH”) SSI Provider Specific and DSH- Medicaid Eligible Days issues.

Background:

A. Procedural History for Case No. 21-0088

On **December 4, 2019**, 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 **May 18, 2020**, CHS filed the Provider’s individual appeal request. The initial Individual Appeal Request included four (4) issues:

1. DSH SSI Provider Specific
2. DSH SSI¹
3. DSH - Medicaid Eligible Days
4. 2 Midnight Census IPPS Payment Reduction²

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 January 26, 2021, CHS transferred one of the issues to a CIRP group.

On **October 15, 2020**, 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 Jan. 26, 2021, this issue was transferred to Case No. 19-1409GC.

² This issue was withdrawn in the Preliminary Position Paper Cover letter (dated Jan. 14, 2021) but filed in OH CDMS on Feb. 1, 2021..

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.*³

On **February 1, 2021**, the Provider timely filed its Preliminary Position Paper (hereafter, Provider's PPP). The Provider withdrew the "2 Midnight Census IPPS Payment Reduction" issue from the case in the cover letter to the PPP.

On **March 22, 2021**, the Medicare Contractor ("MAC") filed a jurisdictional challenge over the DSH SSI Provider Specific issue in the case. 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 **June 11, 2021**, the MAC timely filed its Preliminary Position Paper (hereafter, MAC's PPP).⁴

On **November 14, 2022**, the MAC filed a global jurisdictional challenge for CHS appeals that included the Medicaid Eligible Days issue.

On **December 14, 2022**, CHS filed its response to the MAC's jurisdiction challenge over the Medicaid Eligible Days issue.

On **December 16, 2022**, Quality Reimbursement Services, Inc. ("QRS") became the authorized Representative in Case No. 21-0088.

On **December 28, 2022**, the MAC filed a global Request for Dismissal in response to the Representative's response to the MAC's Medicaid Eligible Days jurisdictional challenge for various CHS appeals, reiterating its position that the Provider abandoned its appeal of the Medicaid Eligible Days issue.

B. Description of Issue 1 in the Individual Appeal Request and the Provider's Participation in Case No. 19-1409GC

In its Individual Appeal Request, the Provider summarizes its DSH- SSI Provider Specific issue as follows:

³ (Emphasis added).

⁴ The MAC indicated that it had not yet received a listing of the additional Medicaid Eligible Days although the Provider's PPP indicated the listing was to be submitted under separate cover, and the MAC subsequently requested one by letter dated Feb. 4, 2021. MAC PPP at 12 and Exhibit C-2.

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 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.⁵

The Group issue Statement in Case No. 19-1409GC, to which the Provider transferred Issue 2 (the DSH SSI), 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,
4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days and

⁵ Issue Statement at 1 (May 18, 2020).

6. Failure to adhere to required notice and comment rulemaking procedures.⁶

In the Provider's February 1, 2021 PPP in Case No. 21-0088, 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 the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Arizona and the Provider that does not support the SSI percentage issued by CMS.

The Provider has worked with the State of Arizona and has learned that 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.

The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") databased, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, 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. *See* 65 Fed. Reg. 50,548 (2000). 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.⁷

The amount in controversy listed on the calculation support for both SSI Percentage Issues 1 and 2 in the Provider's individual appeal request is \$90,085.⁸

C. Description of Issue 3 in the Individual 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 3 as:

⁶ Group Issue Statement, Case No. 19-1409GC.

⁷ Provider's PPP at 8-9 (Feb. 1, 2021).

⁸ The Provider rounded the reimbursement impact for Issues 1 and 2 to \$90,000 in OH CDMS.

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, 11, 12, 13, 15, S-D

Estimated Reimbursement Amount: \$30,000 (rounded from \$29,674 based on calculation support)⁹

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case¹⁰ 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.¹¹

MAC’s Jurisdictional Challenge

Issue 1- DSH SSI (Provider Specific)

In its March 22, 2021 Jurisdictional Challenge, the MAC argues that the Board lacks jurisdiction over the DSH – SSI Provider Specific issue. According to the Provider’s PPP, this issue 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 two components related to SSI data accuracy should be dismissed because they are duplicative of the DSH SSI Percentage issue transferred to Case No. 19-1409GC. Additionally, the portion related to SSI realignment

⁹ Appeal Request at Issue 3.

¹⁰ *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994).

¹¹ Provider’s PPP at 7.

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.¹²

Issue 3 – Medicaid Eligible Days

In a subsequent November 14, 2022 Jurisdictional Challenge, the MAC argued that the Provider failed to include a list of additional Medicaid eligible days it expected to be included (even though the Provider's PPP included a statement indicating a listing of additional Medicaid eligible days would be sent under separate cover.)¹³ In addition, the MAC contends that the Provider did not file complete PPPs in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2. and 25.3.¹⁴ Therefore, since the issue was not properly developed, the Provider did not provide a list of additional Medicaid days, nor did it explain why it could not produce the documentation, the MAC contends the Providers have abandoned the issue.¹⁵

Provider's Jurisdictional Response

Issue 1- DSH SSI (Provider Specific)

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 did not file a response to the Jurisdictional Challenge over the SSI Provider Specific issue 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."

Issue 3 – Medicaid Eligible Days

The Provider's position is that the due date for the listing of additional Medicaid eligible days was the Final Position Paper deadline.¹⁷ The Provider goes on to argue that:

The MAC entirely overlooks that the [CMS] has recognized that "practical impediments" frequently impede a provider's ability to obtain the necessary support claiming additional Medicaid eligible days.

...

These impediments are related to the State eligibility matching being unavailable at this time due to a change in the State's matching vendor changes. Concurrent with this letter to the Board the Providers are sending to the MAC the listing of additional

¹² MAC's Jurisdictional Challenge at 2 (March 22, 2021).

¹³ MAC's jurisdictional challenge at 4 and Exhibit C-1. (Nov. 14, 2022).

¹⁴ *Id.* at 4.

¹⁵ *Id.* at 6.

¹⁶ Board Rule 44.4.3, v. 2.0 (Aug. 2018).

¹⁷ Provider's Jurisdictional Response at 1 (Dec. 14, 2022).

Medicaid eligible days for providers not impacted by practical impediment.¹⁸

The Provider contends that they “have cured the sole defect on which the MAC relies, and the Board should deny the MAC’s motion to dismiss.”¹⁹

Board 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.

As set forth below, the Board hereby dismisses the Provider’s Issue Nos. 1 and 3.

A. DSH SSI Provider Specific

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider’s disagreement with how the MAC 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 MAC computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that the Provider transferred to Case No. 19-1409GC.

The DSH/SSI (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.”²⁰ Per the appeal request, the Provider’s legal basis for its DSH/SSI (Provider Specific) issue asserts 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).”²¹ The Provider argues that “its’[sic] 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

¹⁸ *Id.* at 2.

¹⁹ *Id.*

²⁰ Issue Statement at 1.

²¹ *Id.*

²² *Id.*

The Provider's DSH/SSI Percentage (*Systemic Errors*) issue in group Case No. 19-1409GC also alleges that the MAC 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 SSI Provider Specific issue in Case No. 21-0088 is duplicative of the DSH/SSI Percentage (*Systemic Errors*) issue in Case No. 19-1409GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6²³, the Board dismisses this aspect of the DSH SSI (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.²⁴ Accordingly, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the 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. 19-1409GC.

To this end, the Board also reviewed the Provider's PPP 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. 19-1409GC 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 PPP failed to comply with the Board Rule 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 the merits of its position on Issue 1 and explain the nature of any alleged "errors" in its PPP 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.

²³ PRRB Rules v. 2.0 (Aug. 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).

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 as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule:

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.”

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 2023** and instructs providers to send a request via email to access their DSH data.”²⁷

Accordingly, *based on the record before it*, the Board finds that DSH SSI Provider Specific issue in the instant appeal and the group issue in Case No. 19-1409GC 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, the Board dismisses this component of the DSH SSI Provider Specific issue.

²⁵ (Italics and underline emphasis added.)

²⁶ Last accessed August 6, 2025.

²⁷ Emphasis added.

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 CHS CIRP group per 42 C.F.R. § 405.1837(b)(1).

2. Second Aspect of Issue 1

The second aspect of the DSH - SSI 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 MAC 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 MAC 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

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's issue statement for Issue 3 is stated, *supra*.

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.

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

The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.

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.

Furthermore, 42 C.F.R. § 405.1853 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.*²⁹

Similarly, with regard to position papers,³⁰ Board Rule 25.2.1 requires that “the parties must exchange *all available* documentation as exhibits to fully support your position.”³¹ This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides instruction on the content of position papers as it relates to unavailable documentation/exhibits, as discussed *supra*.

Finally, Board Rule 41.2 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 (*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.

²⁹ (Emphasis added).

³⁰ The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.

³¹ (Emphasis added).

This appeal was initiated on May 18, 2020 (more than 5 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expected to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's PPP indicated that it would be sending the eligibility listing under separate cover.³²

To date, there is no evidence that the listing has been provided—even after the MAC requested the listing on 2 separate occasions.³³ 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.³⁴ 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 is dismissing the two (2) remaining issues in this case: DSH – SSI Provider Specific (Issue 1) and DSH - Medicaid Eligible Days (Issue 3). As no issues remain, the Board hereby closes Case No. 21-0088 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:

8/8/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

³² Provider's PPP at 8.

³³ MAC PPP at 11-12 and Nov. 14, 2022 Jurisdictional Challenge at 2 and Exhibit C-1.

³⁴ 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.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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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: ***Notice of Dismissal***

Springs Memorial Hospital (Prov. No. 42-0036), FYE 11/30/2017, Case No. 21-0434

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 21-0434. Set forth below is the decision of the Board to dismiss the two (2) issues in this appeal challenging the Provider’s Disproportionate Share Hospital (“DSH”) SSI Provider Specific and DSH- Medicaid Eligible Days issues.

Background:

A. Procedural History for Case No. 21-0434

On **July 8, 2020**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end November 30, 2017. The Provider is commonly owned by Community Health Systems, Inc. (“CHS”) so it is subject to the mandatory common issue related party (“CIRP”) group regulation at 42 C.F.R. § 405.1837(b)(1).

On **December 22, 2020**, CHS filed the Provider’s individual appeal request. The initial Individual Appeal Request included three (3) issues:

1. DSH SSI Percentage (Provider Specific)
2. DSH SSI Percentage (Systemic Errors)¹
3. DSH - Medicaid Eligible Days

On **January 5, 2021**, 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***

¹ On July 26, 2021, this issue was transferred to Case No. 20-0997GC.

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 25.²

On **July 20, 2021**, the Medicare Contractor (“MAC”) filed a copy of its Request for DSH Package in connection with Issue 3.

On **September 1, 2021**, the Provider timely filed its Preliminary Position Paper (hereafter, Provider’s PPP”). The Provider advised that a listing of Medicaid Eligible Days was being sent to the MAC under separate cover.³

On **September 1, 2021**, the Medicare Contractor (“MAC”) filed a copy of its 2nd Request for DSH Package in connection with Issue 3, requesting that it be submitted by September 16, 2021.

On **November 2, 2021**, the Medicare Contractor (“MAC”) filed a jurisdictional challenge over the DSH SSI Provider Specific issue in the case. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge.^{4,5}

On **December 8, 2021**, the MAC timely filed its preliminary position paper (hereafter, MAC’s PPP”).⁶

On **January 5, 2023**, the MAC filed its 3rd and Final Request for DSH Package in connection with Issue 3. In this filing, the MAC noted that there had been no response to its first 2 requests.⁷

On **August 17, 2023**, the MAC filed a Motion to Dismiss the Medicaid Eligible Days issue, noting that it had previously filed a jurisdictional challenge over the only other remaining issue, DSH SSI Percentage (Provider Specific).

On **November 14, 2023**, Quality Reimbursement Services, Inc. (“QRS”) became the authorized Representative in Case No. 21-0434. On the same date, QRS filed the “Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission.”⁸ The 11-page listing showed

² (Emphasis added).

³ Provider PPP at 8 (Sept. 1, 2021).

⁴ The Provider’s response to the challenge was filed *over 2 years late*, on **August 12, 2024**.

⁵ Although the reference information in the response pertains to Case No. 21-0434, the body of the letter references an incorrect group case no. (19-1409GC) and an incorrect individual appeal case no. 21-0062.

⁶ The MAC indicated that it had not yet received a listing of the additional Medicaid Eligible Days although the Provider’s PPP indicated the listing was to be submitted under separate cover, and the MAC subsequently requested one by letters dated July 20, 2021 and Sept. 1, 2021. MAC PPP at 5 and Exhibit C-2.

⁷ Nine months later, on **November 14, 2023**, the Provider filed a document titled “Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission” in OH CDMS.

⁸ The submission was 2 months after the deadline for responding to the MAC’s Motion to Dismiss Issue 3.

roughly 1509 eligible days and included a *caveat* that the “Listing [is] *pending finalization* upon receipt of State eligibility data.”⁹

On **August 12, 2024**, QRS filed a *late* response to the MAC’s November 2, 2021 jurisdiction challenge over the SSI Percentage (Provider Specific) issue.

B. Description of Issue 1 in the Individual Appeal Request and the Provider’s Participation in Case No. 20-0997GC

In its Individual Appeal Request, the Provider summarizes its DSH- SSI Provider Specific issue as follows:

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 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)¹⁰

The Group issue Statement in Case No. 20-0997GC, to which the Provider transferred Issue 2 (the DSH SSI), 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. §

⁹ (Emphasis added.)

¹⁰ Issue Statement at 1 (Dec. 22, 2020).

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.¹¹

In the Provider's September 1, 2021 PPP in Case No. 21-0434, 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 the Centers for Medicare and Medicaid Services ("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 (November 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"), 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 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

¹¹ Group Issue Statement, Case No. 20-0997GC.

(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 SSI Percentage Issues 1 and 2 in the Provider's individual appeal request is \$26,000.¹³

C. Description of Issue 3 in the Individual 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 3 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.

Audit Adjustment Number(s): 5, 42, 44, 46, S-D

Estimated Reimbursement Amount: \$52,000 (rounded from \$51,810 shown on calculation support in CDMS)¹⁴

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case¹⁵ 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

¹² Provider's PPP at 8-9 (Sept. 1, 2021).

¹³ Based on the calculation support filed with these issues, the Provider rounded the reimbursement impact down from \$26,229.

¹⁴ Appeal Request at Issue 3.

¹⁵ *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994).

percentage” of the DSH payment adjustment.¹⁶

MAC’s Contentions Issue 1 – DSH SSI Provider Specific

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Provider Specific issue. According to the Provider’s appeal request, 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 two portions related to SSI data accuracy should be dismissed because they are duplicative of the SSI Percentage issue 2 - that was transferred to group Case No. 20-0997GC. The remaining component which is 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.¹⁷

MAC’s Contentions Issue 3 – DSH Medicaid Eligible Days

In a separate Motion to Dismiss, the MAC argued that the Provider abandoned the Medicaid Eligible Days issue when it failed to properly develop its arguments within the preliminary position paper in accordance with Board Rule 25. Additionally, at the time, the Provider had failed to provide a list of additional Medicaid eligible days or any other supporting documents and did not provide an explanation for why it could not produce those documents.¹⁸

Provider’s Jurisdictional Response Issue 1- DSH SSI (Provider Specific)

The Board Rules require that Provider Responses to the MAC’s Jurisdictional Challenge must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.¹⁹ The Provider filed its response to the challenge over the SSI Provider Specific issue ***more than 2.5 years after the time for doing so 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.”

Provider’s Jurisdictional Response Issue 3 – Medicaid Eligible Days

Similarly, the Provider’s response to the Motion to Dismiss was due within 30 days and again the Provider failed to timely file a response. Board Rule 44.3 specifies that with respect to motions, “[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.” Although the Provider filed a “Supplement to Position Paper/Redacted Medicaid Eligible Days,” purportedly in response to the motion -it was filed 2 months after the deadline to respond.

¹⁶ Provider’s PPP at 7 (Sept. 1, 2021).

¹⁷ MAC’s Jurisdictional Challenge at 2 (Nov. 2, 2021).

¹⁸ MAC’s Motion to Dismiss at 3-5 (Aug. 17, 2023).

¹⁹ Board Rule 44.4.3, v. 2.0 (Aug. 2018).

Board 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.

As set forth below, the Board hereby dismisses the Provider’s Issue Nos. 1 and 3.

A. DSH SSI Provider Specific

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider’s disagreement with how the MAC 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 MAC computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that the Provider transferred to Case No. 20-0997GC.

The DSH/SSI (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.”²⁰ Per the appeal request, the Provider’s legal basis for its DSH/SSI (Provider Specific) issue asserts 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).”²¹ The Provider argues that “its[sic] 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. 20-0997GC also alleges that the MAC 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 SSI Provider Specific issue in Case No. 21-0434 is duplicative of the DSH/SSI Percentage (*Systemic Errors*) 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 4.6²³, the Board dismisses this aspect of the DSH SSI (Provider Specific) issue.

²⁰ Issue Statement at 1.

²¹ *Id.*

²² *Id.*

²³ PRRB Rules v. 2.0 (Aug. 2018).

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, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the 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. 20-0997GC.

To this end, the Board also reviewed the Provider's PPP 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. 20-0997GC 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 PPP failed to comply with the Board Rule 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 the merits of its position on Issue 1 and explain the nature of any alleged "errors" in its PPP 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.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 as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule:

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,

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).

²⁵ (Italics and underline emphasis added.)

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 2023** and instructs providers to send a request via email to access their DSH data.”²⁷

Accordingly, *based on the record before it*, the Board finds that DSH SSI Provider Specific issue in the instant appeal and the group issue in Case No. 20-0997GC 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, the Board dismisses this component of the DSH SSI Provider Specific issue.

²⁶ Last accessed August 6, 2025.

²⁷ Emphasis added.

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 CHS CIRP group per 42 C.F.R. § 405.1837(b)(1).

2. Second Aspect of Issue 1

The second aspect of the DSH - SSI 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 MAC 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 MAC 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 asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider's issue statement for Issue 3 is stated, *supra*. Neither the Provider's appeal request, nor the PPP, included a list of the specific additional Medicaid eligible days that are in dispute in this appeal.

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.

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

No Access to Data

The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. See subsections below and Rule 8 for special instructions regarding multicomponent disputes.

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.

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.*²⁹

Similarly, with regard to position papers,³⁰ Board Rule 25.2.1 requires that “the parties must exchange *all available* documentation as exhibits to fully support your position.”³¹ This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides instruction on the content of position papers as it relates to unavailable documentation/exhibits, as discussed *supra*.

Finally, Board Rule 41.2 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 (*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.

²⁹ (Emphasis added).

³⁰ The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.

³¹ (Emphasis added).

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 December 22, 2020 (more than 4.5 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expected to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's PPP indicated that it would be sending the eligibility listing under separate cover.³²

Notably, the MAC sent three requests for the Provider's list of Medicaid Eligible days. The first notice was sent on July 20, 2021; the second request was sent on September 1, 2021; and the third, final, request was sent on January 5, 2023, five years after the end of the Provider's cost reporting period. The MAC also informed the Provider in its final request for information that the deadline to respond was February 4, 2023.

Due to the non-responsiveness of the Provider, on August 17, 2023, the MAC 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 requested by the MAC 3 separate times after that). The MAC 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.³³

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 September 16, 2023 filing deadline (i.e., 30 days after August 17, 2023). Two months after the deadline, on November 14, 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." The Listing was 11 pages with roughly 1509 Medicaid eligible days. QRS' filing did not explain why the listing, which included substantially more than the 100 days noted in the initial appeal, was being submitted at this late date or why it was not final despite having been submitted almost 6 years after the fiscal year at issue had closed.

³² Provider's PPP at 10.

³³ 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.

Regardless, this filing was 2 months past the deadline for responding to the Motion to Dismiss and, more importantly, was more than 2 years past the deadline for including it with its preliminary position paper since the position paper deadline was August 19, 2021.

The Board concurs with the MAC 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 provide any supporting documentation for those days).

The fact that the Listing was filed 1 day after the Provider requested the change of 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 13, 2023 filing as a “Supplement to Position Paper” and does not accept that filing because:

1. The alleged “Supplement” was filed more than 2 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 3 and the alleged “Supplement” was filed more than 2 months after the deadline for filing a response to the Motion to Dismiss 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 1509 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 almost 3 years after this appeal was filed and almost 6 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 January 5, 2021 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 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 PPP or a supplement

of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the PPP 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 PPP (indeed the *tentative* 1509 days listed in the alleged “Supplement” is, without explanation, *exponentially* larger than the original estimated 100 days included with the appeal request).³⁴

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 provided 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

Based on the foregoing, the Board is dismissing the two (2) remaining issues in this case: DSH – SSI Provider Specific (Issue 1) and DSH - Medicaid Eligible Days (Issue 3). As no issues remain, the Board hereby closes Case No. 21-0434 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.

³⁴ 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.”

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.

Board Members Participating:

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

For the Board:

8/8/2025

X Ratina Kelly

Ratina Kelly, CPA

Board Member

Signed by: PIV

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



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***
St. Joseph Hospital, Prov. No. 15-0047, FYE 05/31/2018
Case No. 22-0322

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 22-0322. 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. 22-0322

On **July 6, 2021**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end May 31, 2018. The Provider is commonly owned by Community Health Systems, Inc. (“CHS”).

On **December 27, 2021**, CHS filed the Provider’s individual appeal request. The initial 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 Days²
4. DSH Payment – Medicare Managed Care Part C Days (SSI Fraction & Medicaid Fraction)³
5. DSH Payment – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days) – (SSI Fraction & Medicaid Fraction)⁴

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 **July 12, 2022**, the Provider transferred Issues 2, 4 and 5⁵ to CHS CIRP groups.

¹ On July 12, 2022, this issue was transferred to Case No. 21-1206GC.

² On December 12, 2022, the Medicare Contractor filed a jurisdictional challenge over Issue Nos. 1 and 3.

³ On July 12, 2022, this issue was transferred to Case No. 20-2149GC.

⁴ On July 18, 2022, this issue was transferred to Case No. 21-0066GC.

⁵ Issue No. 5 was originally transferred to the incorrect CIRP Group case on July 12, 2022. This was corrected on July 18, 2022.

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 3 (the DSH Payment – Medicaid Eligible Days).

On **January 3, 2022**, 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 **August 2, 2022**, 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 referred to the original “estimated impact” for this issue of \$14,493 based on an *estimated* 50 days included with the Initial Appeal Request.

On **November 17, 2022**, the Medicare Contractor 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 that Medicaid eligible days listing.

On **December 12, 2022**, the Medicare Contractor timely filed a Jurisdictional Challenge⁷ with the Board over Issues 1 and 3 requesting that the Board dismiss these issues. Pursuant to Board

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

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 **November 10, 2023**, the Provider changed its designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. (“QRS”).

On **November 13, 2023**, 10 months after the deadline for responding to the Jurisdictional Challenge requesting dismissal of Issue 3, 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.”⁸ The Listing was 11 pages with roughly 1,789 Medicaid eligible days. QRS’ filing did not explain why the listing of so many days (again around 1,789 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 1,789 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 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. 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

timely filing requirements and/or jurisdictional requirements.”); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

⁸ (Emphasis added.)

⁹ Issue Statement at 1 (Dec. 27, 2021).

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.¹⁰

On August 2, 2022, the Board received the Provider's preliminary position paper in 22-0322. 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 based on the Provider's Fiscal Year End (May 31).

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

¹⁰ Group Appeal Issue Statement in Case No. 21-1206GC.

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).¹¹

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is \$14,661.

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.¹²

Finally, the MAC argues “the Provider did not file a **complete** preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3.”¹³ The MAC posits that the Provider “failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its Preliminary Position Paper.”¹⁴

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. The MAC argues the Provider has not submitted a Medicaid eligible days listing and therefore, requests the Board dismiss the issue.

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.¹⁵ 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

¹¹ Provider's Preliminary Position Paper at 8-9 (Aug. 2, 2022).

¹² Medicare Contractor's Jurisdictional Challenge at 6-7 (Dec. 12, 2022)

¹³ *Id.* at 7.

¹⁴ *Id.* at 9.

¹⁵ Board Rule 44.4.3, v. 3.1 (Nov. 2021).

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."¹⁶ 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)."¹⁷ 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."¹⁸

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. 22-0322 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

¹⁶ Issue Statement at 1.

¹⁷ *Id.*

¹⁸ *Id.*

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.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 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

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

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.

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 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”) 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

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. 22-0322 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.

2. *Second Aspect of Issue 1*

²¹ (Italics and underline emphasis added.)

²² Last accessed Oct. 15, 2024.

²³ (Emphasis added).

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.

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) (Jul. 2015) states:

B. No Access to Data

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.**

(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.²⁵

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.

²⁵ (Bold emphasis added.)

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:

Rule 25 Preliminary Position Papers²⁶

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 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 The 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.

²⁶ (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 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.

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 with 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 this is a change in previous Board practice. Failure to file a **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 January 3, 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.²⁷

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carry[es 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 August 2, 2022, 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.²⁸ 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 \$14,493 based

²⁷ (Emphasis added.)

²⁸ Provider's Preliminary Position Paper at 11 (May 4, 2020).

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.

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 requested 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.

Pursuant to Board Rule 44.4.3, the Provider had 30 days to respond to the Jurisdictional Challenge. However, the Provider **failed** timely respond to that Motion by the January 11, 2023 filing deadline (*i.e.*, 30 days after December 12, 2022).

However, on November 13, 2023 (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 11 pages with roughly 1,789 Medicaid eligible days. QRS’ filing did not explain why the listing of so many days (again around 1,789 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 3000 included in this belated listing is *exponentially* larger than the original estimate of 50 days included with the appeal request. Regardless, this filing was roughly 10 months past the deadline for responding to the Jurisdictional Challenge *and, more importantly, was more than 3 years past the deadline for including it with its preliminary position paper* since the position paper deadline was August 24, 2022.

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).

The fact that the Listing was filed merely 3 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 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 13, 2023 filing as a “Supplement to Position Paper” and does not accept that filing because:

1. The alleged “Supplement” was filed **more than 3 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 Challenge to Issue 3 and the alleged “Supplement” was filed **10 months after the deadline** for filing a response to the Challenge to 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 1,789 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 roughly 2 years 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 January 3, 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* 1,789 days listed in the alleged “Supplement” is, without explanation, *exponentially* larger than the original estimated 50 days included with the appeal request).²⁹

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”³⁰ 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)(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 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.³¹

²⁹ 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.”

³⁰ (Emphasis added.)

³¹ 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

* * * * *

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. 22-0322 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:

For the Board:

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

8/8/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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



Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

John Traverso
Hartford HealthCare
181 Patricia M. Genova Drive
Newington, CT 06111-1500

RE: ***Notice of Potential Dismissal***
Backus Hospital (Provider Number 07-0024)
FYE: 9/30/2016
Case Number: 21-0001

Dear Mr. Traverso:

The Provider Reimbursement Review Board (“Board” or “PRRB”) received Backus Hospital’s (“Provider”) Individual Appeal Request on **March 17, 2020**, appealing from a Notice of Program Reimbursement (“NPR”) dated **September 26, 2019**. The appeal request contained eleven (11) issues:

1. DSH/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage – ***transferred on December 3, 2020***
3. DSH/SSI Fraction Medicare Managed Care Part C Days – ***transferred on December 3, 2020***
4. DSH/SSI Fraction Dual Eligible Days – ***transferred on December 3, 2020***
5. DSH/Medicaid Eligible Days
6. DSH/Medicaid Fraction Medicare Managed Care Part C Days – ***transferred on December 3, 2020***
7. DSH/Medicaid Fraction Dual Eligible Days – ***transferred on December 3, 2020***
8. Medicaid Eligibility Patient Days - CT State Admin Gen Assist¹
9. Uncompensated Care ("UCC") Distribution Pool – ***withdrawn December 9, 2020***
10. 2 Midnight Census IPPS Payment Reduction – ***transferred on December 3, 2020***
11. Standardized Payment Amount – ***transferred on December 3, 2020***

The Board received the Provider’s Preliminary Position Paper (“PPP”) on **January 27, 2021**, and the Medicare Contractor’s PPP on **May 28, 2021**. A notice of Hearing was issued on **November 14, 2024**, which set a hearing date for **August 26, 2025**.

¹ The Medicare Contractor’s Preliminary Position Paper indicates that this issue was withdrawn on November 3, 2020, but it remains active on OH CDMS and there is no record therein of a withdrawal.

On **July 28, 2025**, the Board Advisor assigned to this case reached out to the parties to inquire whether the three remaining issues may resolve or if they anticipated moving forward with the August 26 hearing. The Board Advisor also noted:

And since it appears that the designated representative, John Traverso, has an inactive email in OH CDMS, I am copying Quality Reimbursement Services as a one time courtesy since they are listed as the representative in other cases for this Provider. Any future communications will be solely to the designated representative listed in OH CDMS in accordance with the Board's Rules.

The Board Advisor received no response from either the designated representative or from Quality Reimbursement Services.

On **August 1, 2025**, the Board issued a Notice of Potential Dismissal. Based on the failure of the Provider's Representative to respond to the Board's direct inquiries and the lack of any contact with the Board since withdrawing an issue in December, 2020 and the filing of its PPP in January, 2021, the Board ordered the Provider's Representative to respond within five (5) days of that Notice to advise whether the Provider is still pursuing this appeal. The Board specifically stated that "[f]ailure of the Provider to respond by the above filing deadline will result in the dismissal of this case." The Provider's Representative filed no response or otherwise replied to any of the Board's communications about the upcoming hearing or status of the case.

Board Rule 5.2 sets forth some of the responsibilities of a designated case representative:

The case representative is responsible for being familiar with the following rules and procedures for litigating before the Board:

- The Board's governing statute at 42 U.S.C. § 1395oo;
- The Board's governing regulations at 42 C.F.R. Part 405, Subpart R; and
- These Rules, which include any relevant Orders posted at <https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-rules-and-board-orders> (*see* Rule 1.1).

Further, the case representative is responsible for:

- Ensuring his or her contact information is current with the Board, including a current email address and phone number;
- Meeting the Board's deadlines; and
- ***Responding timely to correspondence or requests from the Board*** or the opposing party.

Failure of a 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. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.²

Board Rule 5.3 also explicitly notes that “[t]he Board’s communications will be sent to the case representative via email to the case representative’s email address on file with the Board (*see* Rule 5.2). The Board will address notices only to the official case representative.”

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,
- ***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.

Failure to comply with the Board’s requirements or orders 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.

Based on the failure of the Provider’s Representative to respond to the Board’s direct inquiries, the lack of any contact with the Board since withdrawing an issue in December, 2020, and the filing of its PPP in January, 2021, and the failure to respond to the Board’s Notice of Potential Dismissal, the Board is exercising its discretion, pursuant to 42 C.F.R. § 405.1868(b)(1), to dismiss Case 21-0001 with prejudice and hereby 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.

² Emphasis added.

Board Members:

Kevin D. Smith, CPA

Ratina Kelly, CPA

Nicole E. Musgrave, Esq.

Shakeba DuBose, Esq.

For the Board:

8/11/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA

Board Chair

Signed by: Kevin D. Smith -A

cc: Edward Lau, Esq. Federal Specialized Services
Danelle Decker, National Government Services, Inc. (J-K)



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Susan Gristchuk
Prisma Health
300 E. McBee Avenue, Suite 302
Greenville, SC 29601

***RE: Board Determination – Dismissal of Appeal Based on Insufficient Preliminary
Position Paper Filing & Failure to Respond to Motion to Dismiss***

Prisma Health Baptist (Provider Number 42-0086)
FYE: 09/30/2020
Case Number: 24-2763

Dear Ms. Gristchuk:

The Provider Reimbursement Review Board (the “Board”) has reviewed the subject individual appeal in response to the Medicare Contractor’s (“MAC’s”) July 10, 2025 Motion to Dismiss the appeal for failure to furnish a proper and complete preliminary position paper. The pertinent facts and the Board’s determination are set forth below.

Pertinent Facts:

On **September 26, 2024**, Prisma Health (“Prisma”) filed an individual appeal on behalf of Prisma Health Baptist (“Prisma Baptist”/Prov. No. 42-0086) for its fiscal year end (“FYE”) 09/30/2020. The sole issue in the appeal is “Part A Medicare Bad Debt Indigent Claims.”

On **September 27, 2024** the Board issued an Acknowledgement & Critical Due Dates Notice setting the Provider's preliminary position paper (hereafter, “Provider’s PPP”) due date for May 24, 2025 and the MAC’s PPP due date for September 21, 2025.

On **May 23, 2025** the Provider uploaded four documents to the PPP responsive case action in the Office of Hearings Case & Document Management System (“OH CDMS”). All four documents were titled "Position Letter" and when downloaded each document was the same copy of the March 27, 2024 Notice of Program Reimbursement (“NPR”).

On **July 10, 2025**, the MAC filed a Motion to Dismiss. The MAC argues that the Provider has failed to furnish a proper and complete PPP, so it has effectively abandoned its claim for Part A Medicare Indigent Bad Debts. The MAC also noted that it reached out to the Provider on July 8,

2025 to request the complete PPP. According to the MAC, the Provider responded with a copy of the issue statement from its September 26, 2024 appeal request – not a PPP.¹

Pertinent 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 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.

Specifically, with regard to PPP Requirements, Board Rule 25.3 states that Parties are required to:

. . . file a complete PPP 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 unbrieffed issue abandoned and effectively withdrawn.²

The Board Rules require that Provider Responses to the MAC's Motion to Dismiss must be filed within thirty (30) days of the filing of the Motion.³ The Provider has not filed a response and the time for doing so has elapsed. Board Rule 44.4.3 further specifies that a provider's "[f]ailure to respond will result in the Board making a jurisdictional determination with the information contained in the record."⁴

In addition, 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*

¹ Neither a copy of the MAC's July 8, 2025 request for the PPP, nor the Provider's response, were filed in OH CDMS.

² Board Rule 25.3, v. 3.2 (Dec. 15, 2023).

³ Board Rule 44.3, v. 3.2.

⁴ Board Rule 44.4.3, v. 3.2.

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.⁵

Board Determination:

Accordingly, *based on the record before it*, and pursuant to its authority under 42 C.F.R. § 405.1868, the Board finds it appropriate to dismiss the subject appeal because:

- The Provider failed to properly brief its issue in accordance with Board Rule 25.3, which requires parties to file a "complete" PPP and, therefore, the Provider has essentially abandoned its issue, regardless of intent; and
- The Provider failed to respond to the MAC's Motion to Dismiss within the allotted period.

Case No. 24-2763 is hereby closed and removed from the Board's docket.

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:

8/12/2025

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

Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)

⁵ Emphasis added.



DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Corinna Goron
Healthcare Reimbursement Services, Inc.
3900 American Drive, Suite 202
Plano, TX 75075

RE: **EJR Determination**
Case Number: 15-2041GC - *HRS Prime Healthcare 2012 Outlier Threshold Payments CIRP Group*

Dear Ms. Goron:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Request for Expedited Judicial Review ("EJR") filed June 5, 2025 in the above-referenced appeal. The Board's decision with respect to EJR is set forth below.

I. Background

The group issue is described as follows:

Group Issue: Outlier Payments - Fixed Loss Threshold (5.1% Withheld Issue)

Statement of Issue

Whether the Providers received the reimbursement Congress intended under the Medicare Act for treating certain cases that incurred extraordinarily high costs? Was the cost outlier threshold set improperly?

Statement of the Legal Basis

The Providers contend the Secretary's final determination of outlier payments was arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law within the meaning of 5 U.S.C. Section 706(2)(A), and is short of statutory rights within the meaning of 5 U.S.C. Section 706(2)(c), because the Secretary acted in an arbitrary and capricious manner and abused her discretion when setting the outlier threshold and calculating outlier payments. The Secretary failed to consider relevant factors and data which should have been taken into account when setting the criteria, failed to consider alternative methodologies when establishing

the outlier thresholds and failed to demonstrate a reasonable connection between the thresholds and the factors considered. Among other things, the Secretary failed to consider relevant data which showed that the rate of increase in hospital costs per discharge was trending downward and that the relationship of hospital costs to hospital charges was changing. The Secretary thus failed to take into account the established pattern of declining cost-to-charge ratios, which play a significant part in the calculation of outlier payments, despite this problem being repeatedly pointed out in comments and despite proposed methods to account for this phenomenon and to more accurately estimate outlier payments so that thresholds could be set more accurately. Further, the Secretary failed to consider use of the "cost methodology," rather than the "charge methodology," in setting the outlier thresholds, despite the fact that the cost methodology had been more accurate in predicting outlier payments in prior years. Finally, the Secretary failed to require mid-year adjustments and failed to consider adjustments to the reconciliation process. These deficiencies in the Secretary's methodology were identified in the rulemaking comments. By ignoring the flaws in her methodology, the Secretary failed to act reasonably in calculating the amounts of outlier payment to which hospitals are entitled. As a result of these arbitrary and capricious actions, the threshold was set too high, the resulting amount of outlier payments fell short of the percentage required by the Medicare Act and hospitals did not receive the amount of outlier payments that Congress intended.¹

On **June 5, 2025**, the Providers filed a request for EJR. On **August 5, 2025**, the Providers filed their Preliminary Position Paper in this case. The Medicare Contractor's Preliminary Position Paper has not yet been filed and is not due until October 2, 2025.

II. Relevant Law – Outlier Threshold

Part A of the Medicare Act covers "inpatient hospital services." Originally, Medicare reimbursed hospitals based on the "reasonable costs" of these services.² Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").³ Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.⁴ These predetermined, standardized amounts are calculated by the Secretary first determining a nationwide average allowable cost per discharge,⁵ which is then further adjusted based on a wage

¹ Issue Statement at 1 (Mar. 31, 2015).

² See 42 U.S.C. § 1395f(b)(1).

³ See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

⁴ *Id.*

⁵ 42 U.S.C. § 1395ww(d)(2)(A)-(C).

index specific to the locality of the hospital.⁶ Each discharge is also adjusted based on the severity of illness, which are classified as distinct diagnosis-related groups (“DRGs”).⁷ These DRGs are intended to weight the reimbursement based on “the relationship between the cost of treating patients within that group and the average cost of treating all Medicare patients.”⁸

While the IPPS provides a fixed amount of reimbursement per patient regardless of actual costs incurred in rendering services,⁹ Congress also authorized supplemental “outlier payments,” or additional reimbursement for patients’ care if the cost was atypically high.¹⁰ Hospitals may request outlier payments “in any case where charges, adjusted to cost, exceed . . . the sum of the applicable DRG prospective payment rate . . . plus a fixed dollar amount determined by the Secretary.”¹¹

Ensuring that costs are “adjusted to cost” involves evaluating a hospital’s “cost-to-charge ratio,” which represents the hospitals “average markup” of inpatient hospital services.¹² Outlier payments may be requested if the adjusted costs exceed the DRG rate plus a “fixed dollar amount” – commonly referred to as the “fixed loss threshold.”¹³ This amount essentially makes a hospital responsible for a portion of the treatment’s excessive costs.¹⁴ The Secretary is mandated to ensure that the fixed loss threshold for a given fiscal year results in outlier payments between five (5) and six (6) percent of total payments projected or estimated to be made under the IPPS.¹⁵ The sum of the DRG rate plus the fixed loss threshold is known as the “outlier threshold.”¹⁶ Hospitals are typically paid 80% of the costs above the applicable outlier threshold.¹⁷

As noted by the United States District Court for the District of Columbia, basing outlier payment eligibility on a hospital’s own cost-to-charge ratio “led to rampant inflation of hospital charges, a problem that came to be known as ‘turbo-charging.’”¹⁸ To combat turbo-charging, the Secretary began using more recent data and also reserved the right to recalculate a hospital’s eligibility for outlier payments using actual cost data at the time of settlement, a process known as reconciliation.¹⁹

⁶ 42 U.S.C. § 1395ww(d)(2)(H).

⁷ 42 U.S.C. § 1395ww(d)(4).

⁸ See *Cape Cod Hosp. v. Sebelius*, 630 F.3d 203, 205-206 (D.C. Cir. 2011).

⁹ See *Sebelius v. Auburn Reg’l Med. Ctr.*, 133 S.Ct. 817, 822 (2013).

¹⁰ See *County of L.A. v. Shalala*, 192 F.3d 1005, 1009 (1999); 42 U.S.C. § 1395ww(d)(5)(A).

¹¹ 42 U.S.C. § 1395ww(d)(2)(A)(ii).

¹² See *Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d 46, 49-50 (D.C. Cir. 2015) (citing *Appalachian Reg’l Healthcare, Inc. v. Shalala*, 131 F.3d 1050, 1052 (D.C. Cir. 1997)); 42 C.F.R. § 412.84(i).

¹³ See *Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d at 50.

¹⁴ See *Boca Raton Comm. Hosp., Inc. v. Tenet Health Care Corp.*, 582 F.3d 1227, 1229 (11th Cir. 2009).

¹⁵ 42 U.S.C. § 1395ww(d)(5)(A)(iv).

¹⁶ See *Banner Health v. Price*, 867 F.3d 1323, 1329 (D.C. Cir. 2017) (citing *Boca Raton v. Tenet Health*, 582 F.3d at 1229); 42 U.S.C. § 1395ww(d)(5)(A)(ii).

¹⁷ 42 C.F.R. § 412.84(k).

¹⁸ *Billings Clinic v. Azar*, 901 F.3d 301, 306 (D.C. Cir. 2018) (citing *Banner Health v. Price*, 87 F.3d at 1333).

¹⁹ *Id.* (citing 68 Fed. Reg. 34494, 34499 (June 9, 2003)).

III. Positions of the Parties

As noted above, the Providers' group issue statement outlines a number of challenges to their outlier payments, claiming the process was arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law within the meaning of the Administrative Procedure Act.²⁰ They take issue with the outlier thresholds set by the Secretary because they argue that she failed to consider relevant data which would have impacted their cost-to-charge ratios; failed to consider use of the more accurate "cost methodology" versus the "charge methodology"; and failed to require mid-year adjustments to the threshold or adjustments to the reconciliation process.

On **June 5, 2025**, the Providers filed their Request for EJR which explained:

The Hospitals contend that the outlier thresholds applicable to the Hospitals' FYE 2012 were set excessively high and are contrary to the Medicare Act and substantively and/or procedurally invalid and must be reset and applied to the Hospitals' FYE 2012 IPPS discharges to redetermine amounts the Hospitals are owed.²¹

On **June 12, 2025**, the Medicare Contractor's designated representative, Federal Specialized Services ("FSS") filed a response to the Request for EJR which stated:

Federal Specialized Services ("FSS"), as representative for the Medicare Administrative Contractor ("MAC"), writes to advise that a jurisdictional challenge will be filed for provider 05-0739 as the appeal is untimely.²²

The Board issued a Scheduling Order on **June 18, 2025**, requiring any Jurisdictional Challenge be filed by **June 25, 2025** and any response thereto be filed by **July 16, 2025**.

FSS filed a Jurisdictional Challenge on June 25, 2025 alleging that the appeal for Centinela Hospital Medical Center (Provider Number 05-0739, Fiscal Year End 12/31/2012) is premature. The Provider filed a response on July 16, 2025.

²⁰ 5 U.S.C. § 706(2).

²¹ Request for Expedited Judicial Review at 2 (June 5, 2025).

²² Response to Provider's Request for Expedited Judicial Review at 1 (June 12, 2025). The Response also claimed "that the schedule of providers attached as Exhibit 1 to the EJR request appears to be incorrect as the schedule notes that several providers have been withdrawn from the appeal, but those same providers are still listed as active in OH/CDMS." This argument was not raised in the actual Jurisdictional Challenge and does not appear to be accurate.

IV. Decision of the Board

A. Expedited Judicial Review

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.

i. Jurisdiction

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 issue a final determination;²³
- The matter at issue involves a 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.²⁴

Jurisdictional Challenge to the inclusion of Centinela Hospital Medical Center (Provider No. 05-0739, Fiscal Year End 12/31/2012)

FSS filed a Jurisdictional Challenge on June 25, 2025 alleging that the appeal for Centinela Hospital Medical Center (Provider No. 05-0739, Fiscal Year End 12/31/2012) is premature. FSS argued:

The Provider filed its initial cost report on June 4, 2013 (Initial Cost Report). On December 1, 2014, the Provider appealed its Initial Cost Report pursuant to a failure to issue a timely determination. The Provider subsequently filed an amended cost report on March 27, 2015 (Amended Cost Report). The Provider has not filed an appeal from its Amended Cost Report. . . . [Filing an amended cost report] established a new timeline for the Provider to appeal pursuant to a failure to issue a timely determination. Thus, the Provider’s appeal is premature.²⁵

²³ 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).

²⁴ 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.

²⁵ Medicare Contractor’s Jurisdictional Challenge at 2 (June 25, 2025).

The Providers filed a Jurisdictional Response on **July 16, 2025**. They argue:

The fact that the provider amended the cost report on 3/27/2015, after the appeal was already filed, is irrelevant. Both the statute and the regulations give the provider the right to request a PRRB hearing where the MAC has not timely issued an NPR. See 1878(a)(1)(B) of the Social Security Act, 42 C.F.R. §405.1835(c). Neither the statute nor the regulations provide for any resetting of the clock based on an amended cost report.²⁶

42 U.S.C. 1395oo(a)(1)(B) permits a provider to file an appeal if it “has not received [a] final determination from [the] intermediary on a timely basis after filing [its cost] report, where such report complied with the rules and regulations of the Secretary relating to such report[.]” Thus, Medicare contractors must issue an NPR within twelve (12) months of receiving a Provider’s perfected or amended cost report. Providers are afforded the right to appeal if this NPR is not timely received, pursuant to 42 C.F.R. § 405.1835(c), which states:

(1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped “Received” on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.

(2) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section) . . .

The Board notes that the original cost report was filed on June 4, 2013. The Medicare Contractor had twelve (12) months to issue an NPR (*i.e.*, by June 3, 2014), but did not do so. At this point in time, the Provider had a right to file an appeal before the Board. The Provider exercised this right on December 1, 2014. On that date, no NPR had been issued and the Provider had not yet filed its amended cost report. The Board majority finds the applicable statute and regulation clearly establish the Provider’s right to file an appeal with the Board at that time. The Provider then filed an amended cost report on March 27, 2015 (which was accepted by the Medicare Contractor), nearly four (4) months after the Provider’s appeal was filed.

²⁶ Provider’s Jurisdictional Response at 1 (July 16, 2025).

Accordingly, the MAC's argument that the Provider's appeal is premature is faulty because, to preserve its rights to appeal the original cost report, the Provider had to do so "no later than 180 days after the expiration of the 12 month period" for the MAC's issuance of the NPR. *See* 42 C.F.R. § 405.1835(c)(2). The MAC's logic assumes a certain amount of clairvoyancy and where such is not possessed by a provider, to the detriment of its right to an appeal.²⁷ A provider who fails to timely appeal the MAC's untimely NPR, and who does not subsequently file an amended cost report (thus no NPR based on an amended cost report is issued), would be foreclosed from pursuing any appeal at all.

Based on the foregoing, the Board majority finds the filing of an amended cost report does not invalidate the appeal which had previously been filed in accordance with the applicable regulations. Therefore, the Board majority finds that Centinela Hospital Medical Center (Provider No. 05-0739, Fiscal Year End 12/31/2012) has a valid appeal of the outlier issue from the Medicare Contractors failure to timely issue a NPR of the June 4, 2013 cost report.

The Board finds that all of the Providers' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal.²⁸ They have also all made timely appeals from original NPRs or the failure of the Medicare Contractor to issue a timely final determination.

a. Dissatisfaction - FYEs December 31, 2008 to December 31, 2016 (1727-R)

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming an issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen*.²⁹ In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.³⁰

²⁷ PRM-1 §2931.2(A), specifically states: Under limited circumstances, [a MAC] will accept an amended cost report. An amended cost report is one which is intended to revise information submitted on a cost report which has previously been filed by the provider. A provider may file, or an intermediary may require an amended cost report to 1. correct material errors **detected subsequent** to the filing of the original cost report. 2. comply with the health insurance policies or regulations, or 3. reflect the settlement of a contested liability[.] Emphasis added.

²⁸ *See* 42 C.F.R. § 405.1837.

²⁹ 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).

³⁰ *Bethesda* at 1258-59.

On August 21, 2008, new regulations governing the Board were effective.³¹ Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* (“Banner”).³² In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider’s request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.³³

The Secretary did not appeal the decision in *Banner* and decided to largely apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on December 31, 2008 and which began before January 1, 2016. Under this ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

The Board has determined that the Outlier Threshold methodology at issue in these cases is governed by CMS Ruling CMS-1727-R since the Providers are challenging the policy as set forth in 42 U.S.C. § 1395ww(d)(5) and 42 C.F.R. § 412.84 and that Board review of the issues is not otherwise precluded by statute or regulation.

V. Board’s Decision Regarding the EJR Request

The Board finds that:

- 1) The Board has jurisdiction over the matter for the subject years and that the participants in Case 15-2041GC are entitled to a hearing before the Board;
- 2) Based upon the participants’ assertions regarding the Outlier Threshold issue as governed by 42 U.S.C. § 1395ww(d)(5) and 42 C.F.R. § 412.84, there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

³¹ 73 Fed. Reg. 30190, 30240 (May 23, 2008).

³² 201 F. Supp. 3d 131 (D.D.C. 2016).

³³ *Id.* at 142.

- 4) It is without the authority to decide the legal question of whether the Outlier Threshold issue as governed by 42 U.S.C. § 1395ww(d)(5) and 42 C.F.R. § 412.84, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of the Outlier Threshold issue as governed by 42 U.S.C. § 1395ww(d)(5) and 42 C.F.R. § 412.84 properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' EJ Request for the issue and the subject year for Case 15-2041GC. 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 Case 15-2041GC, the Board hereby closes the case 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 Participating:

Kevin D. Smith, CPA (Dissenting with respect to jurisdiction for Centinela FYE 12/31/2012)

Ratina Kelly, CPA

Nicola E. Musgrave, Esq.

Shakeba DuBose, Esq.

FOR THE BOARD:

8/12/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA

Board Chair

Signed by: Kevin D. Smith -A

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Scott Berends, Esq., FSS

Dissent Centinela FYE 12/31/2012

Medicare contractors must issue an NPR within twelve months of receiving a Provider's perfected or amended cost report. Providers are afforded the right to appeal if this NPR is not timely received. This right to hearing, as stated in 42 C.F.R. § 405.1835 is presented below:

. . . a provider. . . has a right to a Board hearing, as a single provider appeal, for specific items for a cost reporting period if –

(1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.

In some instances, Providers file amended cost reports before twelve months has elapsed from the filing of their original cost reports. When that happens, the Medicare Contractor is afforded twelve months to issue an NPR following acceptance of that amended cost report. The right to appeal an untimely NPR, however, is only afforded when the failure to issue an NPR is *through no fault of the provider*. Filing an amended cost report, which resets the timeline to issue an NPR, is a provider action; therefore, the failure to issue an NPR on the original cost report is the provider's "fault." Filing an appeal before twelve months has elapsed from the acceptance of the amended cost report is premature.

In this specific case, the Provider filed its appeal from its original cost report in December, 2014, and then filed, of its own volition, an amended cost report almost 4 months later. The Provider did NOT appeal from the failure to receive a timely NPR of its amended cost report, even though the amended cost report did not receive an NPR within 12 months. Analysis of the OH CDMS system also indicates that the Provider did receive an NPR for FYE 12/31/2012, and filed an appeal of that NPR, which did NOT include the outlier issue.³⁴

The filing of an accepted amended cost report supersedes the originally filed cost report. Upon receipt, and acceptance of an amended cost report, the Medicare contractor will review/audit/adjust only the most recent (amended) cost report, and the NPR will be issued based upon that report, taking into account any Medicare contractor adjustments. Thus, the only cost report that is "perfected" after an amended cost report is filed and accepted is the amended cost report. Accordingly, the amended cost report has appeal rights if an NPR is not issued within 12

³⁴ The Board notes that Case Number 18-1460 was filed on July 16, 2018, from the NPR issued January 29, 2018. That individual appeal contained only one issue (Understated Standardized Amount) which was transferred to a group appeal. This individual appeal was withdrawn after the transfer, at the request of the Provider's representative, Healthcare Reimbursement Services, on March 25, 2019.

months from that amended filing date. Indeed, 42 C.F.R. § 405.1835 addresses amended cost reports specifically. If appeal of the originally filed cost report was sufficient, there would be no reason for the regulation to state:

A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report *or amended cost report*. . .³⁵

The Board majority argues, *supra*, that “[a] provider who fails to timely appeal the MAC’s untimely NPR, and who does not subsequently file an amended cost report (thus no NPR based on an amended cost report is issued), would be foreclosed from pursuing any appeal at all.” However, this is patently untrue, and a full understanding of both the cost report filing/settlement process and the appeals process makes that clear. Appeal from an untimely NPR is only one of the “determinations” which grant appeal rights. As stated in 42 C.F.R. § 405.1835(a),

[a] provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider’s cost reporting period. . .

Thus, while the Provider had the ability to appeal the issue after filing its original cost report (2013) and not receiving an NPR 12 months later (2014), it also had the ability to appeal the issue after filing its amended cost report (2015) and not receiving an NPR 12 months later (2016). It did not do so. The Board majority ignores the fact that the Provider, yet again, had a third opportunity to appeal the *final* determination (2018), and did so, but only for a separate issue, at the time it received its NPR for the FYE 12/31/2012. Indeed, in this group case, the Providers’ representative withdrew the appeals for “Failure to Issue NPR” in 14 of the cases and filed a direct addition of those same providers to the group case based upon their final NPRs. This was NOT done in the case of Centinela. If it was considered necessary by the representative for the other cases, it is unclear why it would not be necessary in this case. It appears to be inconsistency in the handling of the case, which would be considered administrative oversight, and therefore qualify as “fault of the provider.” While the other NPRs were issued within 1-2 years of the original appeals, in Centinela’s case, it was a longer period of time. Thus, it’s possible the representative was not managing its docket after the first group of NPRs came through and missed this one (although it managed to file an appeal of the NPR for a separate issue). However, this again, is administrative oversight.

Had the Provider, or its representative, appealed the amended cost report in a timely fashion for failure to issue an NPR or had they appealed the NPR issued in 2018 settling the amended cost report, they would have preserved their appeal rights. Indeed, many of the other providers in the same case did just that. In this case, it is my opinion, as the Board minority, that this Provider did not properly preserve its appeal rights in this case and therefore, it should not be included in the EJR.

³⁵ (Bold and italics emphasis added.)

8/12/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA

Board Chair

Signed by: Kevin D. Smith -A



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. David Cox
Corporate Cost Reporting Manager
Dialysis Clinic, Inc.
1633 Church Street, Suite 500
Nashville, TN 37203

RE: **Notice of Dismissal**
Dialysis Clinic Inc. (42-2636)
Appealed Period: FYE 09/30/2023
PRRB Case No.: 25-5277

Dear Mr. Cox:

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 subject 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 August 4, 2025, the Provider filed an appeal for the Fiscal Year End ("FYE") 09/30/2023 based on a Notice of Program Reimbursement ("NPR") dated March 11, 2024. The appeal request identified a sole issue in dispute:

Bad Debt amount incorrectly listed as \$0

The Provider stated that the total controversy amount was \$110,421.

Upon review, the Board notes that the appeal was untimely filed since it was filed on the 511th day past the final determination date of March 11, 2024. The Board's review and determination is set forth below.

Furthermore, the Board notes that there were additional filing deficiencies with the appeal request. In lieu of a Letter of Representation, the Provider filed a letter dated July 23, 2024, addressed to the Medicare Contractor ("MAC") advising that it was submitting an amended cost report. The Audit Adjustment Support documentation consisted of a document containing confidential PHI/PII information ("Protected Health Information/Personally Identifying Information") and omitted relevant audit adjustment page(s). The Board further notes that the document incorrectly filed as the "Letter of Representation" was also filed as the "Issue Statement".

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 4.1 states: **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 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 Rule 7.2 states: **Issue-Related Information**

7.2.1 General Information 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:
 - o the relevant adjustment(s), including the adjustment number(s),

- o the controlling authority (e.g., specific regulation, Federal Register issuance, manual provision, or Ruling),
 - o why the adjustment(s) is incorrect,
 - o how the payment should be determined differently,
 - o the reimbursement effect, and
 - o the basis for jurisdiction before the Board.
- A copy of the applicable audit adjustment report page(s) or a statement addressing why an adjustment report is not applicable or available.
 - A calculation or other support for the reimbursement effect noted in the issue statement.
 - Support for protested items or claim of dissatisfaction as noted in Rules 7.3 and 7.4.

The Board's case management system flagged the subject appeal as being filed late. After review, it is noted that, based on the documents filed, the subject appeal is based on a final determination dated March 11, 2024. Allowing for the 180-day appeal period and a five-day presumption for mailing, the 185th day from March 11, 2024 fell on September 12, 2024. The date of delivery of the subject individual appeal, as evidenced by the Confirmation of Correspondence generated by OH CDMS, is August 4, 2025. The appeal was filed 511 days passed the final determination date of March 11, 2024 and was, therefore, untimely filed.

DETERMINATION RE: PHI/PII INFORMATION:

The Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule requires a covered entity and its business associates to make reasonable efforts to limit use, disclosure of, and requests for protected health information ("PHI") or other personally identifiable information ("PII") to the minimum necessary to accomplish the intended purpose. While the Privacy Rule permits uses and disclosures for litigation, subject to certain conditions, such information is generally not necessary for documentation submitted to the Board. Because the record in Board proceedings may be disclosed to the public, the parties must carefully review their documents to ensure that they do not contain patient names, health insurance or social security numbers, addresses or other information that identifies individuals.

The document labeled "422636 Archdale.pdf" submitted as the Audit Adjustment Support document, for the sole issue in dispute, contains PHI/PII. Therefore, this document has been removed from the record and it will not be considered by the Board.

BOARD DETERMINATION:

The Board has determined that, in addition to the lateness of the filing of the appeal request, the Provider failed to meet the minimum filing requirements in that a Letter of Representation was not filed in accordance with Board Rule 5.4, there was no Issue Statement as defined in Board Rule 7.2/7.2.1 and any applicable audit adjustment page(s) were omitted. The Board requires these documents to verify that the appeal request is jurisdictionally valid at the time of filing.

As a result, the Board hereby dismisses case number 25-5277, in its entirety, since it was untimely filed and 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:

8/13/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

Cc: Wilson C. Leong, Federal Specialized Services
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)



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

Leslie Goldsmith, Esq.
Bass, Berry & Sims, PLC
1201 Pennsylvania Avenue NW, Suite 300
Washington, D.C. 20004

RE: ***Expedited Judicial Review Decision***

25-4953GC: *Mount Sinai Health System CY 2021 Capital DSH CIRP Group*
25-4547GC: *New York-Presbyterian CY 2021 Capital DSH CIRP Group*
25-3356GC: *New York-Presbyterian CY 2020 Capital DSH CIRP Group*
24-2203G: *Bass, Berry & Sims, PLC CY 2022 Capital DSH Group*
24-2032GC: *Yale-New Haven CY 2021 Capital DSH CIRP Group*
25-0971GC: *UPMC CY 2022 Capital DSH CIRP Group*

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board (“Board”) has reviewed the July 19, 2025 consolidated request for expedited judicial review¹ (“EJR”) for the above-referenced common issue related party (“CIRP”) and optional group appeals. The decision with respect to EJR is set forth below.²

Issue under Dispute:

In these group cases, the Providers are challenging the 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. In their Request for EJR, they state:

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

¹ Providers’ Petition for Expedited Judicial Review at 1 (July 19, 2025) (“Request for EJR”).

² The Request for EJR encompasses nine (9) group cases. On July 24, 2025, pursuant to Board Rule 44.6 (2023), the Medicare Contractor’s representative made a filing which indicated it would be submitting Substantive Claim Challenges in Cases 24-1768GC, 24-2452G, and 24-1919G, which will be addressed by the Board under separate cover.

³ Request for EJR at 1. The Board notes this statement is almost identical to one found in the Issue Statement filed with the original group appeal for Case No. 24-4953GC on July 10, 2025, which states: “[t]he 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 the Medicare statute, and (c) is arbitrary and capricious.”

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 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 area⁵ 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

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 July 30, 2025) (“*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)(1)-(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.

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

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 were adopted by the Secretary 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 an adjustment 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

¹¹ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

¹² See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)–(xiii); 42 C.F.R. § 412.106(d).

¹³ Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).

(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) 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 *capital* 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

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 July 30, 2025).

¹⁶ 56 Fed. Reg. 43356 (Aug. 30, 1991).

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 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 $(\{1 + \text{DSHP}\}^{0.4176} - 1)$, 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

¹⁷ *Id.* at 43369-70 (emphasis added).

¹⁸ *Id.* at 43377.

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 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,

¹⁹ *Id.* at 43409-10 (bold and underline emphasis added).

that is, as the result of the application by these hospitals for payments under § 412.106(b)(1){ii} of the regulations.²⁰

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 approach 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

²⁰ *Id.* at 43377.

²¹ *Id.* at 43378.

²² *Id.* at 43379.

believe that it is appropriate for Medicare's payment to recognize these higher Medicare patient care costs.²³

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) If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments, the disproportionate share payment adjustment factor equals [e raised to the power of (.025 X the hospital's disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.

²³ *Id.* (Emphasis added.)

²⁴ *Id.*

(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

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

²⁵ *Id.* at 43452-53.

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.)

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 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:

²⁸ 65 Fed. Reg. 47054, 47087-89 (Aug. 1, 2000).

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 Services Administration which is available via the ORHP website at [http:// www.nal.usda.gov/orph](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 or 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

²⁹ 65 Fed. Reg. 47026, 47048.

³⁰ 56 Fed. Reg. at 43452.

redesignation as set forth in § 412.62(f)(1)(iv) or a **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 *Id.*

(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 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 § 412.64.³⁸

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.

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.

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 Secretary⁴⁰ 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:

⁴³ 71 Fed. Reg. 47870, 48104 (Aug. 18, 2006).

⁴⁴ *Id.* at 48105.

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 1999⁴⁹ 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 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:

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 EJRs

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

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 DSH 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 adjustment 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 “[t]he Secretary’s adoption of the regulation was arbitrary and capricious and violates the Administrative Procedure Act” because he “failed to establish that 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 have continued to apply the 2006 regulation, denying capital DSH to the Providers for these periods.”⁷⁰

⁶³ *Id.*

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 9-10.

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 July 19, 2025, the Medicare Contractor's representative, Federal Specialized Services ("FSS") filed a notice on July 24, 2025 certifying that it would be filing Substantive Claim Challenges in cases 24-1768GC, 24-2452G, and 24-1919G. FSS, however, failed to certify that it would file challenges in cases 25-4953GC, 25-4547GC, 25-3356GC, 24-2203G, 24-2032GC, and 25-0971GC within the time required by the Board's Rules.⁷³

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

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 issue a final determination;⁷⁴

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 July 19, 2025. On July 24, 2025 (four business days after the EJR Request), FSS certified that it would be filing Substantive Claim Challenges in Cases 24-1768GC, 24-2452G, and 24-1919G only.

⁷⁴ 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). Medicare Contractors must issue an NPR within twelve months of receiving a Provider's perfected or amended cost report. Providers are afforded the right to appeal if this NPR is not timely received pursuant to 42 C.F.R. § 405.1835(c), which states:

- 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.⁷⁵

The Providers have appealed from original NPRs or the failure of the Medicare Contractor to issue a timely NPR.

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 or failure to issue a determination as required by 42 C.F.R. § 405.1835; that the providers in each case appealed the issue in their respective appeals' and that 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. Jurisdiction – Appropriate Cost Report Claim (FYEs On or After December 31 ,2016)

In the November 13, 2015 Final Outpatient Prospective Payment Rule,⁷⁶ the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.⁷⁷ The Secretary revised the Medicare cost reporting regulations in 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 these six cases have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement for the Board's *jurisdiction* is not applicable.

(1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.

(2) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section) . . .

⁷⁵ 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.

⁷⁶ 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).

⁷⁷ *Id.* at 70555.

3. *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"⁷⁸ 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.⁷⁹ In these six cases, the Medicare Contractor failed to certify that it would be filing a Substantive Claim Challenge⁸⁰ within the time frame specified by Board Rule 44.6 (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,⁸¹ 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 EJRs pursuant to 42 C.F.R. § 405.1873(d).

4. Board's Decision Regarding the EJR Request

The Board finds that:

⁷⁸ 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."

⁷⁹ See 42 C.F.R. § 405.1873(a).

⁸⁰ 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."

⁸¹ 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."

- 1) It has jurisdiction over the matter for the subject years and that the participants in Cases 25-4953GC, 25-4547GC, 25-3356GC, 24-2203G, 24-2032GC, and 25-0971GC are entitled to a hearing before the Board;
- 2) 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;
- 3) 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;
- 4) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 5) 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 25-4953GC, 25-4547GC, 25-3356GC, 24-2203G, 24-2032GC, and 25-0971GC. 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 this case, the Board hereby closes the cases and will remove them from its docket.

Board Members Participating:

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

FOR THE BOARD:

8/13/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA

Board 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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Via Electronic Delivery

Lindsay Webb, Principal
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RE: ***Request for Reinstatement***
Moss Adams Standardized Amount Cases
PRRB Case Numbers: 21-0980GC, *et al.* (See attached Appendix A)

Dear Ms. Webb,

The Provider Reimbursement Review Board (“Board”) has reviewed the Request for Reinstatement submitted by Moss Adams LLP on behalf of the providers on March 27, 2025. (Subsequently, as a result of a merger between Moss Adams LLP and Baker Tilly Advisory Group, LP, on June 3, 2025, the representative for these cases was changed to Baker Tilly.) The decision of the Board is set forth below.

Pertinent Facts:

On **April 24, 2024**, the Medicare Contractor filed a Jurisdictional Challenge to 17 group and individual cases for which Moss Adams LLP was the Group Representative and for which there were two common lead Medicare Contractors: Noridian Healthcare Solutions, LLC (J-F) and Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E). The Group Representative filed a timely response on **May 4, 2024**.

The common issue is known as the Standardized Amount, or alternatively, the DRG Understatement issue. The group issue statement common to these appeals is as follows:

In 1983 CMS established the Inpatient Prospective Payment System (IPPS) and created DRG payments that originate from 1981 cost reporting data. The 1981 cost reporting data is considered a base year from the calculation of every DRG payment since 1983 has originated, including the DRG payments applicable to this year.

A recent decision by the United States Court of Appeals for the District of Columbia . . . in *St. Francis Medical Center v. Azar* allows hospitals the opportunity to correct their Medicare reimbursement due to erroneous 1981 cost reporting data that CMS (acting through its predecessor agency HCFA) used to calculate IPPS standardized amounts in 1983. Specifically, the 1981 cost

reporting data that CMS used to calculate the IPPS standardized amounts for 1983 erroneously characterized transfers of patients from one hospital to another as “patient discharges.” This caused an overstatement of the number of discharges and understatement in the allowable operating costs, which were calculated on a “per discharge” basis. **This, in turn, led to an understatement of the standardized payment amounts for 1983. These understated standardized payment amounts from 1983, as updated annually, have been used to determine IPPS payments for every year thereafter, meaning those Medicare payments were also understated.** The applicable regulation governing this issue is 42 C.F.R. 413.9.

The Providers have included a calculation of underpayment that utilizes an updated labor, non-labor and capital base rate based upon a presumption CMS has understated these national rates by - 0.9.¹

On **September 30, 2024**, the Board dismissed the 17 group and individual cases, finding that it lacked substantive jurisdiction over the issue raised in the appeals. The Board’s decision read, in part:

[T]he Board finds that it lacks substantive jurisdiction over each of the 17 cases because: (1) the initial IPPS standardized amounts set for FFY 1984 are *inextricably* tied to the 1984 and 1985 budget neutrality adjustments to the “applicable percentage increases” for IPPS; (2) the FFY 1985 budget neutrality-adjusted rates were used to determine the rates for FFY 1986 and, thus, became embedded into the rates determined for subsequent FFYs; and (3) 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments. Further, the fact that the Secretary’s budget neutrality adjustment to the FY 1984 Federal Rates was 0.970 demonstrates that, contrary to the Providers’ assertions, the initial standardized amount was *not* understated but rather was *overstated* by a fact of 0.030 (*i.e.*, 1.00 – 0.970).²

Group Representative’s Reinstatement Request

On **March 27, 2025**, the Providers’ Representative submitted a request to reinstate the group cases. The position of the Providers’ Representative is:

¹ *E.g.*, Case 21-0980GC, Providers’ Group Issue Statement (bold and underline emphasis added).

² Board’s Notice of Dismissal for Cases 21-0980GC, *et al.* at 5 (Sept. 30, 2024).

[O]n December 20, 2024, the United States District Court for the District of Columbia issued a decision for St. Mary's Regional Medical Center, et al. v. Xavier Becerra, Secretary of Health and Human Services, Case No. 1:23-cv-1594-RCL. This decision addressed the identical jurisdictional arguments and PRRB decision stated by the Board above. See Exhibit P-02. In summary the court refuted the PRRB's reasoning and concluded in summary the following:

- The Plaintiffs Have Standing to Challenge the Secretary's Discharge Calculation
- The Preclusion Provisions Do Not Preclude Review of the 1984 Standardized Amounts
- The Calculation of the 1984 Standardized Amounts Is Not "Inextricably Intertwined" with the Budget Neutrality Adjustments

The Court accordingly concludes that the plaintiffs may seek administrative and judicial review of their predicate fact challenge to the Secretary's inaugural IPPS standardized amount calculation.

Consequently, based upon the court's decision in [St. Mary's Regional Medical Center], the Providers for the 17 cases listed in the PRRB's Notice of Dismissal dated September 30, 2024, find the Board's Notice of Dismissal decision was implemented in error. Based upon the court's reasoning and decision [St. Mary's Regional Medical Center], the Providers hereby request reinstatement of the 17 cases dismissed by the PRRB, in accordance with PRRB Rule 47.³

Board's Analysis and Decision:

The Board denies the motion for reinstatement for the reasons set forth below.

The Provider's basis for reinstatement is the U.S. District Court for the District of Columbia's decision in *St. Mary's Regional Medical Center, et al.*⁴ However, *St. Mary's* is neither final (*i.e.*, motions are still pending) nor is it binding precedent for the Board.

Additionally, 42 C.F.R. § 405.1885(c)(2) reads:

Prohibited reopenings. A change of legal interpretation or policy by CMS in a regulation, CMS ruling, or other interpretative rules,

³ Providers' Request for Reinstatement at 2-3 (Mar. 27, 2025).

⁴ *St. Mary's Regional Medical Center, et al. v. Becerra*, 2024 WL 5186641 (D.D.C., Dec. 2024).

general statements of policy, and rules of agency organization, procedure, or practice established by CMS, whether made in response to judicial precedent or otherwise, *is not a basis for reopening* a CMS or contractor determination, a contractor hearing decision, a CMS reviewing official decision, *a Board decision*, or an Administrator decision, under this section.⁵

Further, in their Request for Reinstatement, Moss Adams argues that the Board “on its own initiative based upon the written record but without hearing, issued a Notice of Dismissal . . .”⁶ The Board’s decision was actually in response to two (2) Jurisdictional Challenges filed on April 24, 2024, with a timely response filed by Moss Adams, LLP. The Board finds that Moss Adams LLP could have filed a postponement request on their response to the Medicare Contractor’s Jurisdictional Challenge, but instead filed a response, rendering the motion ripe for a Board ruling on the matter.

As such, the Board declines to exercise its discretion and denies the Request for Reinstatement. Accordingly, the cases listed below remain closed.

Board Members Participating:

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

For the Board:

8/14/2025

X Kevin D. Smith, CPA

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

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

⁵ (Emphasis added).

⁶ Providers’ Request for Reinstatement at 1.

APPENDIX A
Jurisdictional Challenges and Responses; Cases at Issue

On April 24, 2024, the Medicare Contractor filed a challenge to the following two (2) group cases and four (4) individual appeals, which all share a common lead Medicare Contractor, Noridian Healthcare Solutions, LLC (J-F):

21-0980GC	Confluence Health FFY 2021 MCARE PYMT DISPUTE CMS DRG BASE RATE CALCULATION ERRORS CIRP Group
24-0617G	Moss Adams CY 2015 MCARE Payment Dispute CMS DRG Base Rate Calculation Errors Group
19-0546	Overlake Hospital Medical Center (50-0051), FYE 06/30/2016
21-0964	St. Charles Bend (38-0047), FFY 2021
21-0985	Virginia Mason Memorial Hospital (50-0036), FFY 2021
21-1016	Salem Hospital (38-0051), FFY 2021

The same April 24, 2024 Jurisdictional Challenge contained three (3) group cases and eight (8) individual appeals which all share a common lead Medicare Contractor, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E):

24-0624GC	Hawaii Pacific Health CY 2015 MCARE Payment Dispute DRG Base Rate Calculation Errors CIRP Group
24-0626GC	PHH CY 2014 MCARE Payment Dispute CMS DRG Base Rate Calculation Errors CIRP Group
24-1714GC	John Muir Health CY 2018 MCARE Payment Dispute CMS DRG Base Rate Calculation Errors CIRP Group
20-1302	Menifee Valley Medical Center (05-0684), FYE 12/31/2015
21-0913	Menifee Valley Medical Center (05-0684), FYE 12/31/2016
21-0987	Valley Presbyterian Hospital (05-0126), FFY 2021
21-1017	El Centro Regional Medical Center (05-0045), FFY 2021
21-1018	Pioneers Memorial Healthcare District (05-0342), FFY 2021
21-1019	Sierra View Medical Center (05-0261), FFY 2021
21-1021	San Mateo Medical Center (05-0113), FFY 2021
21-1022	Victor Valley Global Medical Center (05-0517), FFY 2021



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Via Electronic Delivery

Lindsay Webb, Principal
Baker Tilly Advisory Group, LP
14555 Dallas Pkwy, Suite 300
Dallas, TX 75254

RE: ***Request for Reinstatement***

Moss Adams Standardized Amount Cases

PRRB Case Numbers: 23-1522GC, *et al.* (See attached Appendix A)

Dear Ms. Webb,

The Provider Reimbursement Review Board (“Board”) has reviewed the Request for Reinstatement submitted by Moss Adams LLP on behalf of the providers on March 27, 2025. (Subsequently, as a result of a merger between Moss Adams LLP and Baker Tilly Advisory Group, LP, on June 3, 2025, the representative for these cases was changed to Baker Tilly.) The decision of the Board is set forth below.

Pertinent Facts:

On **November 7, 2023**, the Medicare Contractor filed a Jurisdictional Challenge to 24 CIRP and optional group cases for which Moss Adams LLP was the Group Representative and all shared a common lead Medicare Contractor, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E). The Group Representative filed a timely response on **December 6, 2023**.

The common issue is known as the Standardized Amount, or alternatively, the DRG Understatement issue. The group issue statement common to these appeals is as follows:

In 1983 CMS established the Inpatient Prospective Payment System (IPPS) and created DRG payments that originate from 1981 cost reporting data. The 1981 cost reporting data is considered a base year from which the calculation of every DRG payment since 1983 has originated, including the DRG payments applicable to this year.

A recent decision by the United States Court of Appeals for the District of Columbia Circuit (D.C. Circuit) in *St. Francis Medical Center v. Azar* allows hospitals the opportunity to correct their Medicare reimbursement due to erroneous 1981 cost reporting data that CMS (acting through its predecessor agency HCFA) used to calculate IPPS standardized amounts in 1983. Specifically, the 1981 cost reporting data that CMS used to calculate the IPPS

standardized amounts for 1983 erroneously characterized transfers of patients from one hospital to another as “patient discharges.” This caused an overstatement of the number of discharges and understatement in the allowable operating costs, which were calculated on a “per discharge” basis. This, in turn, led to an understatement of the standardized payment amounts for 1983. These understated standardized payment amounts from 1983, as updated annually, have been used to determine IPPS payments for every year thereafter, meaning those Medicare payments were also understated. . . .

. . . . A calculation of each Provider’s estimated underpayment of this issue has been submitted.¹

On **January 24, 2024**, the Board dismissed the 24 group cases, finding that it lacked substantive jurisdiction over the issue raised in the appeals. The Board’s decision read, in part:

[T]he Board finds that it lacks substantive jurisdiction over each of the twenty-four (24) groups because the initial 1983 standardized amounts, set for the IPPS, are *inextricably* intertwined with the 1984 and 1985 budget neutrality adjustment to the “applicable percentage increases” for IPPS and 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of those budget neutrality adjustments. The fact that the Secretary’s budget neutrality adjustment to the FY 1984 Federal Rates was 0.970 demonstrates that, contrary to the Providers’ assertions, the initial standardized amount was *not* understated but rather was *overstated* by a fact of 0.030 (*i.e.*, 1.00 – 0.970) and thus, these budget neutrality adjustments already automatically accounted for any such alleged errors in setting the initial base rate.²

Group Representative’s Reinstatement Request

On **March 27, 2025**, the Group Representative submitted a request to reinstate the group cases. The position of the Group Representative is:

[O]n December 20, 2024, the United States District Court for the District of Columbia issued a decision for St. Mary’s Regional Medical Center, et al. v. Xavier Becerra, Secretary of Health and Human Services, Case No. 1:23-cv-1594-RCL. This decision addressed the identical jurisdictional arguments and PRRB decision stated by the Board above. See Exhibit P-02. In

¹ *E.g.*, Case No. 23-1522, Statement of Disputed Issue (Jul. 18, 2023).

² Board’s Notice of Dismissal for Cases 23-1522GC, *et al.* at 4-5 (Jan. 24, 2024).

summary the court refuted the PRRB's reasoning and concluded in summary the following:

- The Plaintiffs Have Standing to Challenge the Secretary's Discharge Calculation
- The Preclusion Provisions Do Not Preclude Review of the 1984 Standardized Amounts
- The Calculation of the 1984 Standardized Amounts Is Not "Inextricably Intertwined" with the Budget Neutrality Adjustments

The Court accordingly concludes that the plaintiffs may seek administrative and judicial review of their predicate fact challenge to the Secretary's inaugural IPPS standardized amount calculation.

Consequently, based upon the court's decision in [St. Mary's Regional Medical Center], the Providers for the 24 cases listed in the PRRB's Notice of Dismissal dated January 24, 2024, find the Board's Notice of Dismissal decision was implemented in error. Based upon the court's reasoning and decision [St. Mary's Regional Medical Center], the Providers hereby request reinstatement of the 24 cases dismissed by the PRRB, in accordance with PRRB Rule 47.³

Board's Analysis and Decision:

The Board denies the motion for reinstatement for the reasons set forth below.

The Provider's basis for reinstatement is the U.S. District Court for the District of Columbia's decision in *St. Mary's Regional Medical Center, et al.*⁴ However, *St. Mary's* is neither final (*i.e.*, motions are still pending) nor is it binding precedent for the Board.

Additionally, 42 C.F.R. § 405.1885(c)(2) reads:

Prohibited reopenings. A change of legal interpretation or policy by CMS in a regulation, CMS ruling, or other interpretative rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS, whether made in response to judicial precedent or otherwise, *is not a basis for reopening* a CMS or contractor determination, a contractor hearing

³ Providers' Request for Reinstatement at 2-3 (Mar. 27, 2025).

⁴ *St. Mary's Regional Medical Center, et al. v. Becerra*, 2024 WL 5186641 (D.D.C., Dec. 2024).

decision, a CMS reviewing official decision, *a Board decision*, or an Administrator decision, under this section.⁵

Further, in their Request for Reinstatement, Moss Adams argues that the Board “on its own initiative based upon the written record but without hearing, issued a Notice of Dismissal . . .”⁶ The Board’s decision was actually in response to a Jurisdictional Challenge filed on November 7, 2023, with a timely response filed by Moss Adams, LLP. The Board finds that Moss Adams LLP could have filed a postponement request on their response to the Medicare Contractor’s Jurisdictional Challenge, but instead filed a response, rendering the motion ripe for a Board ruling on the matter.

As such, the Board declines to exercise its discretion and denies the Request for Reinstatement. Accordingly, the cases listed below remain closed.

Board Members Participating:

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

For the Board:

8/14/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA

Board Chair

Signed by: Kevin D. Smith -A

cc: Wilson C. Leong, Esq., Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)

⁵ (Emphasis added).

⁶ Providers’ Request for Reinstatement at 2.

APPENDIX A
Jurisdictional Challenges and Responses; Cases at Issue

On November 7, 2023, the Medicare Contractor filed a challenge to the following twenty four (24) cases which all share a common lead Medicare Contractor, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E):

19-1024GC	KPC Health FFY 2019 MCARE Pymt. Dispute CMS DRG Base Rate Calc. Errors CIRP Grp.
19-1028GC	PHH FFY 2019 MCARE Pymt. Dispute CMS DRG Base Rate Calculation Errors CIRP Grp.
19-2014GC	KPC Health CY 2016 MCARE Pymt. Dispute CMS DRG Base Rate Calc. Errors CIRP Grp.
19-2713GC	Hawaii Pacific Health FFY 2019 MCARE Payment Dispute CMS DRG Base Rate Calculation Errors CIRP Group
19-2756GC	John Muir Health FFY 2019 MCARE Pymt. Dispute CMS DRG Base Rate Calc. Errors CIRP Grp.
21-0028GC	John Muir Health FFY 2020 MCARE PYMT DISPUTE CMS DRG BASE RATE CALCULATION ERRORS CIRP Group
21-0031GC	PHH FFY 2020 MCARE PYMT DISPUTE CMS DRG BASE RATE CALCULATION ERRORS CIRP Group
21-0033GC	KPC Health FFY 2020 MCARE PYMT DISPUTE CMS DRG BASE RATE CALCULATION ERRORS CIRP Group
21-0035GC	Hawaii Pacific Health FFY 2020 MCARE PYMT DISPUTE CMS DRG BASE RATE CALCULATION ERRORS CIRP Group
21-0970GC	John Muir Health FFY 2021 MCARE PYMT DISPUTE CMS DRG BASE RATE CALCULATION ERRORS CIRP Group
21-0973GC	Hawaii Pacific Health FFY 2021 MCARE PYMT DISPUTE CMS DRG BASE RATE CALCULATION ERRORS CIRP Group
21-1025GC	KPC Health FFY 2021 MCARE PYMT DISPUTE CMS DRG BASE RATE CALCULATION ERRORS CIRP Group
21-1028GC	PHH FFY 2021 MCARE Pymnt Dispute CMS DRG Base Rate Calc. Errors CIRP Grp.
22-0691GC	PHH CY 2017 MCARE Pymt Dispute CMS DRG Base Rate Calculation Errors CIRP Group
22-0705GC	John Muir Health CY 2017 MCARE Pymt. Dispute CMS DRG Base Year Rate Calculation Errors CIRP Group
22-1156G	Moss Adams FFY 2019 MCARE Pymt Dispute CMS DRG Base Rate Calc. Errors Grp.
22-1157G	Moss Adams FFY 2020 MCARE Pymt Dispute CMS DRG Base Rate Calc. Errors Grp.
22-1210GC	Hawaii Pacific Health CY 2018 MCARE Payment Dispute CMS DRG Base Rate Calculation Errors CIRP Group
22-1315GC	KPC Health CY 2017 MCARE Pymt Dispute CMS DRG Base Rate Calc. Errors CIRP Grp.
22-1316GC	KPC Health CY 2018 MCARE Pymt Dispute CMS DRG Base Rate Calc. Errors CIRP Grp.
23-1254GC	PHH CY 2018 MCARE PYMT Dispute CMS DRG Base Rate Calculation CIRP Group
23-1341GC	Sharp Healthcare FFY 2018 MCARE Pymt Dispute CMS DRG Base Rate Calc. CIRP Grp.
23-1522GC	Hawaii Pacific Health CY 2019 MCARE Pymt Dispute CMS DRG Base Rate Calc. Errors CIRP Grp.
23-1568G	Moss Adams CY 2014 MCARE Pymt Dispute CMS DRG Base Rate Calc. Errors Grp.



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***

Houston Methodist St. John Hospital (Provider Number 45-0709)

FYE: 12/31/2016

Case Number: 20-2022

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 20-2022. Set forth below is the decision of the Board to dismiss the one remaining issue in this appeal challenging the Provider's Medicaid Eligible Days.

Background

A. Procedural History for Case No. 20-2022

On **March 6, 2020**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2016.

On **August 28, 2020**, the Board received the Provider's individual appeal request. The initial appeal request included eight (8) issues:

1. DSH Payment – Provider Specific
2. DSH Payment – SSI Systemic Errors
3. DSH Payment – Medicare Part C Days
4. DSH Payment – Medicare Dual Eligible Days
5. DSH Payment – Medicaid Eligible Days
6. DSH Payment – Medicaid Part C Days
7. DSH Payment – Medicaid Dual Eligible Days
8. Standardized Payment Amount

On **August 31, 2020**, 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 25.¹*

The Provider is commonly owned/controlled by Houston Methodist Hospital System (hereinafter “HMHS”) and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **March 29, 2021**, the Provider transferred Issues 2, 3, 4, 6, 7 and 8 to HMHS CIRP Groups.

On **April 23, 2021**, the Provider filed its preliminary position paper. Although all issues, other than the SSI Provider Specific and Medicaid Eligible Days issues, had been transferred to CIRP groups in March 2021, the Provider still briefed all eight issues.²

With respect to the last remaining issue #5, the Provider states in its preliminary position paper that it “is seeking reimbursement for an additional 1,816 Medicaid Eligible Days.”³

The following are additional excerpts from the Provider's position on Issue 5 set forth in its preliminary position paper:

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 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.⁴

¹ (Emphasis added).

² On July 21, 2025, QRS withdrew the SSI Provider Specific issue.

³ Provider's Preliminary Position Paper (hereinafter, “Provider's PPP”) at 6 (Apr. 23, 2021). The original issue statement submitted with the appeal request indicated that the Provider was seeking an additional 315 Medicaid Eligible Days with a reimbursement impact of \$63,905. No explanation is given for the increase of 1,500 days in the Provider's PPP.

⁴ Provider's PPP at 6.

The Provider's preliminary position paper issue statement is basically a reiteration of the issue statement from the Provider's appeal request for this issue, but for the fact that the Provider's appeal request identified **315 Medicaid eligible days** whereas the position paper identified **1,816 Medicaid eligible days**.

On **August 10, 2021**, Federal Specialized Services ("FSS") filed the preliminary position paper on behalf of the Medicare Contractor ("MAC").

On **May 10, 2024**, three years after the filing of the Provider's preliminary position paper, QRS became the authorized representative.

On **December 6, 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 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 its position. See Board Rule 27 for more specific content requirements.⁵

On **June 5, 2025**, QRS timely filed the Provider's final position paper. The following is the Provider's **complete** position on Issue #5 set forth therein:

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 [citations omitted].

[CMS] acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:

⁵ (Emphasis added).

[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.

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 Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's 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 directly to the MAC, including Section 1115 waiver days (redacted listing is attached), 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.

With respect to section 1115 waiver days, the courts have firmly rejected CMS's interpretation of its regulations, holding instead that the plain language of the statute and the regulations require inclusion in the Medicaid Fraction of the days belonging to individuals who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool. *See Forrest General Hospital*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. 2018); *Bethesda Health Inc., v. Azar*, 389 F. Supp. 3d 32, (D.D.C. 2019), *aff'd*, 980 F.3d 121 (D.C. Cir. 2020). CMS has acquiesced in *Bethesda* and is now following the statute and the plain meaning of its own regulations (which regulations represent the official policy of CMS all along) and properly accounting for 1115 Waiver days as Medicaid Eligible days. *See CMS Manual Instructions*

System, Change Request 12669, Transmittal No. 11912 (March 16, 2023) (“Transmittal 11912”), attached as Exhibit P-4.⁶

On **June 24, 2025**, FSS, on behalf of the MAC, filed a Jurisdictional Challenge over Issues #1 and #5 in the appeal, to which the Representative responded on **July 11, 2025**. The SSI Provider Specific issue (#1) was subsequently withdrawn from the appeal on July 21, 2025, therefore the Board need not address that portion of the Jurisdictional Challenge.

On **June 26, 2025**, FSS timely filed the MAC’s final position paper.

MAC’s Jurisdictional Challenge

Issue 5 – DSH Payment – Medicaid Eligible Days

The MAC argues that the Provider abandoned the Medicaid Eligible Days issue, violating Board Rules 25.3 and 27.2,

... when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary and final position paper. Moreover, the Provider 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. Accordingly, the DSH-Medicaid Eligible Days issue should be dismissed in its entirety.⁷

The MAC noted that the preliminary position paper identified a larger reimbursement impact of \$221,468 based on 1,816 additional Medicaid eligible days than that in the initial appeal. The MAC indicates, however, that the Provider did not submit a complete listing of eligible days with its preliminary position paper, nor was a listing provided to the MAC as indicated in the Exhibit P-1 to the Provider’s final position paper.⁸

Additionally, the MAC disputes the Provider’s attempt to untimely and improperly add the issue of Section 1115 waiver days as a sub-issue via its submission of the redacted Medicaid Eligible Days listing filed as an exhibit to the June 5, 2025 final position paper. The MAC states that it “issued the Provider’s NPR on [March 6, 2020]. In accordance with 42 C.F.R. § 415.1835(e), the deadline for adding issues to the appeal was [November 1, 2020]. The issue was informally added through the Provider’s final position paper filed on [June 5, 2025], over 5 years after the filing deadline to add an issue.”⁹

⁶ Provider’s Final Position Paper (hereinafter, “Provider’s FPP”) at 9-10 (June 5, 2025) (emphasis added).

⁷ MAC Jurisdictional Challenge at 12 (June 24, 2025).

⁸ *Id.* at 11.

⁹ *Id.* at 16.

Finally, the MAC maintains that the Section 1115 waiver days issue “must be appealed as a separate issue.” The MAC notes that “Board Rule 8 explains that one issue can have multiple components.” It further explains that, within Board Rule 8, “some of the disproportionate share hospital payment (DSH) components are identified. Specifically, the Board identifies Section 1115 waiver days as a distinct DSH component that the Provider must appeal separately.”¹⁰

Provider’s Jurisdictional Response

Issue 3 – DSH Payment – Medicaid Eligible Days

In its jurisdictional response, the Provider only addresses the MAC’s challenge over the Section 1115 waiver days issue. The Provider argues that the phrasing of its issue statement with respect to the Medicaid Eligible days issue “. . . makes clear that the Provider claimed that the MAC needed to include *all* Medicaid eligible days, and that this in fact was the single issue being appealed. By definition, section 1115 waiver days are Medicaid eligible days. Therefore, by definition, section 1115 waiver days were within the scope of the appeal.”¹¹

Further, the Provider argues that:

The regulations, to the extent that they are not violative of the statute, place a time limit on adding ‘issues’ – not on ‘sub issues’ or ‘components’ of an issue. Both the June 25, 2004 proposed rule (69 *Fed. Reg.* 35716) and the 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.¹²

The Provider maintains that Rule 8’s extension to “components of issues” is invalid and “there was no requirement that the Provider was required to include a reference to section 1115 waiver days in its appeal request.”¹³

Finally, the Provider contends that

[t]he Fifth Circuit ruled that the statute and CMS’s own regulations require that CMS regard inpatient days attributable to an uncompensated care pool population as Medicaid eligible days, *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019). The MAC is required by specific command of CMS

¹⁰ *Id.* at 17.

¹¹ Provider’s Jurisdictional Response at 3 (July 11, 2025).

¹² *Id.*

¹³ *Id.* at 4.

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. Following a string of litigation defeats, including those in *Forrest General Hospital and Bethesda Health, Inc. v. Azar*, 980 F.3d 121 (D.C. Cir.2020), CMS issued Change Request 12669, Transmittal No. 11912 (March 16, 2023).¹⁴

The Provider asserts that under this Transmittal, the MAC "has the duty to accept the Provider's listing of Section 1115 waiver days and audit them."¹⁵ The Provider states that it "submitted a redacted listing of section 1115 waiver days as a supplement to the [final] Position Paper submission on July 7, 2025, and an unredacted listing to the MAC."¹⁶

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 sole remaining issue in the appeal.

DSH Payment – Medicaid Eligible Days

1. 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. While the Provider appealed Medicaid Eligible days, this issue is separate and distinct from Section 1115 waiver days.

The appeal was filed with the Board in August of 2020 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,

¹⁴ *Id.* at 6.

¹⁵ *Id.*

¹⁶ *Id.* at 7.

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...¹⁷

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].¹⁸

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

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)***¹⁹

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.²⁰

¹⁷ 42 C.F.R. § 405.1835(b) (2016).

¹⁸ v. 2.0 (Aug. 2018).

¹⁹ (Bold and italic emphasis added).

²⁰ See 73 Fed. Reg. 30190 (May 23, 2008).

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 –

...

(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 ever properly or timely added the Section 1115 waiver days to the case.

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, 2000.²¹ 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. In fact, not every state Medicaid program has a qualifying 1115 expansion program *and* not every inpatient day associated with a 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.

²¹ 65 Fed. Reg. 47054, 47087 (Aug. 1, 2000).

(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 Section 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. Indeed, included as Exhibit 2 to the Provider's Preliminary Position Paper is a letter dated April 21, 2021, from the Provider to its Medicare Contractor, requesting section 1115 waiver days be included. This letter was sent years after the Provider would have needed to submit its as-filed cost report for FY 12/31/2016.

It appears that the Provider did attempt to untimely add the issue in its Preliminary Position Paper which was filed with the Board on April 23, 2021. In this filing, while the narrative of the issue did not specifically address 1115 waiver days, the Provider submitted as exhibits its April 21, 2021 request for 1115 waiver days as well as an unredacted listing of days. The Board notes, however, that this request was submitted only *two days prior* to when the Provider filed its Preliminary Position Paper, long after the cost report had been filed and had received its NPR.

The Board regulations at 42 C.F.R. § 405.1835(e) provide the following with respect to adding issues:

Adding issues to the hearing request. After filing a hearing request in accordance with paragraphs (a) and (b), or paragraphs (c) and (d), of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board only if—

- (1) The request to add issues complies with the requirements of paragraphs (a) and (b), or paragraphs (c) and (d), of this section as to each new specific item at issue.
- (2) The specific items raised in the initial hearing request and the

specific items identified in subsequent requests to add issues, when combined, satisfy the amount in controversy requirements of paragraph (a)(2) or paragraph (c)(3) of this section.

- (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.²²

Similarly, Board Rule 6.2.1 (Aug. 2018) states:

Request and Supporting Documentation

Subject to the provisions of 42 C.F.R. § 405.1835(e), an issue may be added to an individual appeal if the provider:

- timely files a request with the Board to add issues to an open appeal no later than 60 days after the expiration of the applicable 180 days period for filing the initial hearing request. . .

Here, the Provider was issued its final determination on March 6, 2020, and had until September 7, 2020 to file its appeal request. The Provider had an additional 60 days, or until November 6, 2020, to add any additional issues to its appeal. The first time the Provider mentioned the 1115 waiver days issue was in its April 21, 2021 Preliminary Position Paper. Thus, the issue was not appealed or timely added.

Finally, although the Provider did include slightly more information in the Preliminary Position Paper exhibits, once again, in the Provider's final position paper, the Provider fails to identify which Section 1115 waiver program(s) are involved and whether or not the Section 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 final position paper is deficient in that it only makes perfunctory conclusions.²³ Therefore, the Provider failed to develop its final position paper,

²² Emphasis added.

²³ 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 belonging to individuals who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." (Provider's FPP at 10.) 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 days issue as required by 42 C.F.R.

notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (2023) as applied via Board Rule 27.2.

The Board's finding that neither the appeal request nor the final position paper met the Board's 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*.²⁴ In that case, the provider's issue was tied to improper calculation to 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 . . ."²⁵ 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."²⁶ The Court found that this description of the issue was a violation of Board rules and a proper basis for the Board to dismiss the appeal.²⁷ Here, the Board makes the same finding based on similar *overly generalized language*.

Based on the above, the Board finds that the appeal did not include the *alleged* Section 1115 waiver days 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 27.2.²⁸ In the alternative, the Board finds that, even if it had been included as part of the appeal, the issue was not properly developed in the position paper process.

2. Medicaid Eligible Days

The Provider did not include a finalized list of the specific additional Medicaid eligible days that are in dispute in this case in the initial appeal. 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

§ 405.1853(b)(2). Indeed, the quoted sentence is the only time the final position paper references "uncompensated care pool."

²⁴ No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

²⁵ *Id.* at *5.

²⁶ *Id.*

²⁷ *Id.*

²⁸ If Section 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 – to review whether it had jurisdiction over the Section 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).

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.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 Papers³⁰

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... 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.

²⁹ (Bold emphasis added.)

³⁰ (Underline emphasis added to these excerpts and all other emphasis in original.)

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

- 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 <u>complete</u> 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 August 31, 2020 Notice of Case Acknowledgement and Critical Due Dates issued in this case 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.³¹

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carry[es] 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."

³¹ (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.

In this case, although the MAC contends the Provider did not submit a listing of Eligible Days with its preliminary position paper, the Board notes that a copy of the Provider's April 21, 2021 letter to the MAC requesting ". . .to update to the number of Medicaid-eligible days on Worksheet S-2, Line 24 and Worksheet S-3, Column 7. . ." as well as a listing of 1,816 days was included as an exhibit.³² Regardless of this fact, as discussed above, the attempted addition of the Section 1115 Waiver Days in the preliminary position paper is still considered untimely as the preliminary position paper was filed almost six months after the expiration of the add issues deadline. Further, this listing did not include the generic Medicaid eligible days issue.

On May 6, 2025, the Provider filed its final position paper. Attached as Exhibit P-1 was a statement indicating that, "[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." A copy of the 13-page redacted listing titled "Additional ME & 1115 Waiver Days" was included showing 1,816 days. The Provider did not explain why the listing of days was being submitted at this late date, ***more than 8 years after the fiscal year at issue had closed.***³³ Additionally, the Provider did not explain why the 1,816 days is so much more than the 315 days that were initially identified in the Provider's issue statement with the appeal request. Finally, as of June 24, 2025, no listing "suitable for audit" was provided to the MAC, as stated in the MAC's Jurisdictional Challenge filed on that date.³⁴

³² Provider's Preliminary Position Paper Exhibit 1. (April 23, 2021).

³³ The 1,816 days included in this belated listing was *exponentially* larger than the original estimate of 315 days included with the Provider's appeal request, and no explanation was given for the increase.

³⁴ Medicare Contractor's Jurisdictional Challenge at 11.

The Board concurs with the MAC 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 it 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 submit an appropriately auditable, finalized listing of Medicaid eligible days, notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii), 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 regarding 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 to describe why said evidence is unavailable.³⁶

Based on the foregoing, the Board dismisses the sole remaining issue in this case – (Issue 5-DSH Payment – Medicaid Eligible Days). As no issues remain, the Board hereby closes Case No. 20-2022 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.

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.

Board Members Participating:

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

For the Board:

8/15/2025

X Kevin D. Smith, CPA

Kevin D. Smith CPA

Board Chair

Signed by: Kevin D. Smith -A

cc: Michael Redmond, Novitas Solutions c/o GuideWell Source (J-H)
Wilson Leong, Federal Specialized Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Amy Stephens, AVP, Enterprise Reimbursement
West Virginia University Health System
1 Medical Center Drive
Morgantown, WV 26506

RE: ***Notice of Dismissal***

West Virginia University Hospitals, Inc., Prov. No. 51-0001, FYE 12/31/2015
Case No. 21-0303

Dear Ms. Stephens:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 21-0303. 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”) SSI Percentage (Provider Specific) issue.

Background:

A. Procedural History for Case No. 21-0303

On **May 22, 2020**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end December 15, 2015. The Provider is commonly owned by West Virginia University Health System (“WVU HS”).

On **October 23, 2020**, WVU HS filed the Provider’s individual appeal request. The initial Individual Appeal Request included three (3) issues:

1. DSH SSI Percentage (Provider Specific)
2. DSH SSI Percentage¹
3. Standardized Payment Amount²

As the Provider is commonly owned/controlled by WVU HS, 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 **May 20, 2021**, the Provider transferred Issues 2 and 3 to a WVU HS groups.

As a result of the transfers, there is one (1) remaining issue in this appeal: Issue 1 - DSH SSI Percentage (Provider Specific).

¹ On May 20, 2021, this issue was transferred to PRRB Case No. 20-0064GC.

² On May 20, 2021, this issue was transferred to PRRB Case No. 20-0065GC.

On **December 1, 2020**, 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.

On **June 21, 2021**, the Provider timely filed its preliminary position paper.

On **September 13, 2021**, the MAC timely filed its preliminary position paper.

On **October 12, 2021**, the Medicare Administrative Contractor ("MAC") filed a jurisdictional challenge, requesting the dismissal of 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.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20-0064GC

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

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 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.³

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is \$132,746.⁴

The DSH/SSI Systemic Errors Group Issue Statement in Case No. 20-0064GC, to which the Provider transferred Issue No. 2 reads, in part:

Statement of the Issue:

³ Issue Statement at 1 (Oct. 23, 2020).

⁴ The Provider rounded the reimbursement impacts to \$133,000 in OH CDMS.

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,
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 DAYS 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 XVII, 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 Payer ("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) 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.⁵

On June 21, 2021, the Board received the Provider's preliminary position paper in 21-0303. The following is the entirety of Provider's position on Issue 1 set forth therein:

Provider Specific

The Provider contends that its' [sic] SSI percentage published by the Centers for Medicare and Medicaid Services ("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 (April 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"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 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 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).⁶

⁵ Group Issue Statement, Case No. 20-0064GC.

⁶ Provider's Preliminary Position Paper at 7-8 (June 21, 2021).

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 states that Provider's 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, which was transferred to a CIRP group under Case No. 20-0064GC.⁷ In addition, the MAC notes that the portion related to SSI realignment should be dismissed because the MAC has issued a Notice of Reopening and an Amended NPR in response to the Provider's September 25, 2020 Realignment request.⁸ Therefore, the MAC contends that since an amended NPR has been issued, which adjusted the SSI ratio based on the Provider's Fiscal Year End of December 31, 2015, this issue is no longer relevant and should be dismissed.⁹

Provider's Jurisdictional Response

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the MAC's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record. The MAC filed its Jurisdictional Challenge on June 18, 2021. The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed.

Board 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 MAC, 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 Issue No. 1.

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider's disagreement with how the MAC 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

⁷ MAC's Jurisdictional Challenge at 4-5 (Oct. 12, 2021).

⁸ MAC's Jurisdictional Challenge at Exhibit C-4 thru C-6 (Oct. 12, 2021).

⁹ MAC's Jurisdictional Challenge at 6-7 (Oct. 12, 2021).

The first aspect of Issue No. 1—the Provider’s disagreement with how the MAC 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. 20-0064GC.

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.”¹⁰ Per the appeal request, the Provider’s legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts 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).”¹¹ The Provider argues that “its[sic] SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . .” and 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.”¹²

The Provider’s DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-0064GC also alleges that the MAC 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).

The Board has previously noted that CMS’ regulation interpretation for the SSI percentage is clearly not “specific” to a single provider.¹³ Rather, it applies to all SSI calculations. To this end, the Board has also reviewed the Provider’s Preliminary Position Paper to see if it further clarified Issue 1. However, the Provider’s Preliminary Position Paper does not explain how this argument is **specific to this provider**. Instead, the Preliminary Position Paper refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Furthermore, the Provider cites *Loma Linda Community Hospital* and alleges that “SSI entitlement of individuals can be ascertained from State records.”¹⁴ But the Provider fails to explain its alleged similarities to Loma Linda Community Hospital or how it can ascertain SSI entitlement from the state records.

In accordance with 42 C.F.R. § 405.1853(b), the commentary to Rule 23.3 (Aug. 29, 2018) explains that preliminary position papers must “be **fully** developed and include **all available** documentation necessary to provide a *thorough understanding* of the parties’ positions.” The commentary to Rule 25 also explicitly states, “preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.” Moreover, Rule 25.2.2. specifies:

25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)

¹⁰ Issue Statement at 1.

¹¹ *Id.*

¹² *Id.*

¹³ 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).

¹⁴ Provider Preliminary at Position Paper at 7 (June 21, 2021).

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.¹⁵

In its Preliminary Position Paper (filed on June 21, 2021), the Provider only cites the 2000 Federal Register as the source for the MEDPAR data it claims it has yet to receive. 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:

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.”

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>.¹⁶

This CMS webpage describes access to DSH data **from 1998 to 2023** and instructs providers to send a request via email to access their DSH data.”¹⁷ The Provider’s appeal is relative to FYE 2015.

¹⁵ (Italics and underline emphasis added.)

¹⁶ Last accessed June 17, 2025.

¹⁷ Emphasis added.

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 20-0064GC are the same issue.¹⁸ 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[.]” In this case, the Provider forwarded its request for a “CMS SSI Recalculation” to the MAC by letter dated September 25, 2020. On November 3, 2020, the MAC issued a Notice of Cost Report Reopening in order to: 1) address the Provider’s Realignment Request; 2) incorporate settlement amounts from previous settlements; and 3) address any cost report software updates, edits or flow through items. On January 5, 2021, the MAC issued an Amended Notice of Amount of Medicare Program Reimbursement.

If the Provider disagreed with the adjustments made in the amended NPR (which adjusted the SSI recalculated by CMS based on the Provider’s Fiscal Year End of December 31, 2015), it had 180 days from receipt of the January 5, 2021 determination to appeal the issue. That appeal period expired on Friday, July 9, 2021. Therefore, this aspect of the SSI Provider Specific issue is now considered moot.

Based on the foregoing, the Board hereby dismisses the sole remaining issue in this case – (Issue 1: Provider Specific). As no issues remain, the Board hereby closes Case No. 21-0303 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.

SIGNATURE PAGE FOLLOWS

¹⁸ 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 WVU HS CIRP group per 42 C.F.R. § 405.1837(b)(1).

Board Members Participating:

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

For the Board:

8/15/2025

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

cc: Dana Johnson, Palmetto GBA c/o National Government Services (J-M)
Wilson C. Leong, Esq., Federal Specialized Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

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GuideWell Source
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RE: ***Board Decision – DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues***
Naples Community Hospital (Provider No. 10-0018)
FYE 09/30/2017
Case No. 22-0626

Dear Mr. Ravindran and Mr. Pike,

The Provider Reimbursement Review Board (“Board”) has reviewed the documentation in the above referenced appeal. The decision of the Board is set forth below.

Background:

A. Procedural History for Case No. 22-0626

On **August 13, 2021**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end September 30, 2017.

On **February 2, 2022**, the Board received the Provider’s individual appeal request. The initial Individual Appeal Request contained six (6) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)¹
3. DSH Payment – Medicaid Eligible Days
4. DSH Payment – Medicare Managed Care Part C Days (SSI Fraction & Medicaid Fraction)²
5. DSH Payment – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days) – (SSI Fraction & Medicaid Fraction)³
6. Standardized Payment Amount⁴

¹ On August 15, 2022, this issue was transferred to PRRB Case No. 22-0292G.

² On August 15, 2022, this issue was transferred to PRRB Case No. 22-0293G.

³ On August 15, 2022, this issue was transferred to PRRB Case No. 22-0295G. The SSI Fraction portion was bifurcated into Issue #7 and transferred to PRRB Case No. 22-0294G on August 25, 2022.

⁴ On August 15, 2022, this issue was transferred to PRRB Case No. 22-0276G.

On **August 15 and 25, 2022**, the Provider transferred Issues 2, 4, 5, 6 and 7 to optional groups. As a result, there are two (2) remaining issues in this appeal: Issue 1 (DSH Payment/SSI Percentage (Provider Specific)) and Issue 3 (DSH Payment – Medicaid Eligible Days).

On **February 2, 2022**, 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 25.⁵

On **September 27, 2022**, the Provider timely filed its preliminary position paper.

On **December 6, 2022**, the Medicare Administrative Contractor ("MAC") filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 3. 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 **December 9, 2022**, the MAC timely filed its preliminary position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 22-0292G

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

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 their calculation.

...

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

⁵ (Emphasis added).

CMS recalculate the SSI percentage based upon the Provider's cost reporting period.⁶

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is \$218,183.

The DSH/SSI Systemic Errors Group Issue Statement in Case No. 22-0292G, QRS CY 2017 DSH SSI Percentage (2) Group (Systemic Errors), to which the Provider transferred Issue 2 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,
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.⁷

⁶ Issue Statement at 1 (Feb. 2, 2022).

⁷ Group Issue Statement, Case No. 22-0292G.

On September 27, 2022, the Provider filed its preliminary position paper. The following is the entirety of Provider's 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. This is based on certain data from the State of Connecticut and the Provider that does not support the SSI percentage issued by CMS.

The Provider has worked with the State of Florida and has learned that 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.

The Provider is seeking 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 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). 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.⁸

C. Description of Issue 3 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 3 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

⁸ Provider's Preliminary Position Paper at 8-9 (Sept. 27, 2022).

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): 8,43,45,S-D

Estimated Reimbursement Amount: \$212,369⁹

Regarding the Medicaid eligible days issue, in its Preliminary Position Paper, the Provider argues that pursuant to the *Jewish Hospital* case¹⁰ 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.¹¹

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 for three reasons. First, the MAC argues that the SSI realignment portion of the issue has been abandoned by the Provider:

The Provider fails to note that its cost reporting year end is identical to the federal fiscal year end. This oversight leaves the MAC questioning the right the Provider is attempting to preserve.

The MAC contends that the Provider has abandoned the issue of SSI realignment and, therefore, it should be considered withdrawn. The Provider did not brief this issue within its position paper. PRRB Rule 25.3 addresses issues that are not briefed in a provider's position paper. In relevant part, this rule states:

If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn.¹²

⁹ Appeal Request at Issue 3.

¹⁰ *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994).

¹¹ Provider's Preliminary Position Paper at 7-8.

¹² Jurisdictional Challenge at 5-6 (Dec. 6, 2022).

Failing that, the MAC argues the realignment sub-issue is premature:

The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.

...

The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for resolve this issue. The MAC requests that the PRRB dismiss this issue consistent with recent jurisdictional decisions.¹³

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.¹⁴

Finally, the MAC argues “the Provider did not file a **complete** preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3.”¹⁵ The MAC posits that the Provider “failed to sufficiently develop and set forth the relevant facts and regarding the merits of its claim in its Preliminary Position Paper.”¹⁶ Specifically the MAC avers:

Within the Provider's Preliminary Position Paper, the Provider makes the broad allegation that “The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation,” yet offers no evidence or analysis to demonstrate that CMS calculated its SSI percentage inaccurately. The Provider failed to include any evidence to establish the material facts in this case relating to inaccuracies in the SSI Percentage calculation at issue or any evidence pertaining to the alleged systemic SSI ratio data match errors like those referenced in the *Baystate* case. The Provider merely repeats its appeal request which itself is a verbatim recitation of the deficiencies that the Board found in the *Baystate* case.¹⁷

¹³ *Id.* at 6.

¹⁴ *Id.* at 4-5.

¹⁵ *Id.* at 7.

¹⁶ *Id.* at 8.

¹⁷ *Id.* at 8-9.

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC requests that the Board find the Provider abandoned the DSH – Medicaid Eligible Days issue arguing:

The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider 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. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.

Within its preliminary position paper, the Provider makes the broad allegation, “. . . the Provider contends that the total number of days reflected in its’ [sic] 2017 cost report does not reflect an accurate number of Medicaid eligible days. . .” The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats their appeal request.¹⁸

Provider’s Jurisdictional Response

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.” The MAC filed its Jurisdictional Challenge on December 6, 2022. The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed.

Board 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 MAC, 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 Issue No. 1 & 3.

A. DSH Payment/SSI Percentage (Provider Specific)

¹⁸ *Id.* at 10.

The analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider's disagreement with how the MAC 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 MAC 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. 22-0292G.

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.”¹⁹ Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts 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).”²⁰ The Provider argues that “its’ [sic] SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . .” and 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

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 22-0292G also alleges that the MAC 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).

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not “specific” to a single provider.²² Rather, it applies to all SSI calculations. To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, Provider's PPP does not explain how this argument is *specific to this provider*. Instead, the PPP refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Furthermore, the Provider cites *Loma Linda Community Hospital* and alleges that “SSI entitlement of individuals can be ascertained from State records.”²³ But the Provider fails to explain its alleged similarities to *Loma Linda Community Hospital* or how it can ascertain SSI entitlement from the state records.

In accordance with 42 C.F.R. § 405.1853(b), the commentary to Rule 23.3 (Nov. 1, 2021) explains that preliminary position papers must “be **fully** developed and include **all** *available* documentation necessary to provide a *thorough understanding* of the parties' positions.” The commentary to Rule

¹⁹ Issue Statement at 1.

²⁰ *Id.*

²¹ *Id.*

²² 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).

²³ See Provider's PPP at 9.

25 also explicitly states, “[T]he 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.”

Moreover, 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 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.²⁴

In its PPP (filed on September 27, 2022), the Provider only cites the 2000 Federal Register as the source for the MEDPAR data it claims it has yet to receive. But additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have since occurred. For example, as noted in the FY 2006 IPPS Final Rule:

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.

²⁴ (Emphasis added).

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>.²⁵

This CMS webpage describes access to DSH data *from 1998 to 2023* and instructs providers to send a request via email to access their DSH data.”²⁶ The Provider’s appeal is relative to FYE 2017.

Based on the foregoing, the Board finds that the Provider’s *Preliminary Position Paper* failed to comply with Board Rules 23 and 25 (November 1, 2021) governing the content of position papers. The Board also finds that the Provider’s *Preliminary Position Paper* failed to comply with Board Rule 25.2.2 by not addressing why the MEDPAR data for FYE 2017 was allegedly unavailable. Thus, 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. 22-0292G.

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 22-0292G 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.

Pursuant to 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[.]” In this case, there is nothing in the record indicating that a proper written realignment request was made by the Provider and that the MAC made a final determination regarding DSH SSI Percentage realignment from which the Provider can appeal. Moreover, an appeal before the Board may not be used as a conduit

²⁵ Last accessed August 14, 2024.

²⁶ (Emphasis added).

for the MAC (the intermediary) nor for CMS. 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

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation.

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) 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) states:

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.

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

The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.

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.

Furthermore, 42 C.F.R. § 405.1853 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.*²⁷

Similarly, with regard to position papers,²⁸ Board Rule 25.2.1 requires that “the parties must exchange *all available* documentation as exhibits to fully support your position.”²⁹ 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.³⁰

Finally, Board Rule 41.2 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 (*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.

²⁷ (Emphasis added).

²⁸ The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.

²⁹ (Emphasis added).

³⁰ (Emphasis added).

This appeal was initiated on February 2, 2022 (over 3 years ago), and at that time, the Provider 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 Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.³¹ ***To-date, no listing has been provided.*** 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.³² 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.

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 22-0292G and because the purported realignment portion of the issue is premature in absence of a properly submitted written realignment request subject to a final determination from which the Provider can appeal. The Board also dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for submitting fully developed and complete position papers in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 22-0626 and removes it from the Board's docket.

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:

8/15/2025

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

cc: Wilson C. Leong, Esq., Federal Specialized Services

³¹ Provider's Preliminary Position Paper at 8.

³² 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.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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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: ***Request for Reinstatement of Appeal & Acceptance of Additional Information Under Good Cause Extension***
QRS CY 1991 Medicare Fraction (SSI) – Statutory & Systemic Errors Group
Case Number: 25-1955G

Dear Mr. Ravindran,

The Provider Reimbursement Review Board (“Board”) has reviewed the Request for Reinstatement of Appeal & Acceptance of Additional Information Under Good Cause Extension submitted by Quality Reimbursement Services, Inc. (“QRS”) on behalf of the Group participants on May 19, 2025. The decision of the Board is set forth below.

Background:

From **January 7 to January 31, 2025**, the California wildfires were active and uncontained and there was a Federal Presidential declaration of a major disaster.¹ From January 7, 2025 and ongoing through the date of this letter, a formal declaration of a state of emergency was made and remains open.²

On **February 5, 2025**, QRS filed a request to form an optional group appeal, which included a Representative Letter in place of an issue statement.

On **February 7, 2025**, QRS accessed the Office of Hearing Case & Document Management System (“OH CDMS”) to add a Provider to the Group Appeal.

On **February 12, 2025**, the Board issued a Case Acknowledgement and Critical Due Dates Notice, advising that “[t]he Issue Statement as submitted is insufficient pursuant to the Board’s rules. It is noted the Representation Letter was uploaded for the Issue Statement document.” The Notice ***required that the Providers’ Representative submit an Issue Statement in accordance with Board rules by February 19, 2025.***

¹ <https://www.federalregister.gov/documents/2025/01/17/2025-01066/presidential-declaration-of-a-major-disaster-for-the-state-of-california>.

² A link to Open State of Emergency Proclamation and accompanying Executive Orders can be found at <https://www.caloes.ca.gov/office-of-the-director/policy-administration/legal-affairs/emergency-proclamations/>

On **February 13 and 14, 2025**, QRS accessed the OH CDMS on six different occasions to add Providers to the Group Appeal.

On **March 20, 2025**, after no additional filing from QRS on the Board’s request to submit an Issue Statement, the Board closed the appeal.

On **May 19, 2025**, QRS sent the Board a request for reconsideration of the Board’s dismissal.

On **May 20, 2025**, QRS sent the Board a supplement to its request for reconsideration with an attached Declaration from an administrative assistant who works in QRS’s corporate office describing the impact of the fire during January 2025.

Provider Representative’s Reinstatement Request

QRS asks the Board to grant its request for reconsideration and reinstate the dismissed appeal to pending status. In the request for consideration, QRS cites the California wildfires as the reason for its failure to meet minimum requirements for an appeal and respond to the Board’s request for an Issue Statement. QRS asks the Board to accept “the issue statement language” that it purportedly included with its reconsideration request “as timely under the good cause provisions pursuant to 42 C.F.R. § 405.1836, and PRRB Rule 2.1.4.”³ Notably, no such “issue statement language” was included with this request for reconsideration nor has any been provided to date.

As part of its supplement filed May 20th, 2025, QRS submitted a Declaration from Maria Munoz, an employee who works as an Administrative Assistant to J.C. Ravindran, the President of QRS. In this Declaration, Ms. Munoz describes how QRS employees could see the site of one of the fires from QRS headquarters, which was located eight miles away from the origination of the fire.⁴ Ms. Munoz also describes how she assisted Mr. Ravindran in evacuating from his home on January 7, 2025, and returning to the residence three days later. She also describes the shutdown and sporadic interruption of electricity services affecting Mr. Ravindran’s residence and the QRS office, as well as freeway exit closures, which caused heavy traffic in the area.⁵

Board’s Analysis and Decision:

42 C.F.R. § 405.1837(c)(2) establishes the required contents for a group appeal which must include:

An explanation (for each specific item at issue) of each provider’s dissatisfaction with the final contractor or Secretary determination under appeal, including an account of—

³ Request for Reinstatement of Appeal and Acceptance of Additional Information Under Good Cause Extension at 1 (May 19, 2025).

⁴ Declaration of Maria Munoz at ¶ 2 (May 20, 2025).

⁵ *Id.* at ¶¶ 4-6.

- (i) Why the provider believes Medicare payment is incorrect for each disputed item;
- (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item; and
- (iii) If the provider self-disallows a specific item (as specified in § 413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.

Board Rule 7.2 also requires, among other things, that an issue statement includes an issue title and a concise statement describing any relevant adjustment numbers, the controlling authority, why the adjustment is incorrect, how the payment should be determined differently and the basis for the Board’s jurisdiction.

42 C.F.R. § 405.1836 allows the Board, in its discretion, to extend the time limit for filing an appeal upon a good cause showing by the provider “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) or § 405.1835(c)(2).”⁶ The Board may also dismiss an appeal with prejudice pursuant to 42 C.F.R. § 405.1868(b)(1) if a provider “fails to meet a filing deadline or other requirement established by the Board in a rule or order.”⁷

QRS failed to submit an Issue Statement with the appeal request and then failed to respond when the Board offered QRS the opportunity to correct the deficient filing. To date, QRS still has not submitted an Issue Statement for the appeal. QRS alleges that the California wildfires were an extraordinary circumstance beyond its control that prevented it from submitting an Issue Statement with its appeal request or responding to the Board’s deadline for correcting the deficient filing. However, the Board notes that during the time when QRS alleges the wildfires impacted its operations, QRS managed to access OH CDMS system to add seven additional Providers to the Group Appeal. QRS accessed OH CDMS system to add six of such Providers between February 13 and 14, 2025, one or two days after the Board’s February 12, 2025, Notice providing a February 19, 2025, deadline for submission of an Issue Statement.

In response to the Declaration of Ms. Munoz, the Board notes that the Declaration seems particularly focused on events that occurred in January, well before the February 19, 2025, deadline the Board set for the Providers’ corrective filing of an Issue Statement. The Board also notes that, according to QRS’s website, the company consists of over 50 employees located in

⁶ See also PRRB Rule 2.1.4.

⁷ See also PRRB Rule 41.2.

seven offices throughout the country.⁸ QRS’s Arcadia, California location is the only location in California, with the six other offices located in other states that were not affected by the California wildfires.

In a recent matter, *Merit Health River Region v. Kennedy*, a court upheld the Board’s dismissal of a matter where the provider failed to show good cause for missing certain deadlines allegedly due to the death of an employee of its provider representative, QRS.⁹ In that matter, the court noted that “QRS had ‘multiple employees registered to make Board filings,’” so “it would have been ‘altogether reasonable for the Board’ to question QRS’s explanation that [the deceased employee] was solely responsible for preparing, drafting and filing QRS’s final position papers, and meeting its deadlines.”¹⁰ The reconsideration request in this matter describes one employee’s home being totally destroyed by the fire, the temporary evacuation of one individual from his home for three days¹¹, sporadic power interruptions, and heavy traffic caused by local freeway exit closures. However, like the court in *Merit Health River Region* case noted, QRS has “multiple employees registered to make Board filings.” Moreover, there seem to be employees located in offices in other states that were not affected by the California wildfires. Further belying QRS’s claims that it failed to meet minimum requirements for an appeal and respond to the Board’s request for an Issue Statement due to extraordinary circumstances beyond its control is the fact that QRS managed to access the CDMS system on six different occasions after the Board sent its Notice setting a deadline for submission of the Issue Statement.

Board Rule 47.1 addresses Motion[s] for Reinstatement and reads, in pertinent part:

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 . . . The Board will not reinstate an issue(s)/case if the provider was at fault.

In the dismissal, the Board found that QRS had not provided an issue statement. The Provider’s failure to submit an appeal with an issue statement that complied with Board rules and also, failing to comply with the *additional* 7 days that were given to QRS to comply with the Board’s order is indicative of fault. Therefore, the Board declines to reinstate this issue.

While the Board acknowledges the impact of the wildfires, the Board finds their impact did not cause QRS to fail to submit an issue statement in a timely manner.

As such, the Board declines to exercise its discretion and denies the request for reconsideration. Accordingly, the case remains closed.

⁸ www.qualityreimbursement.com/about (last visited Aug. 15, 2025).

⁹ 2025 WL 763704 (Mar. 11, 2025).

¹⁰ *Id.* at *6.

¹¹ Mr. Ravindran, the employee who was evacuated, is not an “approved” user of OH CDMS, and therefore has not made any filings into OH CDMS since its inception in 2018.

Request for Reinstatement of Appeals & Acceptance of Additional Information Under Good
Cause Extension
QRS CY 1991 Medicare Fraction (SSI) – Statutory & Systemic Errors Group
Page 5

Board Members Participating:

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

For the Board:

8/15/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)



DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
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Arcadia, CA 91006

RE: ***Notice of Dismissal***
DeTar Hospital Navarro, Prov. No. 45-0147, FYE 09/30/2017
Case No. 22-1480

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-1480. Set forth below is the decision of the Board to dismiss the two 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. 22-1480

On **April 4, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2017. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **September 22, 2022**, CHS filed the Provider's individual appeal request. The Individual Appeal Request included seven (7) issues:

1. DSH Pymt/ SSI% (Provider Specific)
2. DSH Pymt/ SSI% (Systemic Errors)¹
3. DSH Pymt - Medicaid Eligible Days
4. Dual Eligible Days - SSI Fraction²
5. Medicare Managed Care Part C Days - SSI Fraction³
6. Medicare Managed Care Part C Days - Medicaid Fraction⁴
7. Dual Eligible Days - Medicaid Fraction⁵

On **September 22, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary

¹ On April 26, 2023, this issue was transferred to Case No. 20-0997GC.

² On April 26, 2023, this issue was transferred to Case No. 20-1383GC.

³ On April 26, 2023, this issue was transferred to Case No. 19-2620GC.

⁴ On April 26, 2023, this issue was transferred to Case No. 19-2620GC.

⁵ On April 26, 2023, this issue was transferred to Case No. 20-1383GC.

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 **October 18, 2022**, CHS added the 1115 Waiver Appeal issue to its case.⁷

On **March 15, 2023**, the Board issued an “Extension Critical Due Dates” rescheduling the preliminary position paper (hereafter “PPP”) deadlines.

On **May 10, 2023**, the Provider timely filed its PPP in which it briefed the two remaining issues, SSI Provider Specific and Medicaid Eligible Days: With regard to the SSI Provider Specific issue, the Provider's appeal concerns whether the SSI percentage published by CMS was incorrectly computed because it failed to include all patients entitled to SSI benefits in the DSH calculation.^{8,9} The Provider characterized its appeal of the Medicaid eligible days issue as “. . . whether the [MAC] included in the Provider's Medicaid Fraction of the [DSH] all Medicaid eligible days (including Section 1115 waiver days).” The Provider advised that a listing of Medicaid Eligible Days was being sent to the MAC under separate cover.¹⁰

On **July 5, 2023**, the Medicare Contractor (“MAC”) filed a copy of its Request to the Provider for a DSH Package in connection with the Medicaid Eligible Days Issue.

On **August 24, 2023**, the MAC timely filed its PPP. The MAC indicated it would be filing a jurisdictional challenge over the SSI Provider Specific issue and objected to the Medicaid eligible days issue¹¹ and the inclusion of Section 1115 waiver days as an open issue. The MAC noted that a Section 1115 waiver days issue was added to the appeal and was subsequently transferred to a CIRP group.¹²

On **August 28, 2023**, the Medicare Contractor (“MAC”) filed a jurisdictional challenge over the DSH SSI Provider Specific & Medicaid eligible days issues in the case. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge.

⁶ (Emphasis added.)

⁷ On October 20, 2022, this issue was transferred to Case No. 19-2793GC.

⁸ The Provider did not address the SSI realignment aspect of the issue.

⁹ Provider PPP at 10. (May 10, 2023).

¹⁰ Provider PPP at 9 (May 10, 2023).

¹¹ The MAC indicated that it had not yet received a listing of the additional Medicaid Eligible Days although the Provider's PPP indicated the listing was to be submitted under separate cover and one was subsequently requested. MAC PPP at 23. (Aug. 24, 2023).

¹² MAC PPP at 24.

On **September 1, 2023**, the Provider requested a change of representation from CHS to Quality Reimbursement Services, Inc. (“QRS”), which the Board acknowledged on **September 5, 2023**.

On **November 17, 2023**, *2 months after the deadline for responding to the MAC’s Jurisdictional Challenge*, QRS filed the “Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission.” The 12 page listing, showing roughly 2166 eligible days, included a *caveat* that the “Listing [is] *pending finalization* upon receipt of State eligibility data.”¹³ QRS’ filing did not explain why the listing, which included substantially more than the 100 days noted in the initial appeal, was being submitted at this late date or why it was not final despite having been submitted **almost 6 years after the fiscal year at issue had closed**.

On **June 18, 2024**, *almost 9 months after the deadline*, QRS filed a **late** response to the MAC’s August 28, 2023 jurisdiction challenge over the SSI Percentage (Provider Specific) and Eligible days (including 1115 Waiver days) issues.

B. Description of Issue 1 in the Appeal Request and the Provider’s Participation in Case No. 20-0997GC - CHS CY 2016 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 CMS recalculate the SSI percentage based upon the Provider’s cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).¹⁴

The Group issue Statement in Case No. 20-0997GC, to which the Provider transferred its SSI Percentage 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

¹³ (Emphasis added.)

¹⁴ Issue Statement at 1 (Sept. 22, 2022).

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.¹⁵

On May 10, 2023, the Board received the Provider's preliminary position paper in Case No. 22-1480. 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 the Centers for Medicare and Medicaid Services ("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

¹⁵ Group Appeal Issue Statement in Case No. 20-0997GC.

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-3).¹⁶

Based on the calculation support uploaded with the Provider's individual appeal, the amount in controversy listed for both Issues 1 and 2 is \$50,938.

C. Description of Issue 3 in the Individual 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 3 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.¹⁷

In its Preliminary Position Paper, the Provider argues that, pursuant to the *Jewish Hospital* case¹⁸ 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.¹⁹ In addition, the

¹⁶ Provider's PPP at 10 (May 10, 2023).

¹⁷ Appeal Request at Issue 3.

¹⁸ *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994).

¹⁹ Provider's Preliminary Position Paper at 8 (May 10, 2023).

Provider questioned whether the MAC included all Medicaid eligible days, including section 1115 waiver days, in the Medicaid fraction of the DSH calculation.²⁰

MAC's Contentions Issue 1 – DSH Payment/SSI Percentage (Provider Specific)

In both its PPP and the Jurisdictional Challenge, the MAC argues that the Board lacks jurisdiction over the DSH – SSI Provider Specific issue. According to the Provider's appeal request, the provider indicated it was preserving its right to request realignment. This issue was not briefed in the Provider's PPP, but regardless, the Provider already has a 9/30 cost report end so its year end is already aligned with the Federal fiscal year.²¹ In the Jurisdiction Challenge, the MAC argues that not only should the realignment aspect of the issue be considered abandoned, it should be dismissed for failure of the Provider to file a complete PPP with all supporting documents.

The MAC also contends that the other two aspects of the SSI Provider Specific issue, which involve SSI Data Accuracy and Individuals Eligible for SSI but did not receive SSI Payments, should be dismissed because they are duplicative of the SSI Percentage issue (No. 2) - that was transferred to group Case No. 20-0997GC.²²

MAC's Contentions Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC argues that the Provider abandoned the Medicaid Eligible Days issue when it failed to properly develop its arguments within the PPP in accordance with Board Rule 25. Additionally, the Provider failed to provide a list of additional Medicaid eligible days or any other supporting documents and did not provide an explanation for why it could not produce those documents.²³ The MAC also argues that the Provider is attempting to reinstate the Section 1115 waiver days issue (which was previously added and transferred to a group) by referencing it in its May 10, 2023 PPP. The MAC contends that the Provider's attempt to reinstate the 1115 waiver days issue in the PPP was untimely and improper and duplicative of the issue in Case No. 19-2793GC.²⁴

Provider's Jurisdictional Response – Issues 1 & 3

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.²⁵ The Provider filed its response to the challenge over the SSI Provider Specific and Medicaid eligible days (including 1115 waiver days) issues almost 8 months after the time for doing so 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.

²⁰ A Section 1115 waiver days issue was added to the appeal on October 18, 2022, but was transferred to a CIRP group under Case No. 19-2793GC two days later, on October 20, 2022.

²¹ In its PPP, the MAC also argues that since it did not & cannot make a determination over the realignment, it is not an appealable issue and the Board lacks jurisdiction.

²² MAC's Jurisdictional Challenge at 2 (Aug. 28, 2023).

²³ MAC's Jurisdictional Challenge at 2 (Aug. 28, 2023).

²⁴ MAC's Jurisdictional Challenge at 14 (Aug. 28, 2023).

²⁵ Board Rule 44.4.3, v. 3.1 (Nov. 2021).

A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Therefore, the Board will not consider the Provider's untimely submitted 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 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. 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."²⁶ 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)."²⁷ Further, the Provider argues in its issue statement, 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."²⁸

The Provider's DSH/SSI Percentage issue in group Case No. 20-0997GC also alleges that the MAC 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. 22-1480 is duplicative of the DSH/SSI Percentage issue in Case No. 20-0997GC. Because the issue is duplicative, and duplicative issues appealed from the

²⁶ Issue Statement at 1.

²⁷ *Id.*

²⁸ *Id.*

same final determination are prohibited by PRRB Rule 4.6,²⁹ the Board dismisses this aspect of the DSH/SSI (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.³⁰ 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. 20-0997GC.

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 "[the MEDPAR data] provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction." But that, ". . . upon completion of this review it will be entitled to a correction of these errors of omission to its SSI percentage . . . that errors occurred that did not account for all patient days in the Medicare fraction."³¹ The Provider fails to 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 25.2.³² Moreover, the Board finds that the Provider's PPP failed to comply with Board Rule 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, 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

²⁹ PRRB Rules v. 3.1 (Nov. 2021).

³⁰ 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).

³¹ Provider PPP at 10 (May 10, 2023).

³² 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 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.³³

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,

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.³⁴

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>.³⁵

This CMS webpage describes access to DSH data *from 1998 to 2023* and instructs providers to send a request via email to access their DSH data.”³⁶

³³ (Italics and underline emphasis added.)

³⁴ See 65 Fed. Reg. 50,548 (2000).

³⁵ Last accessed Aug 13, 2025.

³⁶ (Emphasis added).

Accordingly, *based on the record before it*,³⁷ the Board finds that the DSH/SSI (Provider Specific) issue in Case No. 22-1480 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/SSI (Provider Specific) issue.

2. Second Aspect of Issue 1

The second aspect of the DSH/SSI (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 also 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. In this case, the Provider's cost report end is 9/30 which is already aligned with the Federal fiscal year. In addition, the realignment portion of the issue was not addressed in the Provider's preliminary position paper and is, therefore, considered to have been abandoned.

B. DSH Payment – Medicaid Eligible Days

The Provider's appeal request asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider's issue statement for Issue 3 is stated, *supra*. Neither the Provider's appeal request, nor the PPP, included a list of the specific additional Medicaid eligible days that are in dispute in this appeal.

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.

³⁷ 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.

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

No Access to Data

The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. See subsections below and Rule 8 for special instructions regarding multicomponent disputes.

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.

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.*³⁸

Similarly, with regard to position papers,³⁹ Board Rule 25.2.1 requires that “the parties must exchange ***all available*** documentation as exhibits to fully support your position.”⁴⁰ This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides instruction on the content of position papers as it relates to unavailable documentation/exhibits, as discussed *supra*.

Finally, Board Rule 41.2 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 (*see* 42 C.F.R. § 405.1868);

³⁸ (Emphasis added).

³⁹ The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.

⁴⁰ (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.

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 September 22, 2022 (almost 3 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expected to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's PPP indicated that it would be sending the eligibility listing under separate cover.⁴¹ Notably, on July 5, 2023, the MAC sent a request for the Provider's list of Medicaid eligible days, more than five years after the end of the Provider's cost reporting period. The MAC also informed the Provider that the deadline to respond was (*45 days later*) August 19, 2023.

On August 28, 2023, after the Provider had failed to timely respond to the MAC's request, the MAC filed a Jurisdictional Challenge, 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) with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2 (or when requested by the MAC after that); and (2) the Provider is attempting to improperly and untimely reinstate the Section 1115 waiver days issue by including it in the preliminary position paper.⁴² The MAC thus asserts that the Provider has essentially abandoned the Medicaid eligible days 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.⁴³

Pursuant to Board Rule 44.4.3, the Provider had 30 days to respond to the Jurisdictional Challenge. However, the Provider failed timely respond to the Challenge by the September 27, 2023 filing deadline (i.e., 30 days after August 28, 2023). Almost two months after the deadline, on November 17, 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." The Listing was 12 pages with roughly 2166 Medicaid eligible days. QRS' filing did not, however, explain why the listing, which included substantially more than the 100 days noted in the initial appeal, was being submitted at this late date or why it was not final despite having been submitted almost 6 years after the fiscal year at issue had closed.

⁴¹ Provider's PPP at 9.

⁴² The MAC also requested dismissal of the SSI Provider Specific issue as addressed, *supra*.

⁴³ 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.

Regardless, the “Supplement” was filed 2 months past the deadline for responding to the Jurisdictional Challenge and, more importantly, was almost 6 months past the deadline for including it with the PPP since the PPP deadline was May 22, 2023.

The Board concurs with the MAC, 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), as well as 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 provide any supporting documentation for those days).

The fact that the Listing was filed 2.5 months after the Provider requested the change of its designated representative to QRS does not excuse the Provider for its failure to include the information with its preliminary position paper or its late response 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 17, 2023 filing as a “Supplement to Position Paper” and does not accept that filing because:

1. The alleged “Supplement” was filed almost 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 to Dismiss Issue 3 and the alleged “Supplement” was filed almost 2 months after the deadline for filing a response to the Motion to Dismiss 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 2166 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 over a year after this appeal was filed and more than 6 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 22, 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 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 PPP or a supplement

of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the PPP 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 PPP (indeed the *tentative* 2166 days listed in the alleged “Supplement” is, without explanation, *exponentially* larger than the original estimated 100 days included with the appeal request).⁴⁴

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”⁴⁵ 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 provided 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.

Finally, the Board finds that the Section 1115 waiver days (mentioned in the Provider’s PPP) is not a part of this appeal. On October 18, 2022, the Provider timely added an issue characterized as “1115 Waiver Appeal,” which became Issue No. 8. Two days later, the issue was transferred to the “CHS CY 2017 Section 1115 Waiver Days Texas CIRP Group,” Case No.19-2793GC. Therefore, the Board finds the reference to this issue in the Provider’s PPP to be duplicative of the issue that was transferred to Case No. 19-2793GC.

Alternatively, the Board finds that the 1115 waiver days issue was not properly briefed in the Provider’s PPP filing. As discussed *supra* in 42 C.F.R. § 412.106(b)(4)(iii) and § 405.1871(a)(3), 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 PPP briefing fails to establish the merits of its position on the *alleged* § 1115 waiver days sub-issue. This finding 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*.⁴⁶ 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 . . .”⁴⁷ 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.”⁴⁸ 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.⁴⁹ Here, the Board makes the same finding based on similarly *overly generalized language*.

⁴⁴ 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.”

⁴⁵ (Emphasis added).

⁴⁶ No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

⁴⁷ *Id.* at *11.

⁴⁸ *Id.*

⁴⁹ *Id.*

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.⁵⁰

Based on the foregoing, the Board is dismissing the two (2) remaining issues in this case: DSH – SSI Provider Specific (Issue 1) and DSH - Medicaid Eligible Days (Issue 3). As no issues remain, the Board hereby closes Case No. 22-1480 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:

8/18/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

⁵⁰ 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

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Via Electronic Delivery

Corinna Goron
Healthcare Reimbursement Services, Inc.
3900 American Drive, Suite 202
Plano, TX 75075

RE: ***Notice of Dismissal***

HRS Lafayette General Health CYs 2012 – 2014 DSH SSI Percentage CIRP Group
Case Number: 17-1100GC

Dear Ms. Goron:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 17-1100GC. Set forth below is the decision of the Board to dismiss the CIRP Group Appeal challenging the Provider’s Disproportionate Share Hospital (“DSH”) for SSI Percentage (Provider Specific).

Background

A. Procedural History for Case No. 17-1100GC

On **February 21, 2017**, Healthcare Reimbursement Services, Inc. (“HRS”) filed their Request to Establish Group Appeal on behalf of the Providers. The Providers are commonly owned/operated by Lafayette General Health.

On **December 15, 2023**, HRS timely filed a Preliminary Position Paper, and the Medicare Contractor timely filed a PPP on **March 13, 2024**.

On **January 24, 2024**, the Medicare Contractor submitted a Jurisdictional Challenge. The Provider submitted a response to the Jurisdictional Challenge on **February 21, 2024**.

B. Issue at Appeal

In the Group Issue Statement, the Providers describe the issue in dispute as follows:

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 Providers contend that the Lead 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 Providers further contend that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead 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.¹

The Providers' Preliminary Position Paper includes the following Statement of Issue:

The Providers assert that patient days associated with patients entitled to Medicare Part A for whom no Medicare Part A payment is made and who are eligible to Title XIX should be excluded from the Medicare Fraction and included in the numerator of the Medicaid Fraction of the Medicare Disproportionate Share Hospital ("DSH") calculation? Alternatively, if "entitled" to Medicare Part A include patients for whom no payment is made, whether the numerator of the Medicare Fraction of the Medicare DSH percentage should include all of the Providers' patients entitled to supplemental security income ("SSI"), as required by 42 U.S.C § 1395ww(d)(5)(F)(vi), even if such patients were not entitled to receive SSI payments for the month or months of their

¹ Case Number 17-1100GC Group Issue Statement at 1 (Feb. 21, 2017).

hospital stays. Finally, irrespective of whether patients who were not in SSI pay status for the month(s) of their inpatient stay should be included in the numerator of the Medicare Fraction, CMS improperly excludes from the numerator of the Medicare Fraction those patients who were entitled to receive SSI payment for the month(s) of their inpatient stay but did not receive payment because they were placed in suspense status because SSA did not have a current valid address for them or the patients had not been assigned a representative payee or other similar reasons.²

In the section of the Preliminary Position Paper titled “A. The Part A Days Issue,” the Providers claim that “[t]here are two types of non-covered days at issue in this case. . . . patient days for individuals who are eligible for both Medicare and, at times, Medicaid, but who have exhausted their Medicare benefits . . . [and] Medicare Secondary Payer days.”³ The Providers point out that such days are not “covered” days because “Medicare does not pay for the inpatient hospital stay.”⁴ The Providers then recount the FY 2005 IPPS Final Rule, which deleted the word “covered” from 42 C.F.R. § 412.106(b)(2)(i), which effectively changed the DSH calculation to include dual eligible days not actually paid by Medicare in the SSI Fraction. “The Providers contend that such days should be excluded from the DSH Medicare Fraction and included in the DSH Medicaid Fraction because the August 11, 2004, final rule is procedurally invalid.”⁵ They acknowledge that *Empire Health* litigation has resulted in a finding that the 2005 IPPS Final Rule, and the interpretation of “entitled to Part A,” is substantively valid, but there is pending litigation on whether it is procedurally valid.⁶ The Providers then outline their arguments as to why the 2005 IPPS Final Rule is procedurally invalid.⁷

The Providers then separately identify “B. The SSI Days Issue,” and argue that if “entitled to Part A Days does not require Part A payment,” then “‘entitled to SSI’ must have the identical meaning.” They argue that days are being erroneously excluded from the SSI Fraction’s numerator for patients who were “entitled to SSI” but did not receive payment.⁸ The Providers go on to outline CMS Ruling 1498-R and the FY 2011 IPPS Final Rule.⁹ They challenge the use of just three (3) codes, and argue that additional codes should be included in the data matching process.¹⁰

The Providers continue by expanding on some of the “reasons” set forth in their issue statement for why their SSI Fractions are incorrect. They argue there are certain “Fundamental Problems

² Providers’ Preliminary Position Paper (hereinafter, “Providers’ PPP”) at 3 (Dec. 15, 2023).

³ Providers’ PPP at 7.

⁴ *Id.*

⁵ *Id.* at 8.

⁶ *Id.* at 8-9 citing *Becerra v. Empire Health Found.*, 597 U.S. 424 (2022).

⁷ *Id.* at 9-14.

⁸ *Id.* at 14.

⁹ *Id.* at 14-16.

¹⁰ *Id.* at 17-18.

in the SSI Percentage Calculation,” specifically that the data matching methodology contains fundamental flaws. This argument section merely outlines the flaws identified in *Baystate* litigation,¹¹ which CMS has corrected or addressed in its new data matching process. They briefly repeat their argument about the use of “covered” days versus “total” Medicare Part A days.¹² The Providers then re-visit the methodology set forth in CMS Ruling 1498-R, claiming it does not address all the deficiencies identified in *Baystate*. They note CMS does not use Social Security Numbers in the matching process, which results in inaccuracies in identification of entitled individuals.¹³

Finally, the Providers briefly recap the *Advocate Christ* and *Pomona Valley* cases, but make no actual argument related to the cases and do not apply any of the facts from that authority to the instant cases.¹⁴

MAC’s Contentions

The Medicare Contractor filed a jurisdictional challenge asserting that the Providers’ “group appeal involves multiple issues contrary to the Board Rules and Regulations” and that Providers also “untimely and inappropriately added issues to the appeal” and “attempted to include the same issue in multiple appeals.”¹⁵

According to the Medicare Contractor, the Providers’ Preliminary Position Paper addresses three separate issues, two of which the Contractor characterizes as “policy issues” and a third as a “technical issue.”¹⁶ According to the MAC, the first issue, identified by the Providers as “The Part A Days Issue” and the second issue, identified by the Providers as “The SSI Days Issue” are “separate and distinct policy issues.” The third issue, identified by the Providers as “Fundamental Problems in the SSI Percentage Calculation” is characterized by the contractor as being a “technical issue.”¹⁷

The MAC also asserts that the Providers have challenged certain issues in this appeal in other appeals involving the same fiscal years.¹⁸ According to the Medicare Contractor, the Providers in the instant case are also participants in PRRB Case 17-1461GC, HRS Lafayette General Health 2012-2014 DSH SSI Fraction Dual Eligible Days CIRP Group and Case 17-1462GC, HRS Lafayette General Health 2012 DSH Medicaid Fraction Dual Eligible Days CIRP Group. The MAC points out that Board previously closed these cases because the Providers filed a

¹¹ *Id.* at 19-21, citing *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008).

¹² *Id.* at 21.

¹³ *Id.* at 22.

¹⁴ *Id.* at 24-26.

¹⁵ Jurisdictional Challenge at 3 (Jan. 24, 2024).

¹⁶ *Id.* at 6-7.

¹⁷ *Id.* at 7.

¹⁸ *Id.* at 7-8.

complaint in federal district court.¹⁹ The MAC argues that the Providers’ arguments regarding “‘The Part A Days Issue’ of their preliminary paper duplicates the arguments in [these cases].”²⁰

Providers’ Jurisdictional Response

The Providers responded to the Jurisdictional Challenge by claiming that neither the regulations or the statutes cited by the MAC “requires that a group appeal involve a single ‘issue.’”²¹ The Providers claim instead that “the statute requires that a group appeal involve ‘a common question of fact or interpretation of law or regulations’ and the regulations require that ‘[t]he 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.’”²² The Providers characterize their appeal as raising “a single interpretation of law, namely whether CMS has improperly applied the statutory section popularly known as the Medicare Fraction” and including “multiple arguments as to why CMS has interpreted and applied the Medicare Fraction improperly.”²³ The Providers also claim that its appeal is not duplicative of Case Nos. 17-1461GC and 17-1462GC because the cases are no longer pending after being previously dismissed by the Board.²⁴ In addition, the Providers also allege that the issue on appeal in the cases are not the same.²⁵

Relevant Law

1. The Medicare DSH Adjustment

The Medicare DSH adjustment provides additional payments to certain qualifying hospitals that treat a disproportionate share of low-income patients.²⁶ A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage (“DPP”).²⁷ 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.²⁸ The DPP is defined as the sum of two fractions expressed as percentages.²⁹ Those two fractions are referred to as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction.

¹⁹ *Id.* at 3.

²⁰ *Id.*

²¹ Providers’ Response to Jurisdictional Challenge at 1 (Feb. 21, 2024).

²² *Id.* citing section 1878(f)(1) of the Social Security Act; 42 C.F.R. § 405.1837(f)(2).

²³ *Id.*

²⁴ *Id.* at 2.

²⁵ *Id.*

²⁶ 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).

²⁷ *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

²⁸ *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

²⁹ 42 U.S.C. § 1395ww(d)(5)(F)(vi).

The Medicare fraction is calculated by using: (a) in the numerator, the “number of such hospital’s patient days...which were made up of patients who (for such days) were *entitled* to benefits under part A of this subchapter and were *entitled* to supplementary security income benefits...under subchapter XVI of this chapter . . .”; and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A.³⁰

The Medicaid Fraction is calculated by using: (a) in the numerator, 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, and (b) in the denominator, the total number of hospital patient days.³¹

2. Medicare Part A Days

At issue in this case is the calculation of the Medicare fraction – and, in particular, the phrase “patients who (for such days) were entitled to benefits under part A” in the Medicare fraction’s numerator and denominator.³² The Secretary has long interpreted the term “entitled” in the Medicare context to refer to an individual meeting all of the requirements for Medicare benefits.³³ Prior to 2004, however, when HHS calculated a hospital’s DSH adjustment, it nevertheless included in the Medicare fraction only “covered” Medicare patient days or days for which payment from the Medicare program was actually available to the hospital. In rulemaking proceedings that culminated in the FY 2005 IPPS Final Rule, HHS revised its approach to the Medicare fraction, counting in the fraction’s numerator and denominator patient days of individuals who meet the requirements for Medicare Part A regardless of whether Medicare paid for those days.³⁴

In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word “covered.”³⁵ Prior to this revision, § 412.106(b)(2) (2004) had stated:

(2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—

(i) *Determines the number of covered patient days that—*

(A) Are associated with discharges occurring during each month;
and

³⁰ 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) (Emphasis added); *See also* 42 C.F.R. § 412.106(b)(2).

³¹ 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II); *See also* 42 C.F.R. § 412.106(b)(4).

³² 42 U.S.C. 1395ww(d)(5)(F)(vi)(I).

³³ 42 C.F.R. § 400.202.

³⁴ 69 Fed. Reg. 48916, 49098-99 (Aug. 11, 2004)

³⁵ *See id.* at 49098-99, 49246.

(B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .³⁶

As a result of the revision made by the FY 2005 IPPS final rule, § 412.106(b)(2) (2005) states:

(2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—

(i) *determines the number of patient days that--*

(A) Are associated with discharges occurring during each month; and

(B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .³⁷

The effect of this change was to adopt “a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.”³⁸

In *Empire Health Found. v. Price*,³⁹ the U.S. District Court for the Eastern District of Washington (“Washington District Court”) reviewed the question of “the validity” of the 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.”⁴⁰ The hospital alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.⁴¹ 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.⁴² The Washington District Court determined that, without an accurate context in which to view the Secretary’s proposed rule, interested parties could not have known what to expect and would have had no basis on which to make comments.⁴³ Further, the Washington District Court pointed out that interested parties could not

³⁶ (Emphasis added.)

³⁷ (Emphasis added.)

³⁸ 69 Fed. Reg. 49099.

³⁹ 334 F. Supp. 3d 1134 (E.D. Wash. 2018)

⁴⁰ *Id.* at 1141.

⁴¹ *Id.*

⁴² *Id.* at 1153-62.

⁴³ *Id.* at 1162.

have reasonably anticipated the Secretary’s rulemaking contained a misstatement.⁴⁴ Consequently, the Washington District Court found that the Secretary’s notice failed to satisfy the procedural rulemaking requirements of the Administrative Procedure Act (“APA”)⁴⁵ and that the regulation was procedurally invalid.⁴⁶

The U.S. Court of Appeals for the Ninth Circuit (“Ninth Circuit”) reviewed the Washington District Court’s decision in *Empire* 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.⁴⁷ The Ninth Circuit found that the revision “was a logical outgrowth of the notice and the comments received” and that it “met the APA’s procedural requirements.”⁴⁸ The Ninth Circuit then reviewed substantive validity of the 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*”)⁴⁹ 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.”⁵⁰ 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.”⁵¹ 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.”⁵² Accordingly, the Ninth Circuit took the following actions to implement its holding:

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).

⁴⁴ *Id.*

⁴⁵ 5 U.S.C. § 533.

⁴⁶ *Empire Health Found.*, 334 F. Supp. 3d at 1162-63.

⁴⁷ 958 F.3d 873 (9th Cir. 2020), *reh’g en banc denied* (9th Cir. Oct. 20, 2020).

⁴⁸ *Id.* at 884.

⁴⁹ 97 F.3d 1261, 1265-66 (9th Cir. 1996).

⁵⁰ 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).

⁵¹ *Id.* at 886.

⁵² *Id.*

The Secretary appealed the Ninth Circuit decision, and the U.S. Supreme Court subsequently issued its decision in *Becerra v. Empire Health Foundation*⁵³ (“*Empire Health*”) finding that the Secretary “correctly construes the statutory language at issue.”⁵⁴

On June 24, 2022, the U.S. Supreme Court issued its decision in *Empire Health* and 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.”⁵⁵ The Court found that being “entitled” to Medicare benefits means meeting the basic statutory criteria, not actually receiving payment for a given day’s treatment.⁵⁶ Nor did the U.S. Supreme Court find any credence in the argument that “entitled” was modified by the statute by adding “(for such days).” According to the Court, although this parenthetical directs 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.⁵⁷ Based on the foregoing, the U.S. Supreme Court reversed the Ninth Circuit’s *Empire* decision and remanded the case for further proceedings.⁵⁸

3. SSI Days

On remand, the Ninth Circuit reviewed whether the District Court’s dismissal of the *Empire* appellants’ “alternative” legal argument was proper where that dismissal was based on a finding that the appellants’ alternative argument was beyond the scope of the Board’s authorization of EJR.⁵⁹ The *Empire* appellants’ alternative argument challenges the calculation of patient days included in the numerator of the SSI fraction, asserting that the Secretary’s interpretation of the phrase “entitled to supplemental security benefits” is too narrow. The Ninth Circuit determined that the District Court’s dismissal was not proper, and the Board’s authorization encompassed the alternative argument.⁶⁰ Specifically, the Ninth Circuit noted that neither it nor the Supreme Court addressed the appellants’ 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.⁶¹ The appellants’ argue 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

⁵³ 142 S.Ct. 2354 (2022).

⁵⁴ *Id.* at 2362.

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.* at 2365.

⁵⁸ *Id.* at 2368.

⁵⁹ *Empire Health Found. v. Azar*, 2022 WL 17411382, *1 (9th Cir. 2022).

⁶⁰ *Id.*

⁶¹ *Id.*

are eligible for benefits.⁶² Consideration of this issue is currently pending before the District Court for the Eastern District of Washington.⁶³

Like the *Empire* appellants, the Providers, in their PPP, also put forth an alternative argument regarding CMS's determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation. According to Providers, "[i]n the event of a holding that 'entitled' to Part A Days does not require Part A payment . . . 'entitled' to SSI must have the identical meaning as 'entitled' to Part A."⁶⁴

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.⁶⁵ In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.⁶⁶ In contrast, the SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled, administered by the Social Security Administration ("SSA").⁶⁷ 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."⁶⁸ 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.⁶⁹

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *ineligible* for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility⁷⁰ and may terminate,⁷¹ suspend⁷² or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.⁷³ 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:

⁶² *Id.*

⁶³ *Id.* at *2. Following the Supreme Court's remand in *Empire Health*, 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 in this case." *Id.*

⁶⁴ Providers' PPP at 14.

⁶⁵ 42 U.S.C. § 426.

⁶⁶ 42 U.S.C. § 426-1.

⁶⁷ 42 U.S.C. § 1382.

⁶⁸ 42 U.S.C. §§ 1381a, 1382(a).

⁶⁹ 20 C.F.R. § 416.202.

⁷⁰ 20 C.F.R. § 416.204.

⁷¹ 20 C.F.R. §§ 416.1331-1335.

⁷² 20 C.F.R. §§ 416.1320-1330.

⁷³ 20 C.F.R. § 1320.

1. The individual fails to give the SSA permission to contact financial institutions;⁷⁴
2. The individual fails to apply for other benefits to which the individual may be entitled;⁷⁵
3. The individual fails to participate in drug or alcohol addiction treatment;⁷⁶
4. The individual is absent from the United States for more than 30 days;⁷⁷ or
5. The individual becomes a resident of a public institution or prison.⁷⁸

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.⁷⁹

Recently, in *Advocate Christ Medical Center v. Kennedy*, the Supreme Court considered providers' objections to CMS's policy of counting a hospital's Medicare patients as being "entitled to" SSI benefits only if such patients receive SSI payments during the relevant period.⁸⁰ The Court rejected the providers' broad reading of "entitled to" SSI benefits as including all patients enrolled in SSI at the time of hospitalization, regardless of whether they were entitled to receive an SSI payment.⁸¹ Citing the distinction between Medicare Part A, which provides automatic, ongoing health insurance to eligible patients, and SSI benefits, which require recipients to apply for and be deemed eligible for cash payments based on monthly income and resources, the Court held that "an individual is considered 'entitled to [SSI] benefits' for purposes of the Medicare fraction only if she is eligible for such benefits during the month of her hospitalization."⁸²

4. SSI Percentage Calculation

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.⁸³ CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11

⁷⁴ 20 C.F.R. § 416.207.

⁷⁵ 20 C.F.R. § 416.210.

⁷⁶ 20 C.F.R. § 416.214.

⁷⁷ 20 C.F.R. § 416.215.

⁷⁸ 20 C.F.R. § 416.211.

⁷⁹ 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>).

⁸⁰ 145 S.Ct. 1262 (2025).

⁸¹ *Id.*

⁸² *Id.* at 1270.

⁸³ 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).

million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.⁸⁴ To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.⁸⁵ 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.⁸⁶ CMS notifies Medicare contractors of the SSI percentages after they are calculated, posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate each hospital’s DPP to determine whether a hospital should be classified as a disproportionate share hospital and each qualifying hospital’s Medicare DSH payment adjustment.⁸⁷

In support of their argument that the “methodology used by CMS to identify patient days for use in calculating the SSI Percentages contains fundamental flaws, and as a result, understates the Provider’s SSI percentages,”⁸⁸ the Providers cite *Baystate v. Leavitt* (“*Baystate*”).⁸⁹ 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 CMS 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.⁹⁰

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

⁸⁴ *Id.*

⁸⁵ *Id.*

⁸⁶ *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).

⁸⁷ 42 C.F.R. § 412.106(b)(2)-(5); 42 C.F.R. § 405.1803.

⁸⁸ Providers’ PPP at 19.

⁸⁹ 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008).

⁹⁰ *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 field 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 granted or restored 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.

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 Social Security numbers (SSNs) as well as HICANs and Title II numbers."⁹¹ The Ruling also stated that "[i]n 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 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."⁹² 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."⁹³

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.⁹⁴ The proposed rule includes references to 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.⁹⁵ The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").⁹⁶ Significantly, in the preamble to the FY 2011 IPPS 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 is 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 matching process."⁹⁷ 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."⁹⁸ 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

⁹¹ CMS-1498-R at 5.

⁹² *Id.*

⁹³ *Id.* at 5-6.

⁹⁴ 75 Fed. Reg. 23852, 24002-24007 (May 4, 2010).

⁹⁵ *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").

⁹⁶ 75 Fed. Reg. 50042, 50280-50281. (Aug. 16, 2010).

⁹⁷ *Id.* at 50280.

⁹⁸ *Id.* at 50280-50281.

during the month that one of these codes was used.”⁹⁹ The providers in *Advocate Christ*, discussed *supra*, sought to present to the Supreme Court the question of “whether HHS correctly includes only three SSI codes as part of its calculation for the Medicare fraction.”¹⁰⁰ However, the Court declined to consider the issue since the providers raised the argument for the first time in their reply brief when the case was before the D.C. Circuit.¹⁰¹

5. PRRB Appeals

A. 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 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 single 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.¹⁰²

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*

⁹⁹ *Id.* This include all codes with the “S” prefix indicating a suspension of payment; codes beginning with “N” for nonpayment; code “E01” indicating that the individual had countable income which eliminated the 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.

¹⁰⁰ *Advocate Christ*, 145 S.Ct. at 1268 n.2.

¹⁰¹ *Id.*

¹⁰² (Bold and underline emphasis added and italics in original.)

issue in the group appeal.”¹⁰³ In addition, consistent with the requirement that a group contain only one issue, subsection (f) sets forth the “Limitations on group appeals” as follows:

(1) After the date of receipt 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*** regardless of whether the question is common to other members of the appeal (as described in § 405.1837(a)(2) and (g) of this subpart).¹⁰⁴

(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.¹⁰⁵

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 (2015) 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

¹⁰³ (Bold and underline emphasis added and italics in original.)

¹⁰⁴ (Emphasis added.)

¹⁰⁵ (Emphasis added.)

(e.g., dual eligible, general assistance, charity care, HMO days, etc.)¹⁰⁶

Board Rule 13 (Common Group Issue) (2015) states in pertinent part:

The matter at issue *must involve a single* common question of fact or interpretation of law, regulation or CMS policy or ruling.

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 and a provider may not add other questions of fact or law to the appeal.

B. Prohibitions on Duplicate Appeals

Pursuant to its rulemaking authority under 42 U.S.C. § 1395oo(e) and in the interests of conserving Board resources, the Board has adopted Rules prohibiting providers from pursuing duplicate appeals. Board Rule 4.5 (No Duplicate Filings) (2015) states that “[a] Provider may not appeal an issue from a final determination in more than one appeal.” In addition, Board Rule 4.7 (Dismissed or Withdrawn Issues) (2015) states that “[o]nce an issue is dismissed or withdrawn, the issue may not be appealed in another case.”

In addition, 42 C.F.R. § 405.1842(h)(3)(iii) prohibits the Board from conducting Board proceedings once a provider files a lawsuit seeking judicial review. The rule states that if a provider files a lawsuit seeking judicial review “before a final EJR decision is issued on the legal question, the Board may not conduct any further proceedings on the legal question or the matter at issue until the lawsuit is resolved.”

Board’s Analysis

1. Case Nos. 17-1461GC and 17-1462GC

Participants in Case Nos. 17-1461GC and 17-1462GC are identical to the participants in this case.¹⁰⁷ According to the consolidated request for expedited judicial review (“EJR”) in Case Nos. 17-1461GC and 17-1462GC, the issue in these group appeals is:

[w]hether the MAC should have excluded from the Medicare fraction non-covered patient days, i.e., days attributable to patients who were enrolled in Medicare and entitled to SSI, but for whom Medicare did not make a payment for their [] hospital stay, either

¹⁰⁶ (Emphasis added.)

¹⁰⁷ Providers’ Consolidated Request for Expedited Judicial Review in Case Nos. 14-2400GC, *et al.* (hereinafter “Request for EJR”), Ex. P-2 at P-000074-75 (Apr. 13, 2022).

because that patient's Medicare benefit days were exhausted, or because a third party made payment for that patient's hospital stay. The Providers identified in the Schedules[] of Providers . . . contend that these non-covered patient days[] should be excluded from the Medicare fraction. Providers further contends [sic] that these non-covered patient days should be treated consistently; that is, they should either be included in both the top and bottom of the SSI fraction. If excluded from both the top and bottom of the SSI fraction the Title XIX eligible days should then be recognized in the numerator of the Medicaid fraction.¹⁰⁸

The Providers in these cases challenge the FY 2005 IPPS Final Rule requiring the inclusion in the Medicare fraction of patient days that were not actually paid for by Medicare because a patient's Medicare benefit days were exhausted or because a third party made a payment for that patient's hospital stay.¹⁰⁹ However, the Board subsequently closed the appeals on October 19, 2022, after the Board learned that the Providers filed a lawsuit in federal district court before the Board had the opportunity to adjudicate the Providers' requests for EJR.¹¹⁰

2. *Cleveland Clinic v. Kennedy*, No. 22-cv-024648 (C.D. Cal.)

The Providers' claims in Case Nos. 17-1461GC and 17-1462GC are currently pending in federal district court in the *Cleveland Clinic* case.¹¹¹ After bypassing the administrative EJR process, the Providers, as participants in the above-listed group appeals, filed a complaint in the United States District Court for the Central District of California challenging the "Secretary's determination to treat days for which no Part A payments were made as nonetheless 'entitled to benefits under part A' [as] arbitrary and capricious and otherwise contrary to law."¹¹² The Providers also challenge the "Secretary's interpretation of 'entitled to supplemental security income benefits' . . . as including only days for which actual SSI payments were made" as "arbitrarily and capriciously inconsistent" with the Secretary's policy regarding unpaid Part A days.¹¹³ The Providers seek a court order:

Declaring invalid and enjoining the Secretary from applying her policy that unpaid Medicare Part A days are 'days entitled to benefits under part A' for purposes of the DSH SSI and Medicaid fractions or, in the alternative, directing the Secretary to include

¹⁰⁸ Case No. 17-1461GC et al, Request for EJR at 2 (Apr. 13, 2022).

¹⁰⁹ *Id.*

¹¹⁰ See PRRB Letter dated October 19, 2022, Closure of Group Appeals Pursuant to 42 C.F.R. § 4105.1842(h)(3)(iii) in Case Nos. 14-2400GC, *et. al.*, and Case Nos. 15-0555G, *et. al.*

¹¹¹ See Plaintiffs' First Amended Complaint for Declaratory, Restitutionary, and Injunctive Relief and for Sums Due Under the Medicare Act from Final PRRB Decision in Cases 13-3155GC *et al.* at 11 and Exhibit B, *Cleveland Clinic*, No. 22-cv-024648.

¹¹² *Id.* at 25.

¹¹³ *Id.* at 26.

unpaid SSI eligible patient days in the numerator of the SSI percentage utilizing SSI payment status codes that reflect the individuals' eligibility for SSI – even if the individuals did not receive SSI payments[.]”¹¹⁴

The *Cleveland Clinic* case is currently stayed pending the outcome of *Empire Health Found. v. Kennedy*,¹¹⁵ a case remanded by the Ninth Circuit after the Supreme Court's decision in *Becerra v. Empire*¹¹⁶ for the District Court's consideration of the *Empire* Plaintiffs' alternative “argument challenging HHS's calculation of patient days for those patients ‘entitled to supplemental security income [(SSI)] benefits’” in the Medicare fraction.¹¹⁷

3. Late Added Issue

Consistent with §§ 405.1837(c)(3) the group issue statement should only contain one issue. In the group appeal request, Providers define the issue in this case as:

[W]hether 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?

In this regard, similar to the providers in the *Empire* litigation, the Providers are challenging the substantive and procedural validity of 42 C.F.R. § 412.106(b)(2)(i), as amended by the FY 2005 IPPS Final Rule, and the interpretation of “entitled to Part A” in the SSI Fraction. As an alternative argument, the providers challenge the Secretary's interpretation of the phrase “entitled to supplemental security benefits,” in the SSI Fraction which is also at issue in both the *Empire* and *Advocate Christ* litigation.

However, the Provider's Preliminary Position Paper also identifies certain “Fundamental Problems in the SSI Percentage Calculation,” as an issue, alleging that the data matching methodology used by CMS contains fundamental flaws. The Providers then re-visit the methodology set forth in CMS Ruling 1498-R, claiming it does not address all the deficiencies identified in the *Baystate* litigation. They note CMS does not use Social Security Numbers in the matching process, which results in inaccuracies in identification of entitled individuals.¹¹⁸ Providers go so far as to request that the Board “incorporate the entire administrative and judicial record of *Baystate* into the record of this appeal.”¹¹⁹

¹¹⁴ *Id.* at 27

¹¹⁵ No. 2:16-cv-209 (E.D. Wash.).

¹¹⁶ 142 S. Ct. 2354 (2022).

¹¹⁷ *Empire Health Found. v. Azar*, No. 18-35845, 2022 WL 17411382, at *1 (9th Cir. Dec. 5, 2022). For additional information regarding the *Empire* litigation, see *infra* pp. 8-10.

¹¹⁸ Providers' PPP at 22.

¹¹⁹ *Id.* at 21.

As noted *supra*, 42 C.F.R. § 405.1837(f)(1) makes clear that after the Board’s receipt of a group appeal request, a provider cannot “add other questions of fact or law to the appeal.” Further, the Board cannot “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.”¹²⁰ 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.

It is well established that systemic errors or omissions in the CMS data matching process are the subject of the *Baystate* litigation, but the Board finds the Providers’ original appeal request did not incorporate an appeal of the *Baystate* issue. Even if the Providers’ original appeal request did incorporate the *Baystate* issue, the issue would still not be before the Board in this specific case because a group appeal is limited to only one issue and any additional issues would be subject to bifurcation.¹²¹ Here, the Board finds the original group appeal request appealed the issue in the *Empire* litigation with an alternative argument consisting of a combination of the issues in both the *Empire* and *Advocate Christ* litigation. In the Preliminary Position Paper, the Providers attempted to expand the issue in this appeal to encompass the issue in the *Baystate* litigation in violation of the Board Rules and regulations. As such the Board does not consider the late added *Baystate* issue as part of this appeal.

4. Duplicate Case

The Providers in this case are challenging the substantive and procedural validity of 42 C.F.R. § 412.106(b)(2)(i), as amended by the FY 2005 IPPS Final Rule, and the interpretation of “entitled to Part A” in the SSI Fraction. As an alternative argument, the Providers also challenge the Secretary’s interpretation of the phrase “entitled to supplemental security benefits.” The Providers here were also participants in Case Nos. 17-1461GC and 17-1462GC, involving the same cost years at issue in this matter.¹²² The two group appeals, along with a number of other appeals, were part of a consolidated request for EJR with the legal issue in the cases described, *supra*.

Rather than waiting for the Board to adjudicate the consolidated EJR request, the Providers, as participants in two group appeals in conjunction with other providers, filed a complaint in the United States District Court for the Central District of California.

Pursuant to its rulemaking authority under 42 U.S.C. § 1395oo(e) and in the interests of conserving Board resources, the Board has adopted Rules prohibiting providers from pursuing duplicate appeals. Board Rule 4.5 (No Duplicate Filings) and Board Rule 4.7 (Dismissed or Withdrawn Issues) are discussed, *supra*.

¹²⁰ 42 C.F.R. § 405.1837(f)(1)-(2).

¹²¹ See 42 C.F.R. § 405.1837(f)(2)(ii).

¹²² Case No. 17-1461 GC, Request for EJR at Exhibit P-2, P-000074-75.

The participants, years at issue, and issue on appeal in this case are all the same as in Case Nos. 17-1461GC and 17-1462GC. The Providers as participants in this case, as well as the case currently pending in the United States District Court for the Central District of California, challenge the Secretary's interpretation of the phrase "entitled to Part A" and alternatively, the phrase "entitled to supplemental security benefits," in the SSI fraction. However, Board Rule 4.5 prohibits Providers from appealing a final determination in more than one appeal. In addition, as Case Nos. 17-1461GC and 17-1462GC have already been closed by the Board, Board Rule 4.7 prohibits Providers from appealing the same issue for which they sought EJR in another case. Furthermore, as Providers filed a lawsuit before the Board could issue a final EJR decision on the legal question in Case Nos. 17-1461GC and 17-1462GC, the Board is prohibited from conducting any further proceedings on the legal question or the matter until the lawsuit is resolved under 42 C.F.R. § 405.1842(h)(3)(iii). Therefore, the Board dismisses this matter from its docket.

* * * * *

Based on the foregoing, the Board has dismissed the issue in the CIRP Group appeal. The Board hereby closes Case No. 17-1100GC 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:

8/18/2025

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-5)
Wilson Leong, FSS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran
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RE: ***Notice of Dismissal***

Tennova Healthcare, Prov. No. 44-0120, FYE 09/30/2017
Case No. 22-0799

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 22-0799. 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. 22-0799

On **August 25, 2021**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end September 30, 2017. The Provider is commonly owned by Community Health Systems, Inc. (“CHS”).

On **February 16, 2022**, CHS filed the Provider’s individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

¹ On September 8, 2022, this issue was transferred to Case No. 20-0997GC.

² On September 8, 2022, this issue was transferred to Case No. 19-2620GC.

³ On September 8, 2022, this issue was transferred to Case No. 20-1383GC.

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 **September 8, 2022**, the Provider transferred Issues 2, 4, and 5 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 **February 16, 2022**, 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 25.⁴

On **October 3, 2022**, 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’ 2017 cost report does not reflect an accurate number of Medicaid eligible days.” As a result, the Provider included, as an Exhibit, the original amount in controversy for this issue of \$86,609, which was based on an *estimated* 200 days.

On **January 26, 2023**, the Medicare Contractor timely filed a Jurisdictional Challenge⁵ with the Board over Issues 1 and 3 requesting that the Board dismiss these issues. Pursuant to Board Rule

⁴ (Emphasis added.)

⁵ 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

44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider's response was filed on March 14, 2023, *after* the February 25, 2023 deadline (30 days after the filing of the Jurisdictional Challenge).

On **January 27, 2023**, the Medicare Contractor 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 that Medicaid eligible days listing.

On **February 28, 2023**, the Provider changed its designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **November 3, 2023**, over 8 months after the deadline for responding to the Motion to Dismiss Issue 3, 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."⁶ The Listing was 26 pages with roughly 6,502 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 6,502 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*. NOTE—the roughly 6,502 included in this belated listing is *exponentially* larger than the original *estimated* impact of 200 days included with the appeal request.

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.

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

timely filing requirements and/or jurisdictional requirements."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

⁶ (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).⁷

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 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.⁸

On October 3, 2022, the Board received the Provider's preliminary position paper in 22-0799. The following is the Provider's *complete* position on Issue 1 set forth therein:

Provider Specific

⁷ Issue Statement at 1 (Feb. 16, 2022).

⁸ Group Appeal Issue Statement in Case No. 20-0997GC.

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. This is based on certain data from the State of Tennessee and the Provider that does not support the SSI percentage issued by CMS.

The Provider has worked with the State of Tennessee and has learned that 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.

The Provider is seeking the 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 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). 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.⁹

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is \$103,808.

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue. First, the MAC argues that the Provider has abandoned the SSI realignment sub-issue: "[T]he Provider has abandoned the issue of SSI realignment and; therefore, it should be considered withdrawn. The Provider did not brief this issue within its preliminary position paper."¹⁰ The MAC also argues the appeal is premature:

The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own

⁹ Provider's Preliminary Position Paper at 8-9 (Oct. 3, 2022).

¹⁰ Jurisdictional Challenge at 7 (Jan. 26, 2023).

fiscal year end, it is bound by that decision, regardless of reimbursement impact.

. . .

The Provider's appeal is premature as the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.¹¹

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH SSI Percentage issue in PRRB Case No. 20-0997GC are considered the same issue by the Board.¹²

Finally, the MAC argues “the Provider did not file a **complete** preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3.”¹³ The MAC posits that the Provider “failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper.”¹⁴

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC requests that the Board find the Provider abandoned the DSH – Medicaid Eligible Days issue, arguing:

The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider 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. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.

Within its preliminary position paper, the Provider makes the broad allegation, “. . . the Provider contends that the total number of days reflected in its' [sic] 2017 cost report does not reflect an accurate number of Medicaid eligible days. . .” The Provider has failed to include any evidence to establish the material facts in this

¹¹ *Id.* at 7-8.

¹² *Id.* at 4-6.

¹³ *Id.* at 8.

¹⁴ *Id.* at 9-10.

case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats their appeal request.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 Further, Board Rule 5.5.1 requires that Board deadlines continue to be met irrespective of a change in the case representation. The Provider's response to the MAC's Jurisdictional Challenge was not timely. 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. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Therefore, the Board will not consider the arguments enclosed in that filing.

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. 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

¹⁵ *Id.* at 12.

¹⁶ Board Rule 44.4.3, v. 3.1 (Nov. 2021).

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. 20-0997GC 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 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. 22-0799 is duplicative of the DSH/SSI Percentage (Systemic Errors) 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 4.6²⁰, 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. 20-0997GC.

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

¹⁷ Issue Statement at 1.

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ PRRB Rules v. 3.1 (Nov. 2021).

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).

year in question consistent with its obligations under Board Rule 25.2.²² 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

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.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

²² 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.

²³ (Emphasis added).

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

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.

Accordingly, *based on the record before it*,²⁶ the Board finds that the SSI Provider Specific issue in Case No. 22-0799 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.

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.

²⁴ Last accessed Oct. 15, 2024.

²⁵ (Emphasis added).

²⁶ Again, the Board notes that the Provider failed to timely respond to the Jurisdictional Challenge and the Board must make its determination based on the record before it.

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) (Jul. 2015) states:

B. No Access to Data

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.**

(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 (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:

²⁷ (Bold emphasis added.)

Rule 25 Preliminary Position Papers²⁸

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 The 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.

²⁸ (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 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.

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 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 February 16, 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)(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.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

²⁹ (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.

On October 3, 2022, 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, but rather included an exhibit referencing the amount in controversy included with its appeal request (i.e., the estimated impact of \$86,609 based on an estimated 200 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,

³⁰ Provider's Preliminary Position Paper at 8.

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 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.

Pursuant to Board Rule 44.4.3, the Provider had 30 days to respond to the Jurisdictional Challenge. However, the Provider **failed** timely respond to that Motion by the February 25, 2023 filing deadline (*i.e.*, 30 days after January 26, 2023).

However, on November 3, 2023 (more than 8 months after the deadline to respond to the Jurisdictional Challenge), 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 26 pages with roughly 6,502 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 6,502 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**. NOTE—the roughly 6,502 included in this belated listing is *exponentially* larger than the original estimate of 200 days included with the appeal request. Regardless, this filing was more than 8 months past the deadline for responding to the Jurisdictional Challenge *and, more importantly, was nearly a year past the deadline for including it with its preliminary position paper* since the position paper deadline was October 14, 2022.

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).

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 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 3, 2023 filing as a “Supplement to Position Paper” and does not accept that filing because:

1. The alleged “Supplement” was filed *more than a year 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 3 and the alleged “Supplement” was filed *more than 8 months after the deadline* for filing a response to the Jurisdictional Challenge.
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 6,502 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 1.5 years after this appeal was filed and more than 6 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 February 16, 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* 6,502 days listed in the alleged “Supplement” is, without explanation, *exponentially* larger than the original estimated 200 days included with the appeal request).³¹

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”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

³¹ See, *e.g.*, Board Rule 27.3 (Nov. 2021) stating: “A party may also file a revised or supplemental position paper; however, this filing should not present new positions, arguments or evidence except on written agreement between the parties.”

³² (Emphasis added.)

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)(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 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 has dismissed the two (2) remaining issues in this case – (Issues 1 and 3). As no issues remain, the Board hereby closes Case No. 22-0799 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:

For the Board:

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

8/18/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Cecile Huggins, Palmetto GBA (J-J)
Wilson Leong, FSS

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
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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***

Tennova Healthcare - Lebanon, Prov. No. 44-0193, FYE 10/31/2018
Case No. 22-1244

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 22-1244. 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. 22-1244

On **February 17, 2022**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end October 31, 2018. The Provider is commonly owned by Community Health Systems, Inc. (“CHS”).

On **October 4, 2022**, CHS filed the Provider’s individual appeal request. The initial 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
4. DSH Payment – Medicare Managed Care Part C Days (SSI Fraction & Medicaid Fraction)²
5. DSH Payment – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days, Eligible SSI Days for Which No Payment Was Made) – (SSI Fraction)³

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 **March 15, 2023**, the Provider transferred Issues 2, 4 and 5 to CHS CIRP groups.

¹ On March 15, 2023, this issue was transferred to Case No. 21-1206GC.

² On March 15, 2023, this issue was transferred to Case No. 20-2149GC.

³ On March 15, 2023, this issue was transferred to Case No. 21-0066GC.

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 **August 5, 2022**, 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 25.⁴

On **March 21, 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 \$47,860 based on an *estimated* 100 days.

On **June 14, 2023**, the Medicare Contractor timely filed a Jurisdictional Challenge⁵ with the Board over Issues 1 and 3 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. While the Provider did file a response, it was not timely (as it was filed on August 4, 2023) and therefore, will not be considered by the Board.

On **June 28, 2023**, the Medicare Contractor 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

⁴ (Emphasis added.)

⁵ 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).

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 **July 19, 2023**, the Provider changed its designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **November 13, 2023**, almost 4 months after the deadline for responding to the Motion to Dismiss Issue 3, 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."⁶ The Listing was 6 pages with roughly 982 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 982 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***. NOTE—the roughly 982 included in this belated listing is *exponentially* larger than the original *estimated* impact of 100 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 CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).⁷

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

⁶ (Emphasis added.)

⁷ Issue Statement at 1 (Aug. 4, 2022).

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.⁸

On March 21, 2023, the Board received the Provider's preliminary position paper in 22-1244. 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

⁸ Group Appeal Issue Statement in Case No. 21-1206GC.

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).⁹

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is \$19,613.

C. Description of Issue 3 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 3 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.¹⁰

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the Jewish Hospital case¹¹ 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.¹² The Provider then, for the first time in this appeal, states it is seeking reimbursement for section 1115 waiver days as a part of the Medicaid eligible day issue. Specifically, the Provider states:

⁹ Provider's Preliminary Position Paper at 10 (Mar. 21, 2023).

¹⁰ Appeal Request at Issue 3.

¹¹ *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994).

¹² Provider's Preliminary Position Paper at 8.

[M]edicaid 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 all Medicaid eligible days (including section 1115 waiver days).¹³

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 it was not briefed in the preliminary position paper and was therefore abandoned. In the alternative, the Medicare Contractor argues there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.¹⁴

In addition, the MAC argues that the Provider failed to file a complete preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3, and therefore, the Board should consider this issue abandoned and therefore, dismiss the issue from the appeal.¹⁵

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. The MAC argues the Provider has not submitted a Medicaid eligible days listing and therefore, requests the Board dismiss the issue.

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 deadline to respond to the June 14, 2023 filing was July 14, 2023. The Provider did not file a response until August 4, 2023, when the time for doing so had 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." As a result, the Board will not consider the Provider's response to the Jurisdictional Challenge.

¹³ *Id.* at 9.

¹⁴ Medicare Contractor's Jurisdictional Challenge at 6 (Jun. 14, 2023).

¹⁵ *Id.* at 7-10.

¹⁶ Board Rule 44.4.3, v. 3.1 (Nov. 2021).

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.”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. 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. 22-1244 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 4.6²⁰, the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

¹⁷ Issue Statement at 1.

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ PRRB Rules v. 3.1 (Nov. 2021).

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. 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 25.2.²² Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 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 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

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.

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 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.

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 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”) 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

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*,²⁶ the Board finds that the SSI Provider Specific issue in Case No. 22-1244 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

²³ (Italics and underline emphasis added.)

²⁴ Last accessed August 6, 2025.

²⁵ (Emphasis added).

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.

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(b) 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.*²⁷

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 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:

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**

²⁷ (Emphasis added).

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.²⁸

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:

Rule 25 Preliminary Position Papers²⁹

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

²⁸ (Bold emphasis added.)

²⁹ (Underline emphasis added to these excerpts and all other emphasis in original.)

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.

...

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 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. . .

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 August 5, 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)(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.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

³⁰ (Emphasis added.)

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 March 21, 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.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 \$47,860 based on an estimated 100 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

³¹ Provider's Preliminary Position Paper at 9.

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. § 1395(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1) [sic], 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 requested 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.

However, on November 13, 2023 (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 6 pages with roughly 982 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 982 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 982 included in this belated listing is *exponentially* larger than the original estimate of 100 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 7 months past the deadline for including it with its preliminary position paper* since the position paper deadline was April 1, 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)(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 fact that the Listing was filed 4 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 13, 2023 filing as a “Supplement to Position Paper” and does not accept that filing because:

1. The alleged “Supplement” was filed *more than 7 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 4 months after the deadline* for filing a response to the Jurisdictional Challenge.
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 982 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 August 5, 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* 982 days listed in the alleged “Supplement” is, without explanation, *exponentially* larger than the original estimated 100 days included with the appeal request).³²

³² See, *e.g.*, Board Rule 27.3 (Nov. 2021) stating: “A party may also file a revised or supplemental position paper; however, this filing should not present new positions, arguments or evidence except on written agreement between the parties.”

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”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)(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 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.³⁴

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 August 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,

³³ (Emphasis added.)

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.

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...³⁵

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 (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 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)***. . .³⁶

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.³⁷

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 –

...

³⁵ 42 C.F.R. § 405.1835(b).

³⁶ (Bold and italic emphasis added).

³⁷ See 73 Fed. Reg. 30190 (May 23, 2008).

(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, 2000.³⁸ 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) (2018) 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.

³⁸ 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. 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.

The Board’s finding that neither the appeal request nor preliminary 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*.³⁹ 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 . . .”⁴⁰ 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.”⁴¹ 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.⁴² Here, the Board makes the same finding based on similarly *overly generalized language*.

* * * * *

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. 22-1244 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:

For the Board:

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

8/18/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

³⁹ No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

⁴⁰ *Id.* at *11.

⁴¹ *Id.*

⁴² *Id.*

Notice of Dismissal for Tennova Healthcare - Lebanon

Case No. 22-1244

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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.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Notice of Dismissal***
Cox Medical Centers, Prov. No. 26-0040, FYE 09/30/2018
Case No. 23-0675

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 23-0675. 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”) for Medicaid Eligible Days.

Background

A. Procedural History for Case No. 23-0011

On **August 4, 2022**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end September 30, 2018.

On **January 26, 2023**, the Provider filed the individual appeal request. The initial Individual Appeal Request contained one issue:

1. DSH Payment – Medicaid Eligible Days

Attached to the individual appeal request was a calculation support document, which showed an additional 1,633 Medicaid Eligible Days in dispute, with an amount in controversy of \$654,488.

On **January 30, 2023**, 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 25.¹

On **September 21, 2023**, the Provider timely filed its preliminary position paper. In it, the Provider suggested that an unredacted list of Medicaid eligible days at issue was imminently being sent to the Medicare Contractor by promising that one was being sent under separate cover and attached a redacted copy as Exhibit P-1. The redacted list of Medicaid Eligible Days included only 340 days, significantly lower than the 1,633 days included with the individual appeal request. The position paper included no explanation as to the difference in the number of days.

On **November 16, 2023**, the Medicare Contractor filed a Request for DSH Package letter in connection with the Medicaid Eligible Days issue. In this filing, the Medicare Contractor formally requests that a listing of the Medicaid eligible days at issue plus supporting documentation be provided to the Medicare Contractor within 45 days.² Notwithstanding the formal request, the Provider failed to file any response to the Medicare Contractor.

On **January 15, 2024**, the Medicare Contractor 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 adequate supporting documentation, namely an unredacted DSH Medicaid Eligible Days 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 added the Section 1115 Waiver Days issue, which is outside the scope of the original appeal.

As no response was received from the Provider from the November 2013 request for an unredacted listing nor from the request in the MAC's position paper, on **January 4, 2025**, the Medicare Contractor filed a Jurisdictional Challenge³ with the Board over Issue 1 requesting that the Board dismiss the DSH Medicaid Eligible Days because: (1) the Provider abandoned the issue because it did not submit an unredacted list of additional Medicaid Eligible Days to the Medicare Contractor and failed to file a complete position paper; (2) the Provider attempted to untimely add the Section 1115 Waiver Days issue through its preliminary position paper; and (3) the Section 1115 Waiver Days issue are a separate and distinct 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.

¹ (Emphasis added.)

² Note: 45 days from November 16, 2023 is Sunday, December 31, 2023. Taking into account the holiday the next day, the due date would be Tuesday, January 2, 2024.

³ 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).

On **January 15, 2024**, the Medicare Contractor 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 adequate supporting documentation, namely an unredacted DSH Medicaid Eligible Days 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 added the Section 1115 Waiver Days issue, which is outside the scope of the original appeal.

MAC's Contentions

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 an unredacted Medicaid eligible days listing and therefore, requests the Board dismiss the issue. Additionally, there was no reconciliation between the 1,633 additional days in the Appeal Request and the 340 days included in the redacted listing submitted as an exhibit with the Provider's Preliminary Position Paper.

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.⁴ 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."

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.

A. 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 the initial appeal request, and included a deficient listing with its Preliminary Position Paper.

⁴ Board Rule 44.4.3, v. 3.1 (Nov. 2021).

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

The provider must support the determination being appealed and the basis for its dissatisfaction for *each* issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.

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.**

(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.⁵

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:

⁵ (Bold emphasis added.)

Rule 25 Preliminary Position Papers⁶

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... 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 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.
- 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.

...

25.2 Position Paper Exhibits

25.2.1 General

⁶ (Underline emphasis added to these excerpts and all other emphasis in original.)

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 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...

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 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. 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 January 30, 2023 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, 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.⁷

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 September 21, 2023, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the unredacted listing was being sent under separate cover.⁸ Significantly, the position paper did *not* include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather included a redacted listing of 340 days with zero explanation of the discrepancy between this number and the 1,633 days in the individual appeal request. The Provider's complete briefing of this issue in its position paper is as follows:

⁷ (Emphasis added.)

⁸ Provider's Preliminary Position Paper at 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.

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)(i), 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 (a redacted copy is attached), 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 an unredacted 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.

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) – in fact, the redacted listing served only to further confuse the issue by including a significantly less number of days than the individual appeal request with zero explanation.

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”⁹ 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)(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 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.¹⁰

⁹ (Emphasis added.)

¹⁰ 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

B. 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 January of 2023 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...¹¹

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.

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.

¹¹ 42 C.F.R. § 405.1835(b).

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 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)***. . .¹²

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.¹³

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, 2000.¹⁴ 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) states in pertinent part:

¹² (Bold and italic emphasis added).

¹³ See 73 Fed. Reg. 30190 (May 23, 2008).

¹⁴ 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 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.

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)(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.¹⁵

¹⁵ 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

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 preliminary 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*.¹⁶ 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 . . ."¹⁷ 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."¹⁸ 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.¹⁹ Here, the Board makes the same finding based on similarly *overly generalized language*.

* * * * *

Based on the foregoing, the Board has dismissed the remaining issue in this case – (Issue 1). As no issues remain, the Board hereby closes Case No. 23-0675 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:

8/18/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

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."

¹⁶ No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

¹⁷ *Id.* at *11.

¹⁸ *Id.*

¹⁹ *Id.*



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. Harrison Iriafer
CEO
Pure Hands Home Health, Inc.
13615 Victory Blvd., Suite 208
Van Nuys, CA 91401

RE: Pure Hands Home Health, Inc. (75-7202)
Appealed Period: 12/31/2025
PRRB Case No.: 25-5346

Dear Mr. Iriafer:

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 subject 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 August 8, 2025, Pure Hands Home Health, Inc. (the "Provider") filed an appeal request based on a *Home Health Agencies (HHAs) Calendar Year (CY) 2025 Quality Data Reconsideration* dated March 11, 2025 which identified a sole issue in dispute: Quality Reporting Payment 2% Reduction.

Upon review of the appeal request and the Calculation Support documentation, it is noted that the Provider has entered the controversy amount as \$4,277.

In addition, the Board notes that in lieu of a Letter of Representation, as required pursuant to Board Rule 5.4, the Provider filed the appeal request document which was also filed as the Issue Statement and the Audit Adjustment Support document.

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 Rule 6.4 **Amount in Controversy** states ::

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.

BOARD DETERMINATION:

The Board has determined that the Provider failed to meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b) or (d) in that it did not meet the \$10,000 aggregate amount in controversy threshold when the appeal was initially filed.

Based on the fact that the Provider has stated that the controversy amount is only \$4,277 and submitted no further documentation or calculation to indicate that the appeal request had met the \$10,000 amount in controversy threshold, the Board hereby dismisses case number 25-5346, in its entirety, for failure to meet the minimum filing requirements pursuant to 42 C.F.R. § 405.1835(b) or (d), Board Rule 6.1.1 and Board Rule 6.4.

The Board notes that although the subject appeal does not meet the requirements for a hearing before the Board, since the aggregate controversy amount is under \$10,000, it may have appeal rights for a Medicare Contractor (“MAC”) hearing pursuant to 42 C.F.R. § 405.1839(a)(1).

Board Members:

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

FOR THE BOARD:

8/18/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Federal Specialized Services
Pam VanArsdale, National Government Services, Inc. (J-6)



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
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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: ***Request for Reinstatement of Appeal***
Hollywood Presbyterian Medical Center (Provider Number 05-0063)
Case Nos. 25-1616, *et al.* (See attached Appendix A)

Dear Mr. Ravindran,

The Provider Reimbursement Review Board (“Board”) has reviewed the Request for Reinstatement of Appeal submitted by Quality Reimbursement Services, Inc. (“QRS”) on behalf of Hollywood Presbyterian Medical Center (“Provider”) on March 17, 2025. The decision of the Board is set forth below.

Background:

On **January 22 and 23, 2025**, Quality Reimbursement Services, Inc. (“QRS”) filed 26 individual appeals for Hollywood Presbyterian Medical Center (Provider Number 05-0063). The Representation Letter uploaded with all appeals was signed by Robert Allen, President and Chief Executive Officer of Hollywood Presbyterian Medical Center and is dated *June 4, 2020*. In lieu of submitting the final determination in each appeal, QRS submitted a CMS Change Request dated August 13, 2024 detailing the “Instructions for Processing Requests for SSI Realignment for Cost Reporting Periods Starting Before October 1, 2013.”

On **January 23, 2025**, the Board issued Acknowledgement & Critical Due Dates Notices (“ACCD”) in all 26 cases, all of which included a request to submit an updated Representation Letter (due by February 7, 2025). The ACCD explained that the submitted Letter of Representation was more than four (4) years old and set a deadline of February 7, 2025 to submit updated Letters of Representation.

On **February 6, 2025**, the day before the deadline, the Provider Representative, QRS requested a 30-day extension for submitting an updated Representation Letter in all 26 cases. QRS indicated that “due to turn over at the Medical Center,” it is taking “longer than expected” for them to receive a current, up-to-date Representation Letter.¹

¹ Request for Extension at 1 (Feb. 6, 2025). Due to the late nature of the request, no reply was issued prior to the due date.

On **February 27, 2025**, QRS filed an Expedited Judicial Review (“EJR”) Request in all 26 cases.

On **March 4, 2025**, the Board dismissed all 26 cases. In it, the Board cited multiple issues with the Representation Letter. They were:

1. The letter is over **four and a half years old**, as it is dated June 4, 2020.
2. The letter was signed by Robert Allen, who left the Provider organization in 2020, less than 4 months after signing the letter in question. A new president and CEO was hired and replaced him on October 5, 2020. Robert Allen is no longer with the Provider and currently is employed by a different company, where he has been since November, 2020.
3. The letter filed with the appeals was not addressed to the Board, nor did it reference the filing of PRRB appeals. The letter was addressed to the Medicare Contractor, Noridian Healthcare Solutions, LLC, not the Board, and made no mention of PRRB appeals. The letter appointed QRS as its designated representative “with respect to the SSI Recalculation” for FYE 12/31/2013 and all years prior.²

Further, the Board made several findings that ultimately led to their dismissal of the case:

[T]hat QRS has not provided a representation letter from anyone at the Provider who is authorized to designate a case representative on behalf of the hospital . . . [and] the Provider did not authorize QRS as its representative for an appeal before the PRRB, the letter is only for a reopening request for SSI realignment with the Medicare Contractor.

The Board, therefore, found that the Representation Letter submitted with the appeal request was in violation of Board Rule 5.4.³ Additionally, the Board noted that the ACCD required an updated representation letter by February 7, 2025, and the Provider had failed to timely submit an updated letter of representation. Instead, QRS requested an extension the day before the deadline, the Board did not grant it, and as of the Board’s March 4 dismissal (nearly a month since the deadline given in the ACCD, and nearly 6 weeks from the Provider’s initial appeal), the Board had not received a Representation Letter in compliance with Board Rule 5.4.

Finally, the Board also found that the Provider was in violation of 42 C.F.R. § 405.1868(b) by failing to comply with Board rules and orders, an action that permits the Board to dismiss the appeal with prejudice under 42 C.F.R. § 405.1868(b)(1).

² Board Determination – Dismissal of Appeals at 2 (Mar. 4, 2025) (Footnotes omitted).

³ v. 3.2 (Dec. 2023).

Provider Representative's Reinstatement Request

On **March 17, 2025**, QRS submitted a request to reinstate the appeals. The position of QRS is that good faith efforts were made to obtain the required documentation and an extension was requested, stating: “due to circumstances beyond our control, including administrative turnover at the provider level, and the continuing disruption to QRS’s operations caused by the recent California wildfires, we were to obtain[] the authorization within the short, 14-day time period allotted to us.”⁴ QRS also argues the California wildfires should qualify as a good cause exception. Finally, QRS asserts that the dismissal is “unduly punitive”, as “the original representation letter was compliant with Board rules” and they submitted an updated Representation letter with their Reinstatement request.⁵

Board's Analysis and Decision:

Board Rule 47.1 addresses Motion[s] for Reinstatement and reads, in pertinent part:

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 . . . The Board will not reinstate an issue(s)/case if the provider was at fault.

In its dismissal, the Board found that QRS had not provided a representation letter from anyone at the Provider who is authorized to designate a case representative on behalf of the hospital. The Provider’s failure to submit an appeal with a representation letter that complied with Board rules and also, failing to comply within the *additional* 14 days that were granted to QRS for compliance with the Board’s order indicates fault. It is unclear who at the Provider requested QRS file the appeals on behalf of the Provider as the letter’s signatory did not work for Provider at the time the appeals were filed, and had not done so for over 4 years. Even after the appeal was filed QRS was not readily able to find anyone at the Provider to provide them an updated representation letter. Therefore, the Board declines to reinstate this issue.

While the Board acknowledges the impact of the wildfires, the Board finds their impact did not cause QRS to fail to submit these appeals in a timely fashion. Rather, in their reinstatement request, QRS cited “administrative turnover at the Provider” as a circumstance beyond their control. However, the Board has found that the authorizing official in the originally submitted representation letter had not been with the Provider *since 2020*. Therefore, QRS had 4.5 years to obtain a representation letter from an authorizing official, not 14 days (or at least 180 days from the August 14, 2024 publication from which the appeal was filed). Therefore, the Board finds there is no good cause for an exception.

As such, the Board declines to exercise its discretion and denies the request for reconsideration. Accordingly, the cases remain closed.

⁴ Provider’s Request for Reinstatement at 1 (Mar. 17, 2025).

⁵ *Id.* at 2.

Board Members Participating:

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

For the Board:

8/18/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA

Board Chair

Signed by: Kevin D. Smith -A

cc: Wilson C. Leong, Esq., Federal Specialized Services

Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)

APPENDIX A
Jurisdictional Challenges and Responses; Cases at Issue

On March 17, 2025, QRS filed a Request for Reinstatement of Appeals on behalf of Hollywood Presbyterian Medical Center (Prov. No. 05-0063) to the following twenty-six (26) cases which all share a common Medicare Contractor, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E):

Case No.	FYE
25-1616	6/30/1989
25-1619	6/30/1990
25-1622	6/30/1991
25-1625	6/30/1992
25-1628	6/30/1993
25-1630	6/30/1994
25-1632	6/30/1995
25-1633	6/30/1996
25-1634	6/30/1997
25-1636	6/12/1998
25-1637	5/31/1999
25-1639	5/31/2000
25-1640	5/31/2001
25-1642	5/31/2002
25-1643	5/31/2003
25-1644	5/31/2004
25-1646	12/31/2004
25-1647	12/31/2005
25-1649	12/31/2006
25-1650	12/31/2007
25-1652	12/31/2008
25-1653	12/31/2009
25-1654	12/31/2010
25-1656	12/31/2011
25-1657	12/31/2012
25-1658	12/31/2013



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*

Tennova Healthcare – Jefferson Memorial Hospital, Prov. No. 44-0056, FYE 09/30/2015
PRRB Case No. 21-1336

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 21-1336. 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.

Background

A. Procedural History for Case No. 21-1336

On **December 4, 2020**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end September 30, 2015.

On **May 7, 2021**, the Board received the Provider’s individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. SSI Percentage (Provider Specific)¹
2. SSI Percentage²
3. SSI Fraction Medicare Managed Care Part C Days³
4. SSI Fraction Dual Eligible Days⁴
5. Medicaid Eligible Days
6. Medicaid Fraction Medicare Managed Care Part C Days⁵
7. Medicaid Fraction Dual Eligible Days⁶

The Provider is commonly owned/controlled by Community Health Systems, Inc. (hereinafter “CHS”) and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1).

¹ Withdrawn August 12, 2025.

² On 12/14/2021, this issue was transferred to CIRP Group, Case No. 18-0552GC.

³ On 12/14/2021, this issue was transferred to CIRP Group, Case No. 17-1571GC.

⁴ On 12/14/2021, this issue was transferred to CIRP Group, Case No. 20-1234GC.

⁵ On 12/14/2021, this issue was transferred to CIRP Group, Case No. 17-1571GC.

⁶ On 12/14/2021, this issue was transferred to CIRP Group, Case No. 20-1234GC.

On **May 28, 2021**, 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 **December 30, 2021**, the Provider timely filed its preliminary position paper (hereafter, PPP). In the cover letter to the PPP, the Provider indicated all issues other than SSI Provider Specific & Eligible days had been transferred to groups. *The SSI Provider Specific was subsequently withdrawn.* With respect to Issue No. 5, the Provider "is seeking reimbursement for an additional 50 Medicaid eligible days with a reimbursement impact of \$28,834 (rounded to \$29,000).

On **April 22, 2022**, the Medicare Contractor ("MAC") filed its PPP in which it advised that a listing of eligible days had been requested from the Provider on February 11, 2022.⁸

On **January 7, 2025**, the Board issued a Notice of Hearing scheduling the case for a hearing on **September 12, 2025** and requiring final position papers be filed by the Parties.

On **March 7, 2025**, CHS requested that the representative be changed to Quality Reimbursement Services, Inc. ("QRS").

On **June 11, 2025**, QRS timely filed the final position paper, which included a statement that the Listing of Medicaid eligible days, which included section 1115 waiver days, was being sent under separate cover and that a redacted listing was attached. The 3-page redacted listing, which included 333 days, was titled "1115 Waiver and Additional ME Days Consolidated" and indicated "Listing pending finalization upon receipt of State eligibility data."⁹

On **July 10, 2025**, the MAC filed a second Jurisdictional Challenge. With regard the Medicaid eligible days issue the MAC contends the Provider failed to properly develop its arguments for the issue in its PPP and final PP per Rule 25. In addition, the Provider failed to submit an unredacted, auditable list of additional eligible days or any supporting documents or an explanation for why it cannot produce the documents. Finally, the MAC challenged the improper and untimely addition of the 1115 waiver days issue.¹⁰ On **July 10, 2025**, the MAC also timely filed a final position paper.

⁷ (Emphasis added.)

⁸ MAC PPP at 16. (April 22, 2022).

⁹ Provider Final Position paper at Exhibit P-1 (June 11, 2025).

¹⁰ The MAC reiterated its challenge over the SSI P/S issue as well, but the issue was subsequently withdrawn.

On **July 24, 2025**, QRS filed a Redacted Medicaid Eligible Days Listing titled “Additional ME & 1115 Waiver Days). The 3-page listing included 343 days.¹¹

On **July 26, 2025**, QRS filed a timely response to the MAC’s July 24, 2025 challenge in which it argued that the Provider had not abandoned the Medicaid eligible days issue as alleged by the MAC and that the 1115 waiver days, by definition, are part of Medicaid eligible days.

MAC’s Contentions Issue 5 – DSH Payment – Medicaid Eligible Days¹²

The MAC argues that the Provider abandoned the Medicaid eligible days issue when it failed to file complete preliminary and final position papers, including all supporting exhibits, to document the merits of its argument and failed to properly develop its argument within its position papers in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25 and 27. Alternatively, alternatively, the Provider failed to state its efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Section 1115 Waiver Days

Additionally, the MAC contends the Provider is attempting to untimely add the section 1115 waiver days issue as a sub-issue via its final position paper filed on June 11, 2025. The Provider originally characterized the Medicaid eligible days issue in its initial appeal request using the following language:

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.

Neither the appeal request, nor the PPP, identified or mentioned the Section 1115 waiver days issue. It was not until the final position paper submission that the Provider raised the issue – which was almost four years after the regulatory deadline to add a new issue to the case. Therefore, the MAC contends that the section 1115 waiver days issue should be dismissed on the grounds that it was untimely and improperly added to the case.¹³

Provider’s Jurisdictional Response

The Representative argued that, based on the August 2018 Rules in effect at the time of this appeal, “. . . a Final Position Paper is required for appeals filed prior to the effective date of Version 2.0.” Therefore, it was the Provider’s understanding that the deadline to provide the Medicaid eligible days listing was the Final Position Paper deadline.

¹¹ Both the listing submitted with the final pp and the one uploaded on 7/24/2025 were 3 pages. The one submitted as an exhibit to the final pp showed a total of 333 “1115 Waiver and Additional ME Days Consolidated” days, while the one uploaded in OH CDMS did not include a total. An autosum of the exported spreadsheet submitted on 7/24/2025 reflected the no. of days as 343.

¹² Since the SSI Provider Specific issue was withdrawn, only the Medicaid Eligible Days issue will be addressed.

¹³ Jurisdictional Challenge at 8-9 (July 10, 2025).

With regard to the MAC’s claim regarding the untimely addition of the section 1115 waiver days issue, QRS contends that this issue was addressed in the Provider’s May 7, 2021 appeal request¹⁴ based on the issue statement which stated:

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.

QRS contends that the phrase “including but not limited to” makes it clear that all Medicaid eligible days, including section 1115 waiver days were appealed.

QRS also disagrees with the MAC’s contention that the section 1115 waiver days issue was abandoned when it was not briefed in the preliminary position paper. QRS argues that the “. . . the Fifth Circuit ruled that the statute and CMS’s own regulations require that CMS regard inpatient days attributable to an uncompensated care pool population as Medicaid eligible days. *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019).” Based on this Court case, QRS contends that the Medicare Contractor “. . . is required by specific command of CMS to accept and audit the Provider’s section 1115 waiver days.”¹⁵

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 sole 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 case in either the initial appeal or the PPP.

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

¹⁴ QRS incorrectly referenced the appeal filing date as September 20, 2022.

¹⁵ Jurisdictional Responsive Brief at 5 (July 26, 2025).

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 PPP with all available documentation and gives the following instruction on the content of position papers:

Rule 25 Preliminary Position Papers¹⁷

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.

¹⁶ (Bold emphasis added.)

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

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 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 May 28, 2021 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider’s PPP 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.

¹⁸ (Emphasis added.)

On December 30, 2021, the Provider filed its PPP in which it indicated that 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 \$28,834 based 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.

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.

In its July 10, 2025 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid eligible days issue because: (1) the Provider failed to timely furnish documentation (e.g., a

¹⁹ Provider’s PPP at 8 (Dec. 30, 2021).

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 an unredacted, auditable list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2. The MAC 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 Board Rules.²⁰ In addition, the MAC argued the Provider was attempting to untimely and improperly add the section 1115 waiver days issue by including it in its final position paper submission.

On June 11, 2025 (almost 3.5 years after the PPP deadline), as an exhibit to its final position paper, QRS filed a Redacted Medicaid Eligible Days Listing.²¹ The 3-page exhibit, showing 333 Medicaid eligible days, included the caveat that the “Listing [is] pending finalization upon receipt of State eligibility data.”

On July 24, 2025, after being appointed the representative in Case No. 21-1336, QRS uploaded another copy of a Redacted Medicaid eligible days listing. This 3-page version did not include the caveat or the sum, but when totaled, included 343 Medicaid eligible days. Neither listing explained why the number of days included was over the initial 50 days the Provider claimed in its appeal, nor did it explain why they were being submitted at this late date or why the first listing submitted with the final position paper was not final (*i.e.*, why it was “pending finalization”), even though it was being filed ***more than 9 years after the fiscal year at issue had closed***. Regardless, these filings ***were more than 3 years past the deadline for including it with the Provider’s PPP*** for which the deadline was January 2, 2022.

The Board concurs with the MAC - 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).

The Board rejects the Provider’s attempts to include the eligible days listing submitted as an exhibit to its June 11, 2025 final position paper and the subsequent upload to OH CDMS on July 24, 2025 because:

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.

²¹ The listing was titled “1115 Waiver and Additional ME Days Consolidated.”

1. The exhibit and subsequent upload were filed **over 3 years after the deadline** for the exhibits to be included with the PPP filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)).
2. The position paper exhibit (and subsequent uploaded exhibit) fail to explain the following critical information: (a) *why* they were being filed so late (*i.e.*, upon what basis or authority should the Board accept the late filing); (b) *why* the listings of the roughly 333+ days were 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 nearly 4 years after this appeal was filed and more than 9 years after the fiscal year at issue had closed); and (c) why the listing provided as an exhibit to the position paper was **not** a “*final*” listing at that late date.
3. Neither the Board Rules, nor the May 28, 2021 Case Acknowledgment and Critical Due Dates notice, permit the Provider to file a “Supplement” to its PPP (nor did the Provider allege in the exhibit to the final position paper, or the subsequent upload, that they do).
4. Given that the *material* facts (*e.g.*, the days at issue) and all available exhibits were required to be part of the PPP filing, if the Board were to accept a “Supplement,” it would need to be either be a *refinement* of its PPP or a supplement of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the PPP, the final position paper exhibit, nor the subsequent listing uploaded by QRS, identified any “unavailable” exhibits consistent with Board Rule 25.2.2. Further, the final position paper exhibit (and additional upload) cannot be considered a refinement of the PPP since no specific days or listing were included with the PPP (indeed the *tentative* 333-343 days listed in the late exhibits are, without explanation, *significantly* larger than the original estimated 50 days included with the appeal request).²²
5. 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”²³ 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.

B. 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. 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 2021 and the regulations required the following:

²² 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.”

²³ (Emphasis added.)

(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

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

Common examples include: . . . ***Section 1115 waiver days (program/waiver specific).*** . . .²⁵

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.²⁶

²⁴ 42 C.F.R. § 405.1835(b).

²⁵ (Bold and italic emphasis added).

²⁶ See 73 Fed. Reg. 30190 (May 23, 2008).

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 properly or timely added the section 1115 waiver days issue to the case.

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, 2000.²⁷ 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 section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a section 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

²⁷ 65 FR 47054, 47087 (Aug. 1, 2000).

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 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 section 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 PPP filing. First, the Provider's PPP does not even mention section 1115 waiver days (much less 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 (Aug. 2018). 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* Section 1115 waiver days sub-issue.

Finally, even in the Provider's final position paper, the Provider fails to identify what section 1115 waiver program(s) are involved and whether or not the section 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 perfunctory in that it only makes cursory conclusions.²⁸ 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 (Aug. 2018) as applied via Board Rule 27.2.

²⁸ 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, CHS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is CHS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? CHS 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."

The Board’s finding that neither the appeal request nor the 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*.²⁹ 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 . . .”³⁰ 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.”³¹ 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.³² Here, the Board makes the same finding based on similar *overly generalized language*.

* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible Days (Issue 5). As no issues remain, the Board hereby closes Case No. 21-1336 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:

8/19/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Cecile Huggins, Palmetto GBA (J-J)
Wilson Leong, FSS

²⁹ No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

³⁰ *Id.* at *11.

³¹ *Id.*

³² *Id.*



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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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 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Groups***
25-2177GC *et al.* (See Attached Listing of 52 Cases)

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the “Board”) has reviewed the appeal requests in the 52 above-referenced cases. Set forth below is the decision of the Board to dismiss the above-captioned common issue related party (“CIRP”) group appeals. The pertinent facts and the Board’s determination are set forth below.

Introduction

Quality Reimbursement Services, Inc. (“QRS”) filed the above-referenced 52 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

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 inpatient prospective payment system (“IPPS”).² Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.³

¹ See e.g., Case No 25-2177GC, Providers’ Issue Statement at 1 (Feb. 7, 2025)

² See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

³ *Id.*

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.⁴ This case involves the hospital-specific disproportionate share hospital (“DSH”) adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that “serve [] a significantly disproportionate number of low-income patients.”⁵

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage (“DPP”).⁶ 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.⁷ The DPP is defined as the sum of two fractions expressed as percentages.⁸ Those two fractions are referred to as the “Medicare/SSI fraction” and the “Medicaid fraction.”

This matter concerns the Medicare/SSI fraction.⁹ 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 eligibility for and if eligible, the amount of any DSH payment adjustment.¹⁰ 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.

⁴ See 42 U.S.C. § 1395ww(d)(5).

⁵ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

⁶ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(l).

⁷ See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

⁸ See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

⁹ 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).

¹⁰ 42 C.F.R. § 412.106(b)(2)-(3).

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, which 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.”¹¹ 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”¹² 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 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.”¹³

Medicare Contractor Jurisdictional Challenge

The Medicare Contractor asserts that the Board does not have jurisdiction over the issue in these group appeals because “the appeal does not arise from a ‘final determination’ as that term is used

¹¹ CMS Transmittal 12747 at 3 (July 26, 2024).

¹² *Id.*

¹³ CMS Transmittal 12785 at 1 (Aug. 13, 2024).

in 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 1835(a) (as also cross-referenced in 42 C.F.R. § 405.1837(a)(1)).”¹⁴ The Medicare Contractor explains that the Providers appealed from Transmittal 12747 and/or Transmittal 12785, and argues that these documents are not appealable final determinations.¹⁵

The Medicare Contractor also argues that the court decisions the Provider referenced in their appeals are inapplicable to the instant appeals. The Medicare Contractor explains that the Providers recognized the Board’s previous dismissal of appeals from the publication of SSI percentages when they stated, in the original group issue statement:

The Provider [Group] is aware that the PRRB has taken the position that the publication of SSI Ratio is not a final determination and that providers must await a Notice of Program Reimbursement (NPR) setting its total reimbursement before challenging its Medicare Fraction, but the Provider [Group] respectfully submits that the PRRB is incorrect, as decided in two recent court decisions. *See Battle Creek Health Sys. v. Becerra*, Civil Action 17-0545 (CKK) (D.D.C. Oct. 31, 2023); *Baylor All Saints Med Ctr. v. Becerra*, Civil Action 4:24-cv-00432-P (N.D. TX Aug. 15, 2024).¹⁶

The Providers reiterated this statement, almost verbatim, in their response to the Medicare Contractor’s Jurisdictional Challenge.

The Medicare Contractor points to a prior Board decision in which it distinguished the decision in *Battle Creek* from the facts of the appeal before the Board, and argues that the Board should make a similar finding here with respect to the applicability of *Battle Creek* to these transmittal appeals.¹⁷ With respect to *Baylor All Saints*, the Medicare Contractor argues that “[b]ecause the Court failed to address the statutory requirements for Board jurisdiction, the Providers’ reliance on [the case] is without merit.”¹⁸

Last, the Medicare Contractor argues that even if the Transmittals constituted an appealable final determination, the appeals were not timely filed. The final determination support included for each Provider in these groups is a copy of either the July 26, 2024 CMS Transmittal 12747 or the August 13, 2024 Transmittal 12785, both of which implement the Medicare Part C final rule which was issued on June 9, 2023.¹⁹

¹⁴ Jurisdictional Challenge at 2.

¹⁵ *Id.*

¹⁶ *Id.* at 5.

¹⁷ *Id.* at 6.

¹⁸ *Id.*

¹⁹ *Id.*

Providers’ Jurisdictional Response

The Providers argue that the Board has jurisdiction over the appeals under the statute. According to the Provider:

Congress added romanette (ii) to section 1878(a)(1)(A) of the [Social Security] Act, to confer jurisdiction on the Board where a provider is “dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1886.”

The fundamental flaw in the PRRB’s conclusion that providers must wait to receive an NPR is that romanette (i) of section 1878(a)(1)(A) of the Act already requires an NPR for an intermediary determination. The PRRB’s approach renders romanette (II) superfluous. . .²⁰

With respect to the Medicare Contractor’s argument that the appeals were timely filed, the Providers argue that the CMS Transmittals in question in these appeals fall under the category of final determination in PRRB Rule 4.3.1, *not* PRRB Rule 4.3.2, as the Board found. In appeals from the same final determinations, the Board found that the Transmittal appeals were more analogous to a Federal Register notice, and therefore the date of receipt is the publication date, without a five (5) day mailing presumption. The Providers disagree and argue:

[T]he CMS Transmittals in question fall under the category listed in Board Rule 4.3.1, because the Rule does not specify that the ‘[o]ther determinations issued by CMS or its contractors with regard to the amount of total reimbursement due the provider...’ must be specific to ‘each respective provider’ for a CMS determination to be considered an appealable ‘[f]inal determination.’”²¹

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 Provider Group “is dissatisfied with this determination . . . the PRRB has jurisdiction over” this appeal.²² 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

²⁰ Jurisdictional Response at unnumbered page 2.

²¹ *Id.* at unnumbered pages 2-3.

²² *See e.g.* Case No 25-2177GC, Providers’ Issue Statement at 1.

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 52 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);²³ and second, where the provider is dissatisfied with a “final determination . . . as to the amount of the payment” under the prospective payment system.²⁴ 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 the publication of [Medicare/SSI Fraction data on CMS’ website] is not a final determination.”²⁵ But the Providers also note disagreement with the Board’s position, citing *Battle Creek Health Sys. v. Becerra*,²⁶ and *Baylor All Saints Med. Ctr. v. Becerra*,²⁷ 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.²⁸

For the Board, the court’s decision in *Battle Creek* is inapposite because, unlike in the instant cases, the challenged Transmittal and publication of data in that case was described by the court as being a “*fait accompli*.”²⁹ 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.’”³⁰ Yet, in the instant cases, the publication of the challenged 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*.³¹ The Board has maintained that *Memorial Hospital v. Becerra*³² 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 52 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

²³ 42 U.S.C. § 1395oo(a)(1)(A)(i).

²⁴ 42 U.S.C. § 1395oo(a)(1)(A)(ii).

²⁵ See e.g. Case No 25-2177GC, Providers’ Issue Statement at 1.

²⁶ 2023 WL 7156125 (D.D.C. Oct. 31, 2023), *appeal docketed*, No. (D.C. Cir. Dec. 29, 2023).

²⁷ 2024 WL 3833278 (N.D. Tex. Aug. 15, 2024), *appeal docketed*, No. 34-10934 (5th Cir. Oct. 17, 2024).

²⁸ See e.g. Case No 25-2177GC, Providers’ Issue Statement at 1.

²⁹ *Battle Creek*, 2023 WL 7156125 at *5.

³⁰ *Id.*

³¹ See, e.g., Board decisions in PRRB Case Nos. 24-0491, 24-1531GC, and 24-0413GC.

³² 2022 WL 888190 (D.D.C. Mar. 25, 2022).

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.’”³³ 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.”³⁴ 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).’”³⁵

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 that 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.³⁶ 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 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.”³⁷ Transmittal 12785 bears no connection to

³³ *Id.* at *8.

³⁴ *Id.* at *9.

³⁵ *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).”).

³⁶ 42 C.F.R. § 412.106(d)(2)(i)-(ii).

³⁷ See e.g. Case No 25-2177GC, Providers’ Issue Statement at 1. Although the Providers characterize 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

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."³⁸

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).³⁹ 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 which 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.

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.⁴⁰ Given the nature of the Groups' 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 on February 6th or 7th, 2025, nearly two weeks or more 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

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

³⁸ *See* 42 U.S.C. § 1395oo(a)(1)(A)(ii).

³⁹ *See* 42 U.S.C. § 1395oo(b); 42 C.F.R. § 405.1837(a)(3).

⁴⁰ *See also* 42 C.F.R. § 405.1835(a)(3)

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.

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 52 group appeals and removes them from the Board's docket.

Review of this determination may be available under the provision 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:

8/19/2025

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
Michael Redmond, Novitas Solutions, Inc. (J-H)

Listing of 52 Cases

25-2069GC	BS&W Health CY 1988 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2070GC	BS&W Health CY 1989 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2071GC	BS&W Health CY 1990 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2072GC	BS&W Health CY 1991 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2073GC	BS&W Health CY 1992 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2075GC	BS&W Health CY 1993 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2076GC	BS&W Health CY 1994 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2077GC	BS&W Health CY 1995 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2078GC	BS&W Health CY 1996 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2079GC	BS&W Health CY 1997 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2080GC	BS&W Health CY 1998 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2081GC	BS&W Health CY 1999 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2082GC	BS&W Health CY 2000 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2083GC	BS&W Health CY 2001 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2084GC	BS&W Health CY 2002 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2085GC	BS&W Health CY 2003 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2086GC	BS&W Health CY 2004 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2087GC	BS&W Health CY 2005 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2088GC	BS&W Health CY 2006 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2089GC	BS&W Health CY 2007 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2090GC	BS&W Health CY 2008 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2091GC	BS&W Health CY 2009 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2092GC	BS&W Health CY 2010 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2093GC	BS&W Health CY 2011 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2094GC	BS&W Health CY 2012 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2095GC	BS&W Health CY 2013 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2096GC	BS&W Health CY 2014 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2142GC	Houston Methodist CY 1988 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2143GC	Houston Methodist CY 1989 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2144GC	Houston Methodist CY 1990 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2145GC	Houston Methodist CY 1991 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2146GC	Houston Methodist CY 1992 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2147GC	Houston Methodist CY 1993 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2149GC	Houston Methodist CY 1994 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2150GC	Houston Methodist CY 1995 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2152GC	Houston Methodist CY 1996 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2153GC	Houston Methodist CY 1997 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2155GC	Houston Methodist CY 1998 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group

25-2156GC	Houston Methodist CY 1999 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2157GC	Houston Methodist CY 2000 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2158GC	Houston Methodist CY 2001 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2161GC	Houston Methodist CY 2002 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2162GC	Houston Methodist CY 2003 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2163GC	Houston Methodist CY 2004 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2164GC	Houston Methodist CY 2005 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2165GC	Houston Methodist CY 2006 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2167GC	Houston Methodist CY 2007 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2173GC	Houston Methodist CY 2010 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2174GC	Houston Methodist CY 2011 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2175GC	Houston Methodist CY 2012 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2176GC	Houston Methodist CY 2013 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2177GC	Houston Methodist CY 2014 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Robert Roth, Esq.
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RE: ***Expedited Judicial Review Determination***
Westerly Hospital (Provider Number 41-0013)
FYE: 12/31/2018
Case Number: 20-1696

Dear Mr. Roth:

The Provider Reimbursement Review Board (“Board”) has reviewed the Provider’s request for expedited judicial review (“EJR”) filed on July 30, 2025, in the above-referenced appeal. The Board’s decision on jurisdiction and EJR is set forth below.

Issue:

The issue presented in this appeal and which underlies the Request for EJR is:

Whether the MAC’s November 22, 2019 decision properly denied the Hospital’s October 4, 2019 request for MDH classification.¹

Statutory and Regulatory Background:

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates² known as the Inpatient Prospective Payment System (“IPPS”). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (“DRGs”). The base payment rate is comprised of a standardized amount for all subsection (d) hospitals located in “urban” or “rural” labor market areas.³ 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. There is also a mechanism for the geographic reclassification of hospitals to another labor market area in accordance with 42

¹ Request for Expedited Judicial Review at 1 (July 30, 2025).

² 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).

³ 42 U.S.C. § 1395ww(d)(2)(A)-(D).

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U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).⁴ Beginning in 2000, hospitals located in urban areas have been permitted to apply for reclassification as rural via the process set forth in 42 C.F.R. § 412.103.⁵

Medicare-dependent, small rural hospitals (“MDHs”) are eligible for a special payment adjustment under the IPPS.⁶ Section 6003(f) of the Omnibus Budget Reconciliation Act of 1989⁷ established this payment adjustment and also amended Section 1886(d)(5) to the Social Security Act (codified at 42 U.S.C. 1395ww(d)(5)) to add subparagraph (G) (which includes the definition of an MDH) for cost reporting periods beginning on or after April 1, 1990.

The MDH payment adjustment originally applied to cost reporting periods beginning on or after April 1, 1990 and ending before March 31, 1993,⁸ but was later extended through discharges occurring before October 1, 1994.⁹ The adjustment expired but was later reinstated for cost reporting period beginning on or after October 1, 1997 and before October 1, 2001.¹⁰ When reinstated, the implementing statute did not revise the qualifying criteria for MDH hospitals.¹¹ The MDH payment adjustment has been continuously extended since its reinstatement, and is applicable to qualifying hospitals for the cost reporting period at issue in this case.¹²

The statute establishing the MDH payment (42 U.S.C. § 1395ww(d)(5)(G)(iv)) originally defined MDHs as those hospitals:

- (I) located in a rural area,
- (II) that has not more than 100 beds,
- (III) that is not classified as a sole community hospital . . . ,
- (IV) for which not less than 60 percent of its inpatient days or discharges during the cost reporting period beginning in fiscal year 1987 were attributable to inpatients entitled to benefits under Part A.¹³

⁴ <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index> (last visited Aug. 20, 2025).

⁵ Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. 106-113 § 401(a), 113 Stat. 1501A-321, 1501A-369 (Nov. 29, 1999); 65 Fed. Reg. 47026, 47029-47030 (Aug. 1, 2000).

⁶ See 42 U.S.C. § 1395ww(b)(3)(D); see also 65 Fed. Reg. 47026, 47031 (Aug. 1, 2000).

⁷ Pub. Law 101-239, 103 Stat. 2106, 2144-2145 (Dec. 19, 1989).

⁸ 55 Fed. Reg. at 15154 (42 U.S.C. § 1395ww(d)(5)(G)(i)).

⁹ Omnibus Budget Reconciliation Act of 1993, Pub. Law 103-66 § 13501(e)(1), 107 Stat. 312, 575-576 (Aug. 10, 1993).

¹⁰ Balanced Budget Act of 1997 § 4204(a), 111 Stat. 251, 375 (Aug. 5, 1997); see also 62 Fed. Reg. 45966, 46000 (Aug. 29, 1997).

¹¹ See *id.*

¹² See, e.g., Bipartisan Budget Act of 2018, Pub. L. 115-123, § 50205(a), 132 Stat. 64, 182 (Feb. 9, 2018) (“BBA 2018”) (extending the MDH payment adjustment for discharges prior to October 1, 2017 to those occurring before October 1, 2022).

¹³ Pub. Law 101-239, 103 Stat. at 2144 (42 U.S.C. § 1395ww(d)(5)(G)(iv)).

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In 1990, following the statutory establishment of the MDH payment adjustment, the Secretary promulgated 42 C.F.R. § 412.108 to conform with the statutory definition of an MDH and noted that “[t]he term ‘rural area’ will be defined as it is for all other prospective payment special adjustments, that is, any area outside an urban area as provided under § 412.63(b). Thus, a hospital in a rural county that is redesignated as urban under section 1886(d)(8)(C) of the Act would not be considered to be located in a rural area for the purposes of eligibility as an MDH.”¹⁴

In 2018, Congress amended the definition of an MDH to mean any hospital:

- (I) located in –
 - aa. a rural area; or
 - bb. a State with no rural area (as defined by paragraph (2)(D)) and satisfies any of the criteria in subclause (I), (II), or (III) of paragraph (8)(E)(ii),¹⁵**
- (II) that has not more than 100 beds,
- (III) that is not classified as a sole community hospital . . . ,
- (IV) for which not less than 60 percent of its inpatient day for discharges during the cost reporting period beginning in fiscal year 1987 were attributable to inpatients entitled to benefits under Part A.¹⁶

Thus, a hospital in a State with no rural area (an “all-urban” state) qualifies as an MDH if it meets any of the following criteria set forth in 42 U.S.C. § 1395ww(d)(8)(E)(ii)(I-III):

- (I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).
- (II) The hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).¹⁷**
- (III) The hospital would qualify as a rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.

42 C.F.R. § 412.108 was subsequently amended so that hospitals could qualify for MDH status if they are located in a rural area, **or** if they satisfy the criteria under 42 C.F.R. § 412.103(a)(1) or

¹⁴ 55 Fed. Reg. 15150, 15154 (Apr. 20, 1990).

¹⁵ (Emphasis added).

¹⁶ Bipartisan Budget Act of 2018, Pub. L. 115-123, § 50205(a), 132 Stat. 64, 182 (Feb. 9, 2018).

¹⁷ (Emphasis added).

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(3) or under § 412.103(a)(2) as of January 1, 2018.¹⁸ This effectively expanded the definition to permit MDH classification for certain hospitals in states with no “rural” area.¹⁹ Indeed, 42 U.S.C. 1395ww(d)(8)(E) permits a hospital located in an urban area to be reclassified, and treated, “as being located in the rural area of the state in which it is located.”²⁰ Prior to 2018, hospitals in all urban-area states (*i.e.*, states which did not have a rural area) could not reclassify into a rural area and were thus ineligible for MDH classification.²¹

The relevant criteria set forth in 42 C.F.R. § 412.103(a) have not changed in any material way since its promulgation, and state, in pertinent part:

- (a) General Criteria. A prospective payment hospital that is located in an urban area (as defined in subpart D of this part) 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:

- 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.**²²

Provider’s Position:

The Provider sent a request for Urban MDH classification in a letter to the Medicare Contractor.²³ In that request, the Provider explained that the Rhode Island Department of Health considers it to be a rural hospital.²⁴ On **November 22, 2019**, the Medicare Contactor denied the request stating:

In promulgating regulations to implement section 401(a) of Public Law 106-113, which allowed the reclassification of certain urban hospitals as rural hospitals, CMS made clear that if a hospital is seeking to reclassify as rural under § 412.103(a)(2) on the basis

¹⁸ 42 C.F.R. § 412.108(a)(1)(i) (2018).

¹⁹ See 83 Fed. Reg. 20164, 20401-20402 (May 7, 2018).

²⁰ *Id.* at 20402.

²¹ *Id.*

²² (Emphasis added).

²³ Provider’s Preliminary Position Paper (“Provider’s PPP”) at 2, *see also*, Ex. P-2 (Jan. 14, 2021). The Provider also sent a letter directly to the Boston Regional Office of the Centers for Medicare & Medicaid Services, but claims it received no response. *See* Provider’s PPP at 2-3, Ex. P-2 at 6-7, and Ex. P-5.

²⁴ Ex. P-2 at 6 & Attachment B (“RIDOH has long considered Westerly Hospital to be a rural hospital because it is located in the Town of Westerly, which the State and RIDOH consider to be a rural town”).

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that it is designated by the State as a rural hospital, the hospital's designation as a rural hospital must be in the form of either state law or regulation. In the August 1, 2000 final rule, we stated the following:

Additionally, section 401(a) of Public Law 106-113 includes hospitals * * * located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital)." We are requiring that a hospital's designation as rural be in the form of either State law or regulation if it is the basis for a hospital's request for urban to rural reclassification under section 1886(d)(8)(E) of the Act. We believe this will help ensure that the provision is implemented consistently among States. (65 FR 47029)

We have reviewed the supporting documentation you provided and we do not consider the materials you submitted as meeting the requirements of § 412.103(a)(2). Specifically, those materials do not reflect any designation by State law or regulation of the hospital as a rural hospital, or the area in which the hospital is located as a rural area.²⁵

On **May 13, 2020**, the Medicare Contractor reiterated that the denial of Provider's MDH status was because "[t]he documents do not reflect any designation by State law or regulation of the hospital as a rural hospital, or the area in which the hospital is located as a rural area."²⁶

The Hospital argues that it has "met all criteria for classification as an MDH in the applicable statute, 42 U.S.C. § 1395ww(d)(5)(G)."²⁷ The Provider argues that this statute only requires a hospital "is designated by such State as a rural hospital" and does not require such designation to be included in a "State law or regulation."²⁸ It continues, "[t]he added requirement in 42 C.F.R. § 412.103(a)(2), that the Hospital is designated as a rural hospital 'by State law or regulation,' cannot be used to deny the Hospital's MDH classification request because it conflicts with the plain reading of the governing statute."²⁹ It also argues that the Federal Register language cited by the Medicare Contractor was published in 2000, and this preamble could not interpret a statute expanding rural reclassification for hospitals in all-urban states that was not implemented by Congress until 2018.³⁰

²⁵ Provider's PPP, Ex. P-1.

²⁶ Provider's PPP, Ex. P-7 at 1.

²⁷ Provider's PPP at 10.

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.* at 14.

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In its **July 30, 2025** Request for EJR, the Provider argues that the Medicare Contractor's "reliance on 42 C.F.R. § 412.103(a)(2) to deny the Hospital's MDH classification request is unlawful because (a) 42 C.F.R. § 412.103(a)(2) conflicts with the plain meaning of BBA § 50205, and (b) as a matter of law, BBA § 50205, which is a statute, overrides 42 C.F.R. § 412.103(a)(2), which is a regulation."³¹ Since the Board is bound to apply the regulation as written and cannot deem it invalid, the Provider is requesting the Board grant EJR in this case.³²

Medicare Contractor's Position:

The Medicare Contractor insists that "an application from a hospital seeking reclassification from urban to rural under qualification by State designation must include a copy of the State law or regulation that verifies the rural status of the hospital."³³ While the Provider submitted a letter which it argues is from "the State of Rhode Island, acting through the [Rhode Island Department of Health]" indicating it is considered a rural hospital, that letter "does not satisfy the requirement that the application be submitted in a 'form and manner determined by the Secretary' as described at 42 U.S.C. § 1395ww(d)(8)(E)(i)."³⁴ It notes that § 50205 of BBA 2018 merely permits a hospital in an all-urban state to reclassify as rural if it meets the criteria set forth in 42 U.S.C. § 1395ww(d)(8)(E)(ii) as written; it did not amend § 1395ww(d)(8)(E)(ii) for these (or any other) hospitals. It argues that the rural designation requirements at 42 U.S.C. § 1395ww(d)(8)(E) were amended in 1999 and 42 C.F.R. § 412.103 was promulgated in 2000. At that time, "CMS indicated that the hospital's application for MDH classification must include a copy of the State law or regulation that verifies either that the requesting hospital is situated in an area designated rural by the State or that the hospital has been designated as a rural hospital."³⁵

While it disputes the merits of the Provider's argument in its Position Papers, the Medicare Contractor's **August 4, 2025** Response to the Request for EJR states:

Federal Specialized Services ("FSS"), as representative for the Medicare Administrative Contractor ("MAC"), responds to the Providers' request for Expedited Judicial Review (EJR) and notes that no substantive claim challenge has been filed, no jurisdictional challenge has been filed and the MAC does not oppose the request for EJR.³⁶

³¹ Request for Expedited Judicial Review at 2.

³² *Id.* at 7.

³³ MAC's Preliminary Position Paper ("Contractor's PPP") at 9 (Apr. 30, 2021) (citing 65 Fed. Reg. 47026, 47030 (Aug. 1, 2020) (copy at Ex. C-8)).

³⁴ *Id.* at 9-10.

³⁵ *Id.* at 11.

³⁶ Response to Provider's Request for EJR at 1 (Aug. 4, 2025).

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Decision of the Board:

The Provider has filed an appeal involving its FYE December 31, 2018, based on its appeal from both the denial of MDH status and its NPR.

A. Jurisdiction and Request for EJR

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.

An individual Provider generally has a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if

- It is dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing 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 issue a final determination;³⁷ and
- The amount in controversy is \$10,000 or more.³⁸

As previously noted, the Provider is filing its appeal from both the denial of MDH status and its NPR. The Board has determined that (1) the Provider’s documentation shows that the estimated amount in controversy exceeds \$10,000, as required for an individual appeal;³⁹ (2) the appeal was timely filed; and (3) Board review of the matter in these appeals is not precluded by statute or regulation. In finding that the Provider meets the \$10,000 amount in controversy, the Board recognizes that the Group Representative has explained that the amount in controversy (“AiC”) calculation is based on the estimated IPPS payments for the period at issue, plus the MDH add-on, which is 75% of the difference between the Provider’s hospital specific rate (estimated utilizing the FY 2002 NPR cost report updated through FFY 2020) and its total federal payments. This AiC unmistakably demonstrates that the Provider more than clears the minimum \$10,000 AiC hurdle. Based on the above, the Board finds that it has jurisdiction over the Provider in this case for the issue for which EJR is sought. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

³⁷ 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).

³⁸ 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.

³⁹ *See* 42 C.F.R. §§ 405.1835(a)(2), 405.1839(a)(1).

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B. Application of 42 C.F.R. §§ 405.1873 and 413.24(j)

1. Regulatory Background

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 405.1873 and 413.24(j) are applicable. The regulation 42 C.F.R. § 413.24(j) requires that:

(1) *General Requirement.* 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.⁴⁰

⁴⁰ (Bold and underline emphasis added.)

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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.

(b) *Summary of Procedures.*

(2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .

(d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*

(2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .

(e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*

(1) Board jurisdictional dismissal decision. **If the Board issues a jurisdictional dismissal decision** regarding the specific item under appeal (pursuant to § 405.1840(c)), **the Board's specific findings of fact and conclusions of law** (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost

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report included an appropriate claim for the specific item, **must not be included in such jurisdictional dismissal decision.**⁴¹

These regulations are applicable to the cost reporting period in this individual case.

2. Appropriate Cost Report Claims: Findings of Fact and Conclusions of Law

As explained above, at issue in this appeal is a cost reporting period beginning after January 1, 2016, which is subject the regulations on the “substantive reimbursement requirement” for an appropriate cost report claim.⁴² The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board’s findings with regard to whether or not a provider “include[d] in its cost report an appropriate claim for the *specific* item [under appeal] (as prescribed in § 413.24(j))”⁴³ may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law as to whether an appropriate claim was included.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider’s “compliance”⁴⁴ 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.⁴⁵ In this case, the Medicare Contractor specifically noted it did not intend to file a Substantive Claim Challenge.⁴⁶

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,⁴⁷ 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).

⁴¹ (Bold and underline emphasis added.)

⁴² 42 C.F.R. § 413.24(j) (entitled “Substantive reimbursement requirement of an appropriate cost report claim”). *See also* 42 C.F.R. § 405.1873 (entitled “Board review of compliance with the reimbursement requirement of an appropriate cost report claim”).

⁴³ (Emphasis added.)

⁴⁴ 42 C.F.R. § 405.1873 is entitled “Board review of compliance with the reimbursement requirement of an appropriate cost report claim.”

⁴⁵ *See* 42 C.F.R. § 405.1873(a),

⁴⁶ 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.”

⁴⁷ 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.”

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C. Analysis Regarding Appealed Issue

42 U.S.C. § 1395ww(d)(5)(G)(iv)(I)(bb) allows reclassification of an urban hospital to a rural hospital if, among other criteria, it is located in “a State with no rural area . . . and satisfies any of the criteria in subclause (I), (II), or (III) of paragraph (8)(E)(ii).” 42 U.S.C.

§ 1395ww(d)(8)(E)(ii)(II) permits the reclassification if “[t]he hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).” The statute does not specify how a State may “designate” a hospital as a rural hospital other than by law or regulation.

The Provider has a letter from the Rhode Island Department of Health indicating that it considers the Provider to be a rural hospital. The Medicare Contractor argues this is insufficient, and that the plain language of *the regulation* at 42 C.F.R. § 412.103(a) requires the designation be made via State law or regulation. It supports its argument with an explanation in the preamble to the Federal Register, published in 2000, promulgating § 412.103.⁴⁸

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the regulation at 42 C.F.R. § 412.103(a), as written, which requires the rural designation be made via State law or regulation. The Board does not have the authority to grant the relief sought by the Provider, namely invalidating the requirement that the rural designation be made via State law or regulation as impermissibly conflicting with the statute at 42 U.S.C.

§ 1395ww(d)(8)(E)(ii)(II) (in conjunction with § 1395ww(d)(5)(G)(iv)(I)(bb)). As a result, the Board finds that EJRs are appropriate for the issue and fiscal year under appeal in this case.

D. Board’s Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the MDH Classification Denial issue for the subject year in this case and that the Provider is entitled to a hearing before the Board;
- 2) While the Provider appealed a cost reporting period beginning after January 1, 2016, no substantive claim challenge⁴⁹ has been filed pursuant to 42 C.F.R. § 405.1873(a) to trigger either Board review under § 405.1873(b) or reporting under § 405.1873(d)(2);
- 3) Based upon the Provider’s assertions regarding its denial of MDH status and the application of 42 C.F.R. § 412.103(a), there are no findings of fact for resolution by the Board;

⁴⁸ Contractor’s PPP at 11.

⁴⁹ As the Board explained in Board Rule 44.5, “[t]he 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.”

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- 4) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867);
and
- 5) It is without the authority to decide the legal question of whether the regulation at 42 C.F.R. § 412.103(a) is valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.103(a), as applied with 42 U.S.C. § 1395ww(d)(8)(E)(ii)(II) (in conjunction with § 1395ww(d)(5)(G)(iv)(I)(bb)) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for EJR for the issue and subject year.

The Provider has 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 this case, the Board hereby closes the case and removes it from its docket.

Board Members Participating:

Kevin D. Smith, CPA

Ratina Kelly, CPA

Nicole E. Musgrave, Esq.

Shakeba DuBose, Esq.

FOR THE BOARD:

8/20/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA

Board Chair

Signed by: Kevin D. Smith -A

cc: Danelle Decker, National Government Services, Inc. (J-K)
Scott Berends, Esq., Federal Specialized Services



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*

Baylor Scott & White Medical Center – Garland, Prov. No. 45-0280, FYE 12/31/2016
PRRB Case No. 21-0308

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 21-0308. 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.

Background

A. Procedural History for Case No. 21-0308

On **May 28, 2020**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end December 31, 2016.

On **October 29, 2020**, the Board received the Provider’s individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

1. SSI Percentage (Provider Specific)
2. SSI Percentage
3. SSI Fr. Medicare Managed Care Part C Days
4. SSI Fraction Dual Eligible Days
5. Medicaid Eligible Days
6. Medicaid Fr. Managed Care Part C Days
7. Medicaid Fraction Dual Eligible Days
8. 2 Midnight Census IPPS Payment Reduction
9. Standardized Payment Amount

The Provider is commonly owned/controlled by Baylor Scott & White Health (hereinafter “BS&W”) and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **May 24, 2021**, the Provider transferred issues 2, 3, 4, 6, 7 and 9 to BS&W CIRP Groups. Issue #1 was withdrawn on August 12th, 2025 and issue #8 was withdrawn on July 9, 2021, leaving issue #5.

On **December 2, 2020**, 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 25.¹*

On **June 25, 2021**, the Provider timely filed its preliminary position paper (*hereafter* "PPP"). In the cover letter to the PPP, the Provider withdrew the 2 Midnight Census IPPS Payment Reduction issue (No. 8) (which the Board acknowledged on July 9, 2021.) The Provider briefed the two remaining issues: SSI Provider Specific and Medicaid Eligible Days, however the SSI Provider Specific issue was subsequently withdrawn. With respect to Issue No. 5, the Provider indicated that an Eligibility Listing was being sent under separate cover. It included the original calculation support filed with the appeal in which it is seeking reimbursement for an additional 50 Medicaid eligible days with a reimbursement impact of \$32,456.

On **September 30, 2021**, the Medicare Contractor ("MAC") filed its PPP.

On **May 9, 2023**, BS&W requested a change of representative to Quality Reimbursement Services, Inc. ("QRS"). On **May 10, 2023**, QRS was made the representative.

On **January 31, 2025**, the Board issued a Notice of Hearing scheduling the case for a hearing on **September 22, 2025** and requiring final position papers be filed by the Parties.

On **June 21, 2025**, QRS timely filed its final position paper, which included a statement that the Listing of Medicaid Eligible days, which included Section 1115 waiver days, was being sent under separate cover and that a redacted listing was attached (Exhibit P-1). The eighteen-page redacted listing, which included 2,782 days, was titled "1115 Waiver and Additional ME Days Consolidated" and indicated "Listing pending finalization upon receipt of State eligibility data."

On **July 22, 2025**, the MAC timely filed a final position paper and noted that the Provider had not yet supplied an auditable eligible days listing and claimed the Provider was attempting to improperly add the Section 1115 Waiver days.

On **July 30, 2025**, the MAC filed a formal Jurisdictional Challenge over the Medicaid eligible days issue. The MAC contends the Provider failed to file complete PPP & final PPs including all

¹ (Emphasis added.)

support per 42 CFR 405.1853(b)(2) and Rules 25 & 27. In addition, the MAC indicated the Provider failed to provide an auditable listing of days or an explanation as to why it cannot produce the documents. Finally, the MAC argued the Provider is untimely and improperly attempting to add the 1115 waiver days issue to the appeal via its final position paper filing.

On **August 12, 2025**, QRS filed a 17-page Redacted Medicaid Eligible Days listing in OH CDMS.²

On **August 13, 2025**, QRS filed a timely response to the MAC's July 30, 2025 challenge in which it argued the 1115 waiver days are part of the eligible days issue that was included in the initial appeal and that it had not abandoned the issue as alleged by the MAC. QRS also advised that an unredacted listing to the MAC (purportedly on the same date it filed the redacted listing in the supplemental (*final*) position paper).

MAC's Contentions Issue 5 – DSH Payment – Medicaid Eligible Days³

The MAC argues that the Provider abandoned the Medicaid eligible days issue when it failed to file complete preliminary and final position papers, including all supporting exhibits, to document the merits of its argument and failed to properly develop its argument within its position papers in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25 and 27. Alternatively, the Provider failed to state its efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Section 1115 Waiver Days

Additionally, the MAC contends the Provider is attempting to untimely add the section 1115 waiver days issue as a sub-issue via its final position paper filed on June 21, 2025. The Provider originally characterized the Medicaid eligible days issue in its initial appeal request using the following language:

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.

Neither the appeal request, nor the PPP, identified or mentioned the section 1115 waiver days issue. It was not until the final position paper submission that the Provider raised the issue – which was more than four years after the regulatory deadline to add a new issue to the case. Therefore, the MAC contends that the section 1115 waiver days issue should be dismissed on the grounds that it was untimely and improperly added to the case.⁴

² When the listing was extracted and auto-summed, the total no. of days shows 2768.

³ Since the SSI Provider Specific issue was withdrawn, only the Medicaid Eligible Days issue will be addressed.

⁴ Jurisdictional Challenge at 10 (July 30, 2025).

Provider's Jurisdictional Response

In its jurisdictional response, the Provider only responds to the MAC's challenge over the section 1115 waiver days issue. The Provider argues that the phrasing of its issue statement with respect to the Medicaid eligible days issue makes clear that the Provider appealed all Medicaid eligible days, including section 1115 waiver days. Whereas the MAC states that the section 1115 waiver days issue is one component of the DSH issue, 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 "sub-issues" or "components" of an issue. The Provider references both a June 25, 2004 proposed rule (69 *Fed. Reg.* 35716) and a May 23, 2008 final rule (73 *Fed. Reg.* 30190) which 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." The Provider asserts "[t]here is no dispute that the same cost report adjustment that affects other types of Medicaid eligible days also affects section 1115 waiver days." ⁵

The Provider goes on to claim that the version of Board Rule 8 (July 1, 2015) that was effective when the Provider filed its appeal, makes no mention of "section 115 waiver days" nor even "Medicaid eligible days." 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 a denial of due process for the PRRB to dismiss the section 1115 waiver days component of its appeal of Medicaid eligible days. ⁶

Finally, with regard to the MAC's challenge that the section 1115 waiver days issue was abandoned because it was not briefed in the PPP, the Provider argues that, prior to its final position paper,

. . . the Fifth Circuit ruled that the statute and CMS's own regulations require that CMS regard inpatient days attributable to an uncompensated care pool population as Medicaid eligible days. *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019)." The Medicare Contractor is required by specific command of CMS to accept and audit the Provider's section 1115 waiver days in providers' Medicaid Fractions. Following a string of litigation defeats, including those in *Forrest General Hospital* and *Bethesda Health, Inc. v. Azar*, 980 F.3d 121 (D.C. Cir.2020), CMS issued Change Request 12669, Transmittal No. 11912 (March 16, 2023).

The Provider asserts that under this Transmittal, the MAC is required to accept and audit the Provider's listing of section 1115 days. The Provider states that it submitted an unredacted listing to the MAC as a supplement to its final position paper on August 12, 2025.⁷

⁵ Provider's jurisdictional response at 2-3 (Aug. 13, 2025).

⁶ Id at 3.

⁷ Jurisdictional Responsive Brief at 4 (Aug. 13, 2025).

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 sole 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 case in either the initial appeal or the PPP.

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.⁸

⁸ (Bold emphasis added.)

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 PPP with all available documentation and gives the following instruction on the content of position papers:

Rule 25 Preliminary Position Papers⁹

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

⁹ (Underline emphasis added to these excerpts and all other emphasis in original.)

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 December 2, 2020 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP 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.¹⁰

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 June 25, 2021, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.¹¹ 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 \$32,456 based 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.

¹⁰ (Emphasis added.)

¹¹ Provider’s PPP at 8 (June 25, 2021).

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 July 30, 2025 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid eligible days issue 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 an unredacted, auditable list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2. The MAC 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 Board Rules.¹² In addition, the MAC argued the Provider was

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.

attempting to untimely and improperly add the section 1115 waiver days issue by including it in its final position paper submission.

On June 21, 2025 (almost 4 years after the PPP deadline), as an exhibit to its final position paper, QRS filed a Redacted Medicaid Eligible Days Listing.¹³ The 18-page exhibit, showing 2,782 Medicaid eligible days, included the caveat that the “Listing [is] pending finalization upon receipt of State eligibility data.”

On August 12, 2025, QRS uploaded another copy of a redacted Medicaid eligible days listing. This 17-page version did not include the caveat or the sum, but when extracted and totaled, it included 2,768 days. Neither listing explained why the number of days included was over the initial 50 days the Provider claimed in its appeal, nor did it explain why they were being submitted at this late date or why the listing submitted as an exhibit with the final position paper was not final (*i.e.*, why it was “pending finalization”), even though it was being filed ***more than 8.5 years after the fiscal year at issue had closed***. Regardless, these filings ***were more than 4 years past the deadline for including it with the Provider’s PPP*** for which the deadline was June 26, 2021.

The Board concurs with the MAC - 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).

The Board rejects the Provider’s attempts to include the eligible days listing submitted as an exhibit to its June 21, 2025 final position paper and the subsequent upload to OH CDMS on August 12, 2025 because:

1. The exhibit and subsequent upload were filed ***4 years after the deadline*** for the exhibits to be included with the PPP filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)).
2. The position paper exhibit (and subsequent uploaded exhibit) fail to explain the following critical information: (a) *why* they were being filed so late (*i.e.*, upon what basis or authority should the Board accept the late filing); (b) *why* the listings of the roughly 2,700+ days were 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 nearly 5 years after this appeal was filed and more than 8.5 years after the fiscal year at issue had closed); and (c) why the

¹³ The listing was titled “1115 Waiver and Additional ME Days Consolidated.”

listing provided as an exhibit to the position paper was **not** a “*final*” listing at that late date.

3. Neither the Board Rules, nor the December 2, 2020 Case Acknowledgment and Critical Due Dates notice, permit the Provider to file a “Supplement” to its PPP (nor did the Provider allege in the exhibit to the final position paper, or the subsequent upload, that they do).
4. Given that the *material* facts (e.g., the days at issue) and all available exhibits were required to be part of the PPP filing, if the Board were to accept a “Supplement,” it would need to be either be a *refinement* of its PPP or a supplement of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the PPP, the final position paper exhibit, nor the subsequent listing uploaded by QRS, identified any “unavailable” exhibits consistent with Board Rule 25.2.2. Further, the final position paper exhibit (and additional upload) cannot be considered a refinement of the PPP since no specific days or listing were included with the PPP (indeed the *tentative* 2,768 - 2,782 days listed in the late exhibits are, without explanation, *significantly* larger than the original estimated 50 days included with the appeal request).¹⁴
5. 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”¹⁵ 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.

B. 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. 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 2020 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...

¹⁴ 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.”

¹⁵ (Emphasis added.)

(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...¹⁶

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

Common examples include: . . . ***Section 1115 waiver days (program/waiver specific)***. . .¹⁷

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.¹⁸

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

¹⁶ 42 C.F.R. § 405.1835(b).

¹⁷ (Bold and italic emphasis added).

¹⁸ See 73 Fed. Reg. 30190 (May 23, 2008).

(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 properly or timely added the section 1115 waiver days issue to the case.

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, 2000.¹⁹ 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 section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a section 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

¹⁹ 65 FR 47054, 47087 (Aug. 1, 2000).

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 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 section 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 PPP filing. First, the Provider's PPP does not even mention section 1115 waiver days (much less 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 (Aug. 2018). 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* Section 1115 waiver days sub-issue.

Finally, even in the Provider's final position paper, the Provider fails to identify what section 1115 waiver program(s) are involved and whether or not the section 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 perfunctory in that it only makes cursory conclusions.²⁰ 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 (Aug. 2018) as applied via Board Rule 27.2.

²⁰ 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, CHS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is CHS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? CHS 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."

The Board’s finding that neither the appeal request nor the 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*.²¹ 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 . . .”²² 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.”²³ 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.²⁴ Here, the Board makes the same finding based on similar *overly generalized language*.

* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible Days (Issue No. 5). As no issues remain, the Board hereby closes Case No. 21-0308 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:

8/20/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

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

²² *Id.* at *11.

²³ *Id.*

²⁴ *Id.*



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

Byron Lamprecht
WPS Government Health Administrators
1000 N. 90th Street, Suite 302
Omaha, NE 68114-2708

RE: ***Board Decision –Medicaid Eligible Days Issue***
Longview Regional Medical Center (Provider Number 45-0702)
FYE: 09/30/2015
Case Number: 19-0653

Dear Mr. Ravindran and Mr. Lamprecht,

The Provider Reimbursement Review Board (“Board”) has reviewed the documentation in the above referenced appeal. The decision of the Board is set forth below.

Background:

A. Procedural History for Case No. 19-0653

On **May 31, 2018**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end September 30, 2015.

On **November 29, 2018**, the Board received the Provider’s individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. DSH Payment/SSI Percentage (Provider Specific)¹
2. DSH SSI Percentage (Systemic Errors)²
3. DSH Medicaid Eligible Days³
4. Uncompensated Care Distribution Pool⁴
5. Two Midnight Census IPPS Payment Reduction⁵

On **April 11, 2019**, the Medicare Contractor filed a Jurisdictional Challenge over Issues 1, 4, and 5. The Provider filed a Jurisdictional Response on **May 8, 2019**.

¹ On September 12, 2024, the Board dismissed this issue.

² On June 17, 2019, the Provider transferred this issue to PRRB Case No. 18-0552GC.

³ On September 12, 2024, the Board dismissed the Section 1115 waiver portion of this issue. The case remained open for additional Medicaid eligible days.

⁴ On June 17, 2019, the Provider transferred this issue to PRRB Case No. 18-0555GC.

⁵ On June 17, 2019, the Provider transferred this issue to PRRB Case No. 18-0554GC.

On **July 23, 2019**, the Provider filed its Preliminary Position Paper, and the Medicare Contractor filed its Preliminary Position Paper on **November 21, 2019**.

On **November 14, 2022**, the Medicare Contractor filed a Jurisdictional Challenge over the DSH Medicaid Eligible Days Issue. The Provider filed a Jurisdictional Response on **December 14, 2022**.

On **December 15, 2022**, the Provider requested a Representative Change, and the Board acknowledged the change on December 16, 2022.

On **December 28, 2022**, the MAC filed a Request to Dismiss the DSH Medicaid Eligible Days issue.

On **January 20, 2023**, the Provider filed a Submission of Listings labeled “Administrative Resolution Package” to the MAC.

On **February 29, 2024**, the Provider filed a Final Position Paper, and the Medicare Contractor filed its Final Position Paper on **July 30, 2024**.

On **April 15, 2024**, the Medicare Contractor filed a Jurisdictional Challenge over issue 1 and Issue 3 (late addition of Section 1115 waiver days).

On **August 12, 2024** the Provider filed a late response to the juris challenge. The Provider had until May 15, 2024, to file a timely response.

On **September 12, 2024**, the Board issued a decision on the SSI Percentage (Provider Specific) and Medicaid Eligible Days issue (Section 1115 Waiver Days).

On **November 8, 2024** the MAC filed a renewed Motion to Dismiss the Medicaid Eligible Days issue.

B. Description of Issue 3 – Medicaid Eligible Days

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 3 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.⁶

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the Jewish Hospital case⁷ 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.⁸

On January 20, 2023, the Provider filed a Submission of Listings labeled "Administrative Resolution Package" to the MAC. In its letter to the MAC, the Provider included "Exhibit 2 – Medicaid Eligible Days" and details –

These are additional days that the provider is requesting be added to the Medicare DSH calculation – 35 days.⁹

The Provider's Final Position Paper, filed a year later, does not reference the January 20, 2023 submission of Medicaid eligible days, instead referring to a "[l]isting of Medicaid Eligible days being sent under separate cover directly to the MAC, including Section 1115 waiver days."¹⁰

MAC's Motion to Dismiss

Issue 3 – DSH Payment – Medicaid Eligible Days

On December 28, 2022, the Medicare Contractor filed a request for dismissal of various PRRB cases, including Case No. 19-0653. In its letter addressed to the Board, the Medicare Contractor states:

Each of the appeals were filed and received by the Board after the August 29, 2018, effective date of Version 2.0 of the PRRB Rules. The earliest appeals (PRRB Case Numbers 19-0652 and 19-0653) were filed and received by the Board on November 29, 2018. Two of the appeals (PRRB Case Numbers 22-0123

⁶ Appeal Request at Issue 3 (Nov. 29, 2018).

⁷ *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994).

⁸ Provider's Preliminary Position Paper at 9 (Jul. 23, 2019).

⁹ Provider's Administrative Resolution Package (Jan. 20, 2023).

¹⁰ Provider's Final Position Paper at 10 (Feb. 29, 2024).

and 22-0238) were filed and received by the Board after the November 1, 2021 effective date of Version 3.1 of the PRRB Rules.

...

The PRRB Rules make clear that providers are to file with the Board complete preliminary position papers, including exhibits, and final position papers are optional for appeals filed on or after the August 29, 2018 effective date of Version 2.0. The Providers' understanding and expectation that the preliminary position papers could be filed without fully developed positions and exhibits is clearly erroneous and without merit.

Simply stated, for each of the appeals, a complete Provider preliminary position paper with exhibits was required to be filed with both the MAC and the Board. The Providers failed to submit preliminary position papers with fully developed positions, as required under both Versions 2.0 and 3.1 of the PRRB Rules.¹¹

The MAC contends that it is not requesting the Board to deny jurisdiction, but rather to dismiss the issue due to the Provider's failure to file preliminary position papers in accordance with Board rules.¹²

Following the Provider's January 20, 2023 submission of documentation for 35 additional Medicaid Eligible Days, on April 15, 2024, in its renewed Jurisdictional Challenge, the Medicare Contractor acknowledged the Provider's submission:

The MAC also received a non-redacted copy of the 35 Medicaid eligible days and completed the review of those documented days.¹³

On November 8, 2024, the Medicare Contractor filed a renewed Motion to Dismiss for Issue 3 – Medicaid Eligible Days. Here, the Medicare Contractor provides the timeline of events, including attempts to receive the Medicaid Eligible Days listing from the Provider:

3. The Provider submitted its complete Preliminary Position Paper to the MAC on July 23, 2019. Its preliminary paper failed to specify the number of additional days to which it contends it is entitled. Rather, the paper included Exhibit 1, which states in total:

ELIGIBILITY LISTING

NOT INCLUDED – TO BE EMAILED SEPARATELY

¹¹ Medicare Contractor's Request for Dismissal at 2-3 (Dec. 28, 2022).

¹² *Id.* at 3 (Dec. 28, 2022).

¹³ Medicare Contractor's Jurisdictional Challenge at 3 (Apr. 15, 2024).

4. On February 06, 2019, the MAC emailed the Provider and requested the DSH package.
5. On September 09, 2022, the MAC emailed the Provider and requested the DSH package again.
6. On November 14, 2022, the MAC filed a consolidated jurisdictional challenge contending the issue should be dismissed due to abandonment.
7. On December 14, 2022, the Provider responded to the MAC's jurisdictional challenge.
8. On December 28, 2022, the MAC filed a Motion to Dismiss the issue from the appeals for Providers' failure to meet the Board requirements for position papers. Specifically, the Providers' preliminary position papers have failed to develop the merits of the case and failed to file supporting documentation (or describe why such documentation was unavailable).
9. On January 20, 2023, the Provider submitted the DSH listing to the MAC. The MAC completed the review of the listing but cannot proceed with an administrative resolution unless the Board rules in favor of the Provider on the pending motion to dismiss.¹⁴

Provider's Response

On January 22, 2025, the Provider submitted a response to the Medicare Contractor's Motion to Dismiss, and states:

1. The Board has already accepted jurisdiction over the ME day issue
2. The MAC has already fully audited an additional 35 ME days.
3. The MAC has already approved those additional 35 ME days for inclusion in an AR
4. The Board has acknowledged that these 35 additional days are includable in an AR when it stated in its 9/12/2024 decision 'The case remains open as there are 35 Medicaid Eligible Days still pending which the Medicare Contractor has reviewed and purportedly agreed to include'¹⁵

Board 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

¹⁴ Medicare Administrative Contractor's Motion to Dismiss at 2 (Nov. 8, 2024).

¹⁵ Provider's Response to Motion to Dismiss at 1 (Jan. 22, 2025).

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

The Provider 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 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:

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.**

(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 Papers¹⁷

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. . . 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

- 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.

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

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 January 14, 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, 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.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 carry[s] the] burden of production of evidence and burden of proof by

¹⁸ (Emphasis added.)

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 February 6, 2019, the Medicare Contractor submitted a request to the Provider which stated the following:

This is to confirm receipt of your hearing request dated 11/28/2018, inclusive of the Medicaid eligible days issue. If possible, we would like to resolve this issue administratively by performing a review of the additional Medicaid eligible days. However, we have yet to receive a DSH package and will need the following items:

1. An electronic list (in Excel format) of Medicaid days included on the filed cost report or which was submitted for audit. For each patient record on the list, please include the patient’s name, patient account number, date of admission and discharge, birth date, Social Security number, medical record number, DRG, location of stay (PPS area, Rehab, SNF, Psych, Observation, Swing, etc.), days claimed per patient, and in total.
2. The electronic list (in Excel format) of the additional Medicaid days included in the appeal request. The list should include all necessary information as described in item 1 above.
3. Ensure all non-allowable days (including but not limited to: Dual eligible days, Medicare Part C days, general assistance days, unmet spend down days, duplicates days, etc.) are excluded from the list of additional days.

4. Documentation of Medicaid eligibility for each of the patients during their respective stays related to the additional days requested, in a searchable electronic format.

5. Documentation to support all additional days related to a unit or ward of the hospital providing acute care services generally payable under the prospective payment system. This should also be submitted in a searchable electronic format.

Please submit such documentation, within 45 days from the date of this letter. If additional time is needed, please explain (for each item) why the additional time is necessary and identify the length of time needed to gather the data.¹⁹

On July 23, 2019, the Provider filed its preliminary position paper in which no eligibility listing was submitted as an exhibit. 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 \$82,601 based on an estimated 150 days).

On September 8, 2022, the Medicare Contractor emailed the Provider and stated:

Please see the attached spreadsheet that included the list of the PRRB appeal cases where Medicaid eligible days required information has been requested with no response. Please forward the requested information as soon as possible or **30 days** from the date of this email. I’d like to recommend the reopening approach where the 3-year window is still open.²⁰

On December 28, 2022, the Medicare Contractor filed a dismissal request with the Board. Only following this request, on January 20, 2023, the Provider submitted an unredacted Medicaid Eligible Days Listing to the Medicare Contractor. No explanation was provided as to why the listing of days was being submitted at this late date, ***more than 7 years after the fiscal year at issue had closed, and almost 4 years after the Medicare Contractor’s first request for the data, as discussed, supra.*** Regardless, this filing, importantly, ***was more than 3 years past the deadline for including it with the preliminary position paper*** since the position paper deadline was July 27, 2019.

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 after multiple requests by the Medicare Contractor.

¹⁹ Medicare Contractor’s Motion to Dismiss (Nov. 8, 2024) at Exhibit C-1 (emphasis added).

²⁰ *Id.*

The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider failed to identify any specific Medicaid eligible days at issue, until 42 months after the filing of its preliminary position paper.

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”²¹ 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.

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 and has failed to describe why said evidence was unavailable.²² The MAC is in no way required to or responsible for the review of the late filed listing, even though in this case, it chose to do so. This does not negate that the Provider failed to meet the Board’s requirements as stated above, and the Board has the authority to enforce its rules, regardless of whether the MAC performed a review of the 35 days in question.

Based on the foregoing, the Board dismisses the remaining issue, Issue 3, in this case. As no issues remain, the Board hereby closes Case No. 19-0653 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.

²¹ (Emphasis added.)

²² 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
Shakeba DuBose, Esq.

For the Board:

8/21/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., Federal Specialized Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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August 25, 2025

Cris Colberg
Director, Reimbursement and Regulatory Reporting
Stamford Hospital
1351 Washington Boulevard, 7th Floor
Stamford, CT 06904

Danelle Decker
Lead Auditor
National Government Services, Inc. (J-K)
Mail point INA102AF42 P.O. Box 6474
Indianapolis, IN 46206-6474

RE: Dismissal - Failure to Respond
Stamford Hospital
Provider Number: 07-0006
Appealed Period: FYE 09/30/2017
PRRB Case Number: 21-0202

Dear Mr. Colberg and Ms. Decker:

Pursuant to 42 C.F.R. § 405.1868, the Provider Reimbursement Review Board ("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 provision of section 1878 of the Act and of the regulations. The Board's powers include the authority to take appropriate actions in response to the failure of a party to comply with Board rules and orders. Specifically, if a Provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may dismiss the appeal with prejudice.

On December 20, 2024, a Notice of Hearing was issued and established critical due dates and set forth a live hearing date for September 15, 2025. Emails to the Provider representative inquiring about a status on this case have been returned as undeliverable.

Board Rule 41.2 states:

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);
- 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.

As the Board has been unable to contact the Provider Representative regarding the September 15, 2025 hearing, the Board hereby dismisses this case.

Board Members Participating:

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

FOR THE BOARD:

A handwritten signature in dark ink, appearing to read "R-Kelly", written over a horizontal line.

Ratina Kelly, CPA
Board Member

cc: Wilson C. Leong, Federal Specialized Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Michael Newell
Southwest Consulting Associates
2805 North Dallas Parkway
Suite 620
Plano, TX 75093-8724

RE: *Expedited Judicial Review Determination*

24-2498GC Banner Health CY 2012 Medicare Part C Days CIRP Group
24-2789GC Baystate Health CY 2013 Medicare Part C CIRP Group

Dear Mr. Newell:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed on August 8, 2025 in the above-referenced group appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Board received requests to establish Common Issue Related Party ("CIRP") groups for Banner Health's calendar year ("CY") 2012 and Baystate Health's CY 2013 on September 13, and September 29, 2024, respectively. Both CIRP groups contain providers appealing from revised Notices of Program Reimbursement ("RNPRs") which implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")¹ as it pertains to the Providers' FYEs June 30, 2012 or December 31, 2012, and September 30, 2013, respectively.

The issue in these appeals is "the proper treatment in the Medicare disproportionate share hospital ("DSH") calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Allina* litigation. The Providers contends that part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction (for patients eligible for Medicaid)."² The Providers are seeking to challenge the CMS policy adopted in the June 2023 Final Rule to be applied *retroactively* for periods prior to October 1, 2013.³

¹ 88 Fed. Reg. 37772 (June 9, 2023).

² See, e.g., Case No. 24-2498GC, Statement of Group Issue at 1 (Sept. 13, 2024).

³ *Id.*

EJR Determination

Southwest Consulting Medicare Part C Days CIRP Groups

PRRB Case Nos. 24-2498GC & 24-2789GC

Page 2

Statutory and Regulatory Background:

A. Medicare DSH Payment

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 the inpatient prospective payment system (“IPPS”).⁴ Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.⁵

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.⁶ 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.⁷

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage (“DPP”).⁸ 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.⁹ The DPP is defined as the sum of two fractions expressed as percentages.¹⁰ Those two fractions are referred to as the “Medicare/SSI fraction” and the “Medicaid fraction.” Both fractions consider whether a patient was “entitled to benefits under part A.”

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 ¹¹

⁴ See 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.

⁵ *Id.*

⁶ See 42 U.S.C. § 1395ww(d)(5).

⁷ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

⁸ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(l).

⁹ See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

¹⁰ See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

¹¹ (Emphasis added.)

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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 DSH payment adjustment.¹²

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter***, and the denominator of which is the total number of the hospital's patient days for such period.¹³

The Medicare contractor determines 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.¹⁴

B. Establishment of Medicare Part C and Treatment of Part C Days in the DSH Calculation

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations (“HMOs”) and competitive medical plans (“CMPs”) is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for “payment to the eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A and enrolled under part B . . .” Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In the September 4, 1990 Federal Register, the Secretary¹⁵ stated that:

Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include “patients who were entitled to benefits under Part A,” we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was

¹² 42 C.F.R. § 412.106(b)(2)-(3).

¹³ (Emphasis added.)

¹⁴ 42 C.F.R. § 412.106(b)(4).

¹⁵ of Health and Human Services.

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included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].¹⁶

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.¹⁷

With the creation of Medicare Part C in 1997,¹⁸ Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C, and following that election, the beneficiary's benefits are no longer administered under Medicare Part A.¹⁹ As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."²⁰ The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.²¹

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.²² In the FFY 2005 IPPS final rule, the Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."²³ In response to a comment regarding this change, the Secretary explained that:

¹⁶ 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).

¹⁷ *Id.*

¹⁸ The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999" This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

¹⁹ 68 Fed. Reg. 27154, 27208 (May 19, 2003).

²⁰ *Id.*

²¹ 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).

²² 69 Fed. Reg. 28196, 28286 (May 18, 2004).

²³ 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).

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. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.²⁴

This statement would require inclusion of Medicare Part C inpatient days in the Medicare fraction of the DSH calculation.

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.²⁵ In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made “technical corrections” to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These “technical corrections” are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).²⁶ As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the “Part C DSH policy”). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) “to clarify” the Part C DSH policy by replacing the word “or” with “including.”²⁷

There has been substantial litigation over whether enrollees in Part C plans are “entitled to benefits” under Medicare Part A when determining their placement in either the DSH Medicare or Medicaid fraction.

²⁴ *Id.* (emphasis added).

²⁵ 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

²⁶ *Id.* at 47411.

²⁷ 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: “We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word ‘or’ with the word ‘including’ in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B).”); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff’d in part and rev’d in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

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First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.²⁸

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),²⁹ vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.³⁰ In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.³¹ However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.³² However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.³³ A number of hospitals appealed this action.³⁴ In *Azar v. Allina Health Services* ("*Allina II*"),³⁵ the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.³⁶ There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."³⁷ The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.³⁸

²⁸ *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).

²⁹ 746 F. 3d 1102 (D.C. Cir. 2014).

³⁰ *Id.* at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").

³¹ *Id.* at 2011.

³² 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).

³³ *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).

³⁴ The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, **none** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(ii). Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo(a)(1)(B)* as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board, pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)*, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).

³⁵ 139 S.Ct. 1804 (2019).

³⁶ *Id.* at 1817.

³⁷ *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.

³⁸ 139 S.Ct. at 1814.

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On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.³⁹ On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as “CMS has announced its intention to conduct the rulemaking required by the Supreme Court’s decision in *Allina II*”:

This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.⁴⁰

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.⁴¹ The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS’s response to the Supreme Court’s decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not “entitled to benefits under part A” for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court’s decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.⁴²

Finally, the following excerpts from the June 9, 2023 Final Rule discussing a hospital’s right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule or subsequent publication of SSI ratios to be an appealable “final determination”:

³⁹ 85 Fed. Reg. 47723 (Aug. 6, 2020).

⁴⁰ CMS Ruling 1739-R at 1-2.

⁴¹ 88 Fed. Reg. 37772 (June 9, 2023).

⁴² 88 Fed. Reg. at 37788 (emphasis in original).

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1. “Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports. In order to calculate these payments, CMS must establish Medicare fractions for each applicable cost reporting period during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days.*”⁴³
2. “We do not agree that it is arbitrary or capricious to treat hospitals’ Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II*. It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital’s appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary’s interpretation set forth in this final action.**”⁴⁴
3. “Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions contained in the NPRs or revised NPRs*. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised NPRs will provide hospitals with a vehicle to appeal the new final action* even if the Medicare fraction or DSH payment does not change numerically.”⁴⁵
4. “*When the Secretary’s treatment of Part C days in this final action is reflected in NPRs and revised NPRs, providers, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], will be able to challenge the agency’s interpretation by appealing those NPRs and revised NPRs*. While some providers have already received reopening

⁴³ 88 Fed. Reg. at 37774-75 (emphasis added).

⁴⁴ *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).

⁴⁵ *Id.* at 37788 (emphasis added).

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notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings.”⁴⁶

The above discussion in the preamble to the June 9, 2023 Final Rule makes clear that hospitals covered by that Final Rule would have appeal rights maturing with the yet-to-be-issued NPRs (original or revised) that would apply the finalized policy.

Providers’ Position:

A. Providers’ Appeal Request

The Providers’ appeal requests include a “Statement of Jurisdiction” asserting that the Providers have met the applicable statutory conditions for appeal because they are dissatisfied with their revised NPRs which apply the June 9, 2023 retroactive final rule related to Part C days. They cite language from that final rule which outlined Providers’ ability to challenge this final rule once they were issued NPRs implementing the rule.⁴⁷

The “Statement of Group Issue” included with the appeal requests state that the issue concerns the proper treatment in the Medicare DSH calculation of days for Medicare Part C patients in the aftermath of the *Allina* litigation. The Provider contends that the Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.⁴⁸

The Provider characterized the relevant background facts as follows:

1. In the FY 2005 IPPS Final Rule, CMS first announced a policy change to count Part C days in the SSI fraction and to exclude those days from the numerator of the Medicaid fraction.
2. In *Allina I*, the D.C. Circuit vacated that policy change.
3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary’s continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking. The Supreme Court’s decision “did not address the D.C. Circuit’s alternate ruling that the readopted policy was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the policy could not ‘take effect’ under the terms of the statute until after proper notice-and-comment rulemaking.”⁴⁹
4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.

⁴⁶ *Id.* (emphasis added).

⁴⁷ *See, e.g.*, Case No. 24-2498GC, Provider No. 06-0001, Statement of Jurisdiction at 1 (citations omitted).

⁴⁸ *See, e.g.*, Case No. 24-2498GC, Statement of Group Issue at 1.

⁴⁹ *Id.* (citing to 139 S. Ct. at 1816).

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Based on the above, the Provider maintains that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule “is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, exceeds the agency’s statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence.”⁵⁰

B. Providers’ Petition for EJ R

The Providers have requested EJ R over the “post-*Allina* retroactive Part C policy issue” because they believe they have met the requirements for a hearing before the Board, but the Board lacks “the authority to decide the substantive and procedural validity of CMS’ final rule published in the Federal Register on June 9, 2023.”⁵¹ They seek a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.⁵² The requests state: “The Providers contend that the new, post-*Allina* retroactive part C days rule, applied in the [RNPRs] appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency’s statutory authority and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence.”⁵³ Since the Board is bound by this regulation,⁵⁴ it lacks the authority to provide the relief requested, and thus the Providers believe EJ R is appropriate.

On August 15, 2025, the Medicare Contractor’s representative, Federal Specialized Services, filed timely responses to the Requests for EJ R in both cases. They simply advised that, in each case, “no substantive claim challenge has been filed, no jurisdictional challenge has been filed.”⁵⁵

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 EJ R 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.

⁵⁰ *Id.* (citing 4 U.S.C. § 706(2)).

⁵¹ *E.g.*, Case No. 24-2498GC, Providers’ Petition for Expedited Judicial Review at 12 (Aug. 8, 2025).

⁵² *Id.* at 15.

⁵³ *Id.* at 1-2.

⁵⁴ 42 C.F.R. § 405.1867.

⁵⁵ *See, e.g.*, Case No. 24-2498GC, Response to Provider’s request for EJ R at 1 (Aug. 15, 2025).

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A. Jurisdiction

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 issue a final determination;⁵⁶
- 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.⁵⁷

For these CIRP Groups, the providers all appealed from revised NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. All of the providers were directly added to the group within 180 days of the issuance of their RNPRs and the amount in controversy exceeds \$50,000.

The Board finds that the Providers in Cases 24-2498GC and 24-2789GC have all filed timely appeals from their revised NPRs concerning the same common issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these RNPRs. The Board also finds that the amount in controversy in each case exceeds \$50,000 as required by 42 C.F.R. § 405.1837(a)(3). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

B. Board’s Decision Regarding the EJRs Requests

The Board finds that:

- 1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in Cases 24-2498GC and 24-2789GC and that the Providers in each group appeal are entitled to a hearing before the Board;
- 2) Based upon the Providers’ assertions regarding the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

⁵⁶ 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).

⁵⁷ 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

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- 4) It is without the authority to decide the legal question of whether the Part C Days policy issue, as adopted on a retroactive basis in the June 9, 2023 Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, properly falls within the provisions of 42 U.S.C.

§ 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years.

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 group cases, the Board hereby closes both cases.

Board Members Participating:

Kevin D. Smith, CPA

Ratina Kelly, CPA

Nicole E. Musgrave, Esq.

Shakeba DuBose, Esq.

FOR THE BOARD:

8/26/2025

X

Kevin D. Smith, CPA

Kevin D. Smith, CPA

Board Chair

Signed by: Kevin D. Smith -A

Enclosures: Schedules of Providers

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

Scott Berends, Federal Specialized Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
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Via Electronic Delivery

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Blvd. Suite 700
Los Angeles, CA 90064-1582

RE: ***Request for Reconsideration***
Blumberg Ribner Independent Hospitals 1989-1998 Part C/HMO Days Group
Case Number: 17-1948G

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (“Board”) has reviewed the above referenced appeal in response to the Provider’s motion for reinstatement (“Request for Reconsideration”) submitted on June 11, 2024. The decision of the Board is set forth below.

Pertinent Facts:

On **August 3, 2017**, Blumberg Ribner, Inc. (“Blumberg”) filed the group appeal request on behalf of the Providers.

On **December 18, 2023** the Board issued a Notice of Hearing and Critical Due Dates providing the filing deadlines for the parties’ final position papers. The deadline for the Group’s Final Position Paper set forth in the Notice of Hearing was **April 10, 2024**.

On **April 15, 2024**, the Board issued a letter dismissing Case No. 17-1948G as the Providers failed to submit their final position paper by the aforementioned due date.

On **June 11, 2024**, the Providers submitted a Reconsideration Request. In their request, the Group Representative states they never received the Board’s Notice of Hearing issued on December 18, 2023, and submitted a sworn affidavit to that effect. The Group Representative additionally asserts they would have submitted the final position paper in this appeal if they had received timely notice of the deadline. The Group Representative claims the Board’s dismissal of the case “when the Providers did not have notice of the deadline in order to timely file the Final Position Paper, is arbitrary and capricious, and violates due process.”¹

Board Decision:

The Board *denies* the motion for reinstatement for the reasons set forth below.

¹ Request for Reconsideration at 2 (June 11, 2024).

Failure to comply with the Board's deadline for submission of a required filing 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.

Board Rule 47.1 (Dec. 2023) governs motions to reinstate an issue:

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.*** If an issue(s)/case was remanded pursuant to a CMS ruling (*e.g.*, CMS Ruling 1498-R), the provider must address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board reinstates an issue(s) or case, the provider will have the same rights (no greater and no less) that it had in its initial appeal. These requirements also apply to Rule 47.2 below.²

More specifically, Board Rule 47.3 governs 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

² Emphasis added.

Request for Reconsideration

PRRB Case No.: 17-1948G

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*good cause to reinstate. If the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, **then the motion for reinstatement must, as a prerequisite, include the required filing before the Board will consider the motion.***³

As stated in the Board rules, generally, the Board will not reinstate an appeal that was closed due to untimely filing based on administrative oversight except for good cause. The Group Representative did not provide “good cause” to explain why the response to the Final Position Paper deadline was missed. It is undetermined what kind of technical error is responsible for the group’s representative inability to receive or find the Notice of Hearing, but there is not any evidence of error by the Board. The Board has record of the Notice of Hearing being properly sent by its case and docket management system and received by the opposing party.⁴ The email address used in the Outlook email sent by the Board on December 18, 2023, matches the email address the affidavit states is used by the Group Representative, iblumberg@bricare.com.⁵ Further, Blumberg admits that the Notice of Dismissal was received, which was also sent within the docket management system, and to the same email address.

Further, per Board Rule 47.3, a request for reinstatement for a case in which it was dismissed for failure to file with the Board a required position paper must "as a prerequisite, include the required filing before the Board will consider the motion." The Request for Reconsideration did not include a final position paper, and one year after the motion the Provider has still not filed a final position paper. For the above reasons, the Board **denies** the request for reconsideration and Case 17-1498G remains 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

8/27/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA

Board Chair

Signed by: Kevin D. Smith -A

³ Emphasis added.

⁴ See **Appendix A** at 2.

⁵ See **Appendix A** at 1.

Request for Reconsideration

PRRB Case No.: 17-1948G

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

APPENDIX A

Email Documentation of the Notice of Hearing sent on December 18, 2023

Request for Reconsideration

PRRB Case No.: 17-1948G

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1. Record of Notice of Hearing sent via Email

Thompson, Sage (CMS/OHI)

From: noreply@salesforce.com on behalf of CMS PRRB_OHCDMS
Sent: Monday, December 18, 2023 2:53 PM
To: iblumberg@bricare.com; jeprrbappeals@noridian.com
Cc: board@fssappeals.com; CMS PRRB_OHCDMS; Narayan, Hari (CMS/OHI)
Subject: PRRB Case No. 17-1948G, Blumberg Ribner Independent Hospitals 1989-1998 Part C/HMO Days Group, Hearing Notice
Attachments: N-36731.pdf

Please find the attached information regarding PRRB case number 17-1948G.

Regards,
Provider Reimbursement Review Board

Request for Reconsideration

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2. Record of Notice of Hearing Receipt by Federal Specialized Services

Thompson, Sage (CMS/OHI)

From: board-fss@filestar.io on behalf of board-fss <board-fss@filestar.io>
Sent: Monday, December 18, 2023 2:55 PM
To: CMS PRRB_OHCDMS
Subject: RE:PRRB Case No. 17-1948G, Blumberg Ribner Independent Hospitals 1989-1998 Part C/HMO Days Group, Hearing Notice

Your e-mail has been received by Federal Specialized Services (FSS).

****Please note that this e-mailbox is NOT for corresponding with the Provider Reimbursement Review Board. Sending documents to this mailbox does NOT constitute filing with the PRRB. You may review the PRRB's rules for correspondence on the CMS Web site here: <https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions.html> ****

If you have any questions for FSS, please e-mail us at questions@fssappeals.com.



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

Dean Wolfe
Noridian Healthcare Solutions
P.O. Box 6722
Fargo, ND 58108-6722

RE: ***Board Decision –Bad Debt Issues 3 & 4***
Asante Three Rivers Medical Center (Provider Number 38-0002)
FYE: 09/30/2015
Case Number: 19-1887

Dear Mr. Ravindran and Mr. Wolfe,

The Provider Reimbursement Review Board (“Board”) has reviewed the documentation in the above referenced appeal. The decision of the Board is set forth below.

Background:

A. Procedural History for Case No. 19-1887

On **November 19, 2018**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end Sept. 30, 2015.

On **May 10, 2019**, the Board received the Provider’s individual appeal request. The initial Individual Appeal Request included two (2) issues:

1. DSH SSI (Provider Specific)¹
2. DSH – Medicaid Eligible Days²

On **June 4, 2019**, Quality Reimbursement Services, Inc. (“QRS”) timely added 2 more issues to the appeal:

3. ***Bad Debt Sample Errors***
4. ***Misapplication of Bad Debt Sample Results***

The Provider is commonly owned/controlled by Asante Health System (hereinafter “Asante Health”) and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1).

¹ The Board dismissed issue 1 on August 5, 2025. *See infra* n.6.

² The Board dismissed issue 2 on August 5, 2025. *See infra* n.6.

On **May 20, 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 25.³

On **January 6, 2020**, the Provider timely filed its preliminary position paper.^{4,5}

On **April 28, 2020**, Federal Specialized Services ("FSS") filed a preliminary position paper on behalf of the Medicare Contractor ("MAC").

On **August 13, 2024**, the Board issued a Notice of Hearing, scheduling the case for a hearing on May 13, 2025. On **May 5, 2025**, the case was rescheduled (FINAL) for a hearing on August 13, 2025.

On **February 12, 2025**, QRS filed the Provider's final position paper.

On **March 12, 2025**, FSS filed the MAC's final position paper.

On **April 11, 2025**, the MAC filed a Jurisdictional Challenge over the Section 1115 Waiver Days, Medicaid Eligible Days, ***Bad Debt Sample Errors and Misapplication of Bad Debt Sample Results*** issues.

Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. The Provider's response was due to the Board by May 11, 2025 but the Provider ***failed to*** timely respond.

³ (Emphasis added.)

⁴ The preliminary position paper due date was Sunday, January 5, 2020, so per the Rules of Civil procedure, the due date was the following business day, Monday, January 6, 2020.

⁵ The Provider initially filed a preliminary position paper on January 3, 2020, but subsequently filed another on January 6th. The January 6th submission included a note that the January 3rd filing should be disregarded and replaced with the January 6th version.

On **August 5, 2025**, the Board issued a Jurisdiction Determination in Part, dismissing Issue 1 – DSH SSI Provider Specific and Issue 2 – Medicaid Eligible Days.⁶

B. Description of Issue 3 – Bad Debt Sample Errors

Following the initial appeal filed on May 10, 2019, the Provider timely added Issue 3 – Bad Debt Sample Errors on June 4, 2019.

In its Individual Appeal Request, the Provider summarizes its Bad Debt Sample Errors issue as follows:

Did Noridian Administrative Solutions LLC, the Medicare Administrative Contractor (MAC), improperly disallow certain bad debt claims included in its audit sample, thereby overstating the calculated Error Rate which, when applied to the Provider's population of Medicare bad debts claimed, reduced bad debt reimbursement?⁷

On January 6, 2020, the Board received the Provider's preliminary position paper in Case No. 19-1887. The following is the Provider's complete position on Issue 3 set forth therein:

Medicare Charity Care Bad Debts

The Provider contends that the MAC did not determine Medicare reimbursement for allowable Bad Debts in accordance with the Statutory instructions at 42 U.S.C §1395x(v). Specifically, the Provider disagrees with the MAC's failure to include all possible bad debts associated with Charity Care. This action was contrary to the criteria set forth at 42 C.F.R. § 413.89 of the Secretary's regulations and the PRM, Part 1, § 312. According to the PRM, Part 1, § 312, "[p]roviders can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively." *See* Exhibit 3.

Provider's Medicare charity care bad debts claimed were disallowed because the MAC claimed that all four (4) tests to determine indigency (assets, liabilities, income, and expenses) were not performed and not properly documented or because Medicaid eligibility verification was not completed, which would have substantiated that the patient met the poverty guidelines and

⁶ Jurisdiction Determination in Part (Aug. 5, 2025). In this determination, the Board notes: *Challenges to the two Bad Debt issues will be addressed under separate cover.*

⁷ Individual Appeal Request, Issue Added Issue Statement (June 4, 2019).

determined to be indigent. The provider's indigency policy does ask for income and asset information on its application for indigency determination (if the patient does not qualify for Medicaid eligibility) but does not ask for liability or expense information. The PRM, Part I, § 312 does not mandate that a provider take into account the all aspects of a patient's financial condition in order to determine the patient's indigency. The wording of the PRM, Part 1, § 312 in which the word "should" is used has been challenged in Federal court as to whether it requires that the four (4) tests be performed. In a decision dated August 18, 2009, the District Court for the District of Columbia made clear that Section 312 of CMS Pub. 15-1 did not require that a provider perform an asset test in order to determine if a Medicare patient is indigent for purposes of bad debt reimbursement. Rather, the Court concluded that the use of the term "should" in Section 312 are best construed as "strong but noncompulsory recommendations." *Baptist Healthcare Sys. v. Sebelius*, No. AW-08-0677, 2009 WL 2514065 D.D.C. (August 19, 2009).

The Provider contends that it has identified Medicare beneficiaries and determined them to be indigent in accordance with the PRM, Part 1, § 312. In addition, the Provider contends that since indigence was determined, there has been no improvement in these beneficiaries' financial condition. As a result, the Provider has deemed the debt uncollectible, and has included these beneficiaries in the Medicare Charity Care Bad Debts listing ("Listing") to be sent under separate cover. Based on the Listing which will be furnished, the Provider contends that the total number of Bad Debts in the cost report does not reflect an accurate number of Medicare Charity Care Bad Debts. The Provider requests that the MAC review the Listing, select a sample, if necessary and revise the cost report to include these Charity Care Bad Debts as the MAC misapplied the sample results to the bad debts claimed by the Provider.⁸

Medicare Crossover Bad Debts

The Provider contends that the MAC improperly treated Medicare crossover bad debts that the Provider had incurred during FYE September 30, 2015. The MAC audited the Provider's Medicare cost report, and the MAC failed to include or excluded all of the Medicare crossover bad debts that the Provider had incurred during that fiscal year.

⁸ Provider's Preliminary Position Paper at 9-11 (January 6, 2020). *Also see* Provider's Final Position Paper at 9-10 (February 12, 2025).

The PRM, Part I, Section 322, specifically allows Medicare bad debts for unpaid deductibles and coinsurance by State Medical Assistance (Medicaid) plans. *See Exhibit 3.* The Florida State Medicaid Plan does not pay for certain inpatient and outpatient deductible and coinsurance amounts incurred by Medicare beneficiaries when the beneficiary is also eligible for Medicaid in the State of Florida.

The Provider will furnish listings which document inpatient deductible and coinsurance amounts billed and not paid by the State of Oregon. These additional Medicare crossover bad debts are supported by remittance advices from the MAC proving that these amounts were billed, but the deductible and coinsurance amounts were not paid. These bad debts are in compliance with Section 322 of the PRM, Part I. These bad debts were not claimed on any previous fiscal year cost reports.

Additionally, the MAC misapplied the sample results to the bad debts claimed by the Provider.⁹

C. Description of Issue 4 – Misapplication of Bad Debt Sample Results

Following the initial appeal filed on May 10, 2019, the Provider timely added an additional issue: Issue 4 – Misapplication of Bad Debt Sample Results, on June 4, 2019.

In its Individual Appeal Request, the Provider summarizes its Misapplication of Bad Debt Sample Results issue as follows:

Did Noridian Administrative Solutions LLC, the Medicare Administrative Contractor (MAC), improperly disallow 100% of charity bad debts because the sample Error Rate exceeded the MAC's 30-percent Error Rate threshold, rather than prorate charity bad debts using the audited sample results?¹⁰

On February 12, 2025, the Board received the Provider's final position paper in Case No. 19-1887. The following is the Provider's complete position on Issue 4 set forth therein:

The Provider contends that the MAC improperly treated Medicare crossover bad debts that the Provider had incurred during FYE

⁹ Provider's Preliminary Position Paper at 11 (January 6, 2020). *Also see* Provider's Final Position Paper at 11 (February 12, 2025). *Note* the Provider does not denote "Issue 3" or "Issue 4" in its Preliminary Position Paper. In its Final Position Paper, it denotes "Issue 3" as the argument for Medicare Charity Care Bad Debts, and "Issue 4" as the argument for Medicare Crossover bad debts.

¹⁰ Individual Appeal Request, Issue Added Issue Statement (June 4, 2019).

September 30, 2015. The MAC audited the Provider's Medicare cost report, and the MAC failed to include or excluded all of the Medicare crossover bad debts that the Provider had incurred during that fiscal year.

The PRM, Part I, Section 322, specifically allows Medicare bad debts for unpaid deductibles and coinsurance by State Medical Assistance (Medicaid) plans. *See* Exhibit P-4. The Florida State Medicaid Plan does not pay for certain inpatient and outpatient deductible and coinsurance amounts incurred by Medicare beneficiaries when the beneficiary is also eligible for Medicaid in the State of Florida.

The Provider will furnish listings which document inpatient deductible and coinsurance amounts billed and not paid by the State of Oregon. These additional Medicare crossover bad debts are supported by remittance advices from the MAC proving that these amounts were billed, but the deductible and coinsurance amounts were not paid. These bad debts are in compliance with Section 322 of the PRM, Part I. These bad debts were not claimed on any previous fiscal year cost reports.

Additionally, the MAC misapplied the sample results to the bad debts claimed by the Provider.¹¹

Medicare Contractor's Contentions

Issue 3 – Bad Debt Sample Errors

In its preliminary position paper, the Medicare Contractor argues that for the two types of bad debts disallowed during audit – Indigent (Charity) Bad Debts and Crossover Bad Debts – the auditor, based on documentation available, proposed two adjustments – adjustments 20 and 24, and further applied error rates to the population based on the samples reviewed.¹²

The Medicare Contractor further argues:

It may be possible that the Provider could “cure” the errors noted. If the Provider wishes, the MAC will agree to review documentation submitted by the Provider in the future as part of this appeal. To the extent the Provider adequately documents its

¹¹ *See supra* n. 9. Provider's Preliminary Position Paper at 11 (January 6, 2020 & Provider's Final Position Paper at 11 (February 12, 2025).

¹² Medicare Contractor's Preliminary Position Paper at 11 (April 28, 2020).

claim for Medicare Bad Debt reimbursement, the MAC will agree to resolve this issue administratively.¹³

Finally, the Medicare Contractor contends:

The MAC adjustments are in accordance with Medicare regulations for Bad Debt reimbursement at 42 C.F.R. §413.89 and CMS instructions at CMS Pub. 15-1, Section 312. The MAC adjustment is also in accordance with the Medicare Regulations at 42 C.F.R. §413.20 and §413.24(c), as the Provider has failed to document all required information to support the claimed amounts as allowable Medicare Bad Debts.

If the Provider cannot provide adequate support for the bad debt amounts adjusted by the MAC, the MAC asks the Board to dismiss this issue.¹⁴

In its Final Position Paper, the Medicare Contractor notes that it has “no record of receiving any listings or required documents from the Provider.”¹⁵ The Medicare Contractor reiterates its arguments from its preliminary position paper that it has properly adjusted to disallow the claimed bad debts in accordance with the regulations.

Issue 4 – Misapplication of Bad Debt Sample Results

In its preliminary position paper, the Medicare Contractor notes the adjustments it made during audit. The Medicare Contractor then argues:

The MAC is unsure of what the Provider’s argument is related to this issue.

The MAC can not tell the difference between issue 3 and 4. Both issues were added to this case June 4, 2019.

...

The Provider has not provided an adequate explanation of what this issue is. The MAC asks the Board to dismiss this issue.¹⁶

Further, in its final position paper, the Medicare Contractor states:

¹³ *Id.* at 12.

¹⁴ *Id.* at 12-13.

¹⁵ Medicare Contractor’s Final Position Paper at 18 (March 12, 2025).

¹⁶ Medicare Contractor’s Preliminary Position Paper at 15.

The provider argues that “the MAC misapplied the sample results”, but there is no further explanation or supporting evidence on how MAC “misapplied the sample results.”

MAC points to its workpapers at Exhibit C-14 and Exhibit C-15 to illustrate that the error rates were properly calculated and the methodology used in determining the final bad debts to be disallowed was consistent and proper across the different types of bad debts reviewed.¹⁷

The Medicare Contractor concludes by stating the Provider has “failed to adequately explain or brief this issue.”¹⁸

Medicare Contractor’s Jurisdictional Challenge

On April 11, 2025, the Medicare Contractor filed a jurisdictional challenge on Issue 3 – Bad Debt Sample Errors and Issue 4 – Misapplication of Bad Debt Sample Results.

Issue 3 – Bad Debt Sample Errors

The Medicare Contractor contends Issue 3 should be dismissed because the Provider failed to comply with 42 C.F.R. §405.1835 and Board Rule 8 in regards to framing of its bad debt issues. Specifically, the Medicare Contractor notes:

Provider’s Request to Add Issues specifically identified only the Bad Debt Sample Errors element of Medicare Bad Debts reimbursement as being in dispute in Issue 3. Furthermore, the Provider did not properly raise the issue of a New Charity Bad Debts Listing as set forth in the Board Rules and Regulations.¹⁹

Further the Medicare Contractor argues the Provider’s attempt to add the charity care bad debt issue through its Preliminary Position Paper was untimely:

[T]he Provider did not raise the issue of the New Charity Bad Debts Listing in its May 10, 2019 Appeal Request. In fact, the New Charity Bad Debts Listing issue was first raised in the Provider’s PPP dated January 5, 2020, several years after the deadline forth in 42 C.F.R. § 405.1835(e)(3). Accordingly, the MAC asserts that the New Charity Bad Debts Listing must be

¹⁷ Medicare Contractor’s Final Position Paper at 25-26.

¹⁸ *Id.* at 26.

¹⁹ Medicare Contractor’s Jurisdictional Challenge at 9 (April 11, 2025).

dismissed as the Provider failed to timely raise the issue in accordance with Board Rules and Regulations.²⁰

Finally, the Medicare Contractor contends the Provider abandoned its originally filed appeal for Issue 3 in its preliminary and final position papers.

The Provider effectively abandoned originally appealed Issue 3 when it failed to properly brief this issue in its PPP and FPP. Specifically, the Provider failed to state the material facts that support its claim that the bad debt samples disallowed by MAC were disallowed in errors as required by Board Rule 25.1.1(B). The Provider also failed to identify controlling authority supporting its position that the disallowed bad debt samples were allowable (Board Rule 25.1.1(C)), to provide a conclusion applying the material facts to the controlling authorities (Board Rule 25.1.1(D)) and to identify or produce any documents explaining or demonstrating how the bad debt samples were improperly disallowed by the MAC (Board Rule 25.2.2). No explanation was given as to why the Provider disagreed with the adjustments, and no information was presented as to how the disallowance of bad debts should be determined differently. In fact, nothing in the Provider's Final Position Paper resembles a fully developed narrative supporting its claims in Issue 3 as required by Board Rules 25.3 and 27.2.²¹

Issue 4 – Misapplication of Bad Debt Sample Results

The Medicare Contractor essentially reiterates its arguments for Issue 4 as it had stated in Issue 3. The Medicare Contractor contends the Provider “failed to specifically include the Additional Crossover Bad Debts in its Appeal Request” and effective[ly] abandoned the originally appealed Issue 4 in its Preliminary Position Paper and Final Position Papers.”²²

Provider's Jurisdictional Responses

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. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record.” The MAC filed its Jurisdictional Challenge on April 11, 2025, after the final position paper deadlines. Further, the Board postponed the previously scheduled May hearing date to provide ample time for the Provider to sufficiently respond to the Medicare Contractor's jurisdictional challenge.

²⁰ *Id.* at 10.

²¹ *Id.* at 12.

²² *Id.* at 16.

The Provider, to date, has not filed a Jurisdictional Challenge Response. As a result, the Board will not consider the Provider's contentions.

Board 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.

The Provider timely added Issue 3 – Bad Debt Sample Errors, and Issue 4 – Misapplication of Bad Debt Sample Results, to its instant appeal. However, as explained below, the Provider fails to properly brief each issue, and for the reasons set forth below, the Board hereby dismisses Issue 3 and Issue 4 from this appeal.

First, the Provider's Preliminary Position Paper²³ fails to specifically identify "Issue 3" or "Issue 4" – instead, the Provider simply identifies the issues as "Medicare Charity Care Bad Debts" and "Medicare Crossover Bad Debts." Effectively here, the Provider fails to comply with 42 C.F.R. § 405.1835(b) (2016), which requires the following contents of request for a Board hearing:

- (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the final contractor or Secretary determination under appeal.
- (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 contractor or Secretary determination under appeal, including an account of *all of the following*:
 - (i) *Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).*
 - (ii) *How and why the provider believes Medicare payment must be determined differently for each disputed item.*

²³ See Provider's Preliminary Position Paper at 9-11 (January 6, 2020). Also see *supra* n. 9.

(iii) If the provider self-disallows a specific item (as specified in § 413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.²⁴

Board Rule 8 (Aug. 2018) expands upon this requirement in regard to “framing” of issues involving multiple components:

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. Several examples are identified below, but these are not exhaustive lists of categories or issues.

...

B. Bad Debts

Common examples include: crossover bad debts, collection effort, use of collection agency, 120-day presumption, and indigence determination.²⁵

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 Papers²⁶

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... 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.

²⁴ (Emphasis added).

²⁵ (emphasis added).

²⁶ (Bold, Italics and Underline emphasis added to these excerpts and all other emphasis in original.)

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

- 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 <u>complete</u> 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 20, 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.

The fact that the Provider did not provide specifics on Issue 3 – Bad Debt Sample Errors, and Issue 4 – Misapplication of Bad Debt Sample Results in the Provider's preliminary and final position papers serves notice that the Provider has effectively abandoned these issues. If the Provider had expanded upon which samples were erroneous and provided those results to the Medicare Contractor and further developed those positions in its preliminary and final position papers, the merits of the Provider's arguments would be more plausible. Instead, the Provider details two types of bad debts – Charity Care and Crossover Bad Debts – which individually should have been separately labeled issues in the instant appeal.

The Provider attempts to additionally add issues to the instant appeal by effectively contending that it is supplying listings under separate cover for the MAC to review:

The Provider contends that it has identified Medicare beneficiaries and determined them to be indigent in accordance with the PRM, Part 1, § 312. In addition, the Provider contends that since indigence was determined, there has been no improvement in these beneficiaries' financial condition. As a result, the Provider has deemed the debt uncollectible, and has included these beneficiaries in the Medicare Charity Care Bad Debts listing ("Listing") ***to be sent under separate cover***. Based on the Listing ***which will be furnished***, the Provider contends that the total number of Bad

Debts in the cost report does not reflect an accurate number of Medicare Charity Care Bad Debts.

...

The Provider will furnish listings which document inpatient deductible and coinsurance amounts billed and not paid by the State of Oregon. These additional Medicare crossover bad debts are supported by remittance advices from the MAC proving that these amounts were billed, but the deductible and coinsurance amounts were not paid. These bad debts are in compliance with Section 322 of the PRM, Part I. These bad debts were not claimed on any previous fiscal year cost reports.²⁷

These statements do not support the Provider's contention that it is arguing "Bad Debt Sample Errors" or "Misapplication of Sample Results." Instead, it appears as if the Provider is attempting to add an issue to the appeal, which is governed by 42 C.F.R. § 405.1835(e):

(e) *Adding issues to the hearing request.* After filing a hearing request in accordance with paragraphs (a) and (b), or paragraphs (c) and (d), of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board only if —

(1) The request to add issues complies with the requirements of paragraphs (a) and (b), or paragraphs (c) and (d), of this section as to each new specific item at issue.

(2) The specific items raised in the initial hearing request and the specific items identified in subsequent requests to add issues, when combined, satisfy the amount in controversy requirements of paragraph (a)(2) or paragraph (c)(3) of this section.

(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.²⁸

Such attempts by the Provider appear as untimely additions to the instant appeal. Further, as addressed by the Medicare Contractor in its March 12, 2025 Final Position Paper, the Medicare Contractor has no record of receiving any listings or documents from the Provider. The Provider added bad debt issues 3 and 4 on June 4, 2019 to the instant appeal. The Provider filed its Preliminary Position Paper on January 6, 2020.

²⁷ Provider's Preliminary Position Paper at 10-11 (emphasis added).

²⁸ (emphasis added).

In the Medicare Contractor's April 28, 2020 Preliminary Position Paper, it states:

It may be possible that the Provider could "cure" the errors noted. If the Provider wishes, the MAC will agree to review documentation submitted by the Provider in the future as part of this appeal. To the extent the Provider adequately documents its claim for Medicare Bad Debt reimbursement, the MAC will agree to resolve this issue administratively.²⁹

In its Final Position Paper dated March 12, 2025, the Medicare Contractor notes:

The MAC asserts that it has no record of receiving any listings or required documents from the Provider to demonstrate that the MAC's adjustments to disallow the claimed Medicare bad debts were not in accordance with 42 C.F.R. § 413.89, 42 C.F.R. § 413.20, and 42 C.F.R. § 413.24.³⁰

Effectively, ***the Provider had over five (5) years to supply documentation*** to the Medicare Contractor and yet did not furnish any documentation. Further, the Provider did not submit any documentation or additional exhibits to the Board, and did not respond to the Medicare Contractor's Jurisdictional Challenge filed on April 11, 2025. The Provider has been afforded ample time to comply with the filing deadlines and response timelines.

The Board, for the reasons set forth above, finds that the Provider failed to develop its case as required by the regulations and the Board Rules for the remaining bad debts issues. The Provider moreover failed to develop arguments regarding its dispute in both its preliminary and final position papers and only states that it allegedly has additional documentation to supply to the Medicare Contractor which has never been sent to the Board or the Medicare Contractor. The Provider further failed to set forth the merits of its claims, explain why the Medicare Contractor's audit is incorrect, identify missing documents to support its claim, and explain both why these documents remain unavailable and when they will become available. As such, the Board finds that the Provider has essentially abandoned the appeal by filing perfunctory position papers that did not include any discussion or analysis about the Medicare Contractor's sample errors and application of the sample results and instead attempts to raise new issues which are untimely additions to the instant appeal.

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. § 405.1835 and Board Rules 8, 25.1.1, 25.2.2 and 25.3.3 related to identifying and properly framing the issues in dispute and timely submission of evidence required to support its claims or describe why said evidence was unavailable. This the Provider also failed to do.

²⁹ Medicare Contractor's Preliminary Position Paper at 12.

³⁰ Medicare Contractor's Final Position Paper at 18.

Based on the foregoing, the Board dismisses the remaining issues, Issue 3 and Issue 4, in this case. As no issues remain, the Board hereby closes Case No. 19-1887 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:

8/27/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., Federal Specialized Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Dismissal of Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Groups***
25-1952G et al. (See Attached Listing of 25 Cases)

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the “Board”) has reviewed the appeal requests in the 25 above-referenced cases. Set forth below is the decision of the Board to dismiss the above-captioned common issue related party (“CIRP”) group appeals. The pertinent facts and the Board’s determination are set forth below.

Introduction

Quality Reimbursement Services, Inc. (“QRS”) filed the above-referenced 25 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

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 inpatient prospective payment system (“IPPS”).² Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.³

¹ See e.g., Case Number 25-1952GC, Providers’ Issue Statement at 1 (Feb. 5, 2025)

² See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

³ *Id.*

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.⁴ 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.”⁵

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage (“DPP”).⁶ 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.⁷ The DPP is defined as the sum of two fractions expressed as percentages.⁸ Those two fractions are referred to as the “Medicare/SSI fraction” and the “Medicaid fraction.”

This matter concerns the Medicare/SSI fraction.⁹ 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 eligibility for and if eligible, the amount of any DSH payment adjustment.¹⁰ 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.

⁴ See 42 U.S.C. § 1395ww(d)(5).

⁵ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

⁶ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(l).

⁷ See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

⁸ See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

⁹ 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).

¹⁰ 42 C.F.R. § 412.106(b)(2)-(3).

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, which 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.”¹¹ 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”¹² 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 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.”¹³

¹¹ CMS Transmittal 12747 at 3 (July 26, 2024).

¹² *Id.*

¹³ CMS Transmittal 12785 at 1 (Aug. 13, 2024).

Medicare Contractor Jurisdictional Challenge

A. The Transmittal is Not an Appealable Final Determination

The Medicare Contractor asserts that the Board does not have jurisdiction over the issue in these group appeals “because the appeal does not arise from a ‘final determination’ as that term is used in 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 1835(a) (as also cross-referenced in 42 C.F.R. § 405.1837(a)(1)).”¹⁴ The Medicare Contractor explains that the Providers appealed from Transmittal 12747 and/or Transmittal 12785, and argues that these documents are not appealable final determinations.¹⁵

The Medicare Contractor also argues that the court decisions the Provider referenced in their appeals are inapplicable to the instant appeals. The Medicare Contractor explains that the Providers recognized the Board’s previous dismissal of appeals from the publication of SSI percentages by stating:

The Provider [Group] is aware that the PRRB has taken the position that the publication of SSI Ratio is not a final determination and that providers must await a Notice of Program Reimbursement (NPR) setting its total reimbursement before challenging its Medicare Fraction, but the Provider [Group] respectfully submits that the PRRB is incorrect, as decided in two recent court decisions. *See Battle Creek Health Sys. v. Becerra*, Civil Action 17-0545 (CKK) (D.D.C. Oct. 31, 2023); *Baylor All Saints Med Ctr. v. Becerra*, Civil Action 4:24-cv-00432-P (N.D. Tex. Aug. 15, 2024).¹⁶

The Medicare Contractor points to a prior Board decision in which it distinguished the decision in *Battle Creek* from the facts of the appeal before the Board, and argues that the Board should make a similar finding here with respect to the applicability of *Battle Creek* to these transmittal appeals.¹⁷ With respect to *Baylor All Saints*, the Medicare Contractor argues that “[b]ecause the Court failed to address the statutory requirements for Board jurisdiction, the Providers’ reliance on [the case] is without merit.”¹⁸

Next, the Medicare Contractor argues that even if the Transmittals constituted an appealable final determination, the appeals were not timely filed. The final determination support included for each Provider in these groups is a copy of either the July 26, 2024 CMS Transmittal 12747 or the August 13, 2024 Transmittal 12785, both of which implement the Medicare Part C final rule which was issued on June 9, 2023.¹⁹

¹⁴ See e.g., Case No. 25-1952G, Jurisdictional Challenge at 2 (May 6, 2025).

¹⁵ *Id.*

¹⁶ *Id.* at 5.

¹⁷ *Id.* at 6.

¹⁸ *Id.*

¹⁹ *Id.* at 6-7.

B. Providers Not Timely Added

Additionally, the Medicare Contractor has pointed out a number of Providers that it argues were untimely added to their respective group appeals based on the direct add date and the August 13, 2024 date of the Transmittal. The Medicare Contractor has listed all of the Providers it argues were untimely added at pages 8-16 of the Jurisdictional Challenge.

C. Provider Appealed from Revised NPR

With respect to Case No. 25-1971G, the Medicare Contractor argues that Provider No. 39-0009, St. Vincent Hospital, FYE 6/30/2007, was added to the appeal in error, as the Provider is appealing from a revised Notice of Program Reimbursement, rather than the Transmittal from which all the other Providers are appealing. The Medicare Contractor also argues that the Provider's revised NPR only included an adjustment "to remove HCRIS errors from the cost report and to include the most recent settlement data;" the revised NPR did not include an adjustment to the SSI percentage.²⁰

Providers' Jurisdictional Response

A. The Transmittal is Not an Appealable Final Determination

The Providers argue that the Board has jurisdiction over the appeals under the statute. According to the Provider:

Congress added romanette (ii) to section 1878(a)(1)(A) of the [Social Security] Act, to confer jurisdiction on the Board where a provider is "dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1886."

The fundamental flaw in the PRRB's conclusion that providers must wait to receive an NPR is that romanette (i) of section 1878(a)(1)(A) of the Act already requires an NPR for an intermediary determination. The PRRB's approach renders romanette (II) superfluous. . .²¹

B. Providers Not Timely Added

With respect to the Medicare Contractor's argument that the appeals were not timely filed, the Providers argue that the CMS Transmittals in question in these appeals fall under the category of final determination in PRRB Rule 4.3.1, *not* PRRB Rule 4.3.2, as the Board found. In appeals from the same final determinations, the Board found that the Transmittal appeals were more

²⁰ *Id.* at 14-15.

²¹ *See, e.g.*, Case. No. 25-1952G, Jurisdictional Challenge Response at unnumbered page 2 (June 5, 2025).

analogous to a Federal Register notice, and therefore the date of receipt is the publication date, without a five (5) day mailing presumption. The Providers disagree and argue:

[T]he CMS Transmittals in question fall under the category listed in Board Rule 4.3.1, because the Rule does not specify that the “[o]ther determinations issued by CMS or its contractors with regard to the amount of total reimbursement due the provider...” must be specific to “each respective provider” for a CMS determination to be considered an appealable “[f]inal determination.”²²

C. Provider Appealed From RNPR

The Provider did not respond to the challenge that one of the providers was added to this group in error as it appealed from a revised NPR rather than the Transmittal, or that the revised NPR did not adjust the SSI percentage.

Board Determination:

A. Transmittals 12747 and 12785 Are Not Appealable Final Determinations

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 Provider Group “is dissatisfied with this determination . . . the PRRB has jurisdiction over” the appeal.²³ 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”²⁴ 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 25 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);²⁵ and second, where the provider is dissatisfied with a “final determination . . . as to the amount of the payment” under the prospective payment system.²⁶ 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.

²² *Id.* at unnumbered pages 2-3.

²³ *See e.g.* Case No 25-1952G, Providers’ Issue Statement at 1.

²⁴ CMS Transmittal 12785/Change Request 13413 at 1 (Aug. 13, 2024).

²⁵ 42 U.S.C. § 1395oo(a)(1)(A)(i).

²⁶ *Id.* § 1395oo(a)(1)(A)(ii).

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.”²⁷ But the Providers also note disagreement with the Board’s position, citing *Battle Creek Health Sys. v. Becerra*,²⁸ and *Baylor All Saints Med. Ctr. v. Becerra*,²⁹ 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.³⁰

The Board has continued to find that the district court’s decision in *Battle Creek* is inapposite because, unlike in the instant cases, the challenged Transmittal and publication of data in that case was described by the court as being a “*fait accompli*.”³¹ The district 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.’”³² On appeal, however, the Court of Appeals for the D.C. Circuit very recently disagreed with the lower court’s reasoning, and reversed that decision finding:

According to the Board, the hospitals needed to wait until they knew the final amount of their DSH adjustment rather than just the determination of one component of it. The district court disagreed and concluded that the hospitals’ challenge could go forward. Because we agree with the Board, we reverse the district court.³³

The Court also distinguished *Battle Creek* from *Washington Hospital Center*, and continued:

This case is different. Here, the Medicare fraction had been published and the hospitals sought to challenge its calculation. But other components of the DSH adjustment (and thus of the per-patient payment amount) had yet to be finalized. Indeed, the hospitals could not know that they would be eligible for a DSH adjustment based on the Medicare fraction alone. The Medicaid fraction remained outstanding, and so too, therefore, did the disproportionate-patient percentage, and ultimately the hospitals’ eligibility for, and amount of, any DSH adjustment. *See pp. — — — — —, — — — — —, supra*. Those are finally settled upon issuance of an NPR. Unlike in *Washington Hospital Center*, then, in this case there had been no “final determination of the Secretary as to the amount of the payment” under the PPS. 42 U.S.C. §

²⁷ *See e.g.* Case No 25-1952G, Providers’ Issue Statement at 1.

²⁸ 2023 WL 7156125 (D.D.C. Oct. 31, 2023), *appeal docketed*, No. (D.C. Cir. Dec. 29, 2023).

²⁹ 2024 WL 3833278 (N.D. Tex. Aug. 15, 2024), *appeal docketed*, No. 34-10934 (5th Cir. Oct. 17, 2024).

³⁰ *See e.g.* Case No 25-1952G, Providers’ Issue Statement at 1.

³¹ *Battle Creek*, 2023 WL 7156125 at *5.

³² *Id.*

³³ *Battle Creek Health Sys. v. Kennedy*, No. 23-5310, 2025 WL 2423686, at *1 (D.C. Cir. Aug. 22, 2025).

13950o(a)(1)(A)(ii).³⁴

The Board agrees and has found that the publication of the challenged 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 the district court decision in *Battle Creek* and by extension, other court decisions like *Baylor All Saints*.³⁵ The Board maintains that *Memorial Hospital v. Becerra*,³⁶ and now the Court of Appeals decision in *Battle Creek* are better-reasoned decisions. In *Memorial Hospital*, a group of providers filed an appeal similar to the Providers' appeals in the instant 25 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.'"³⁷ 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."³⁸ For the court, a challenge to an element of payment under 42 U.S.C.

§ 13950o(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).'"³⁹

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

³⁴ *Id.* at *6.

³⁵ *See, e.g.*, Board decisions in PRRB Case Nos. 24-0491, 24-1531GC, and 24-0413GC.

³⁶ 2022 WL 888190 (D.D.C. Mar. 25, 2022).

³⁷ *Id.* at *8.

³⁸ *Id.* at *9.

³⁹ *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. § 13950o(a)(1)(A)(ii).").

also exceed certain thresholds to qualify for any DSH adjustment.⁴⁰ 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 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."⁴¹ 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."⁴²

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).⁴³ 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.

⁴⁰ 42 C.F.R. § 412.106(d)(2)(i)-(ii).

⁴¹ See e.g. Case No 25-1952G, Providers' Issue Statement at 1. Although the Providers characterize 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.

⁴² See 42 U.S.C. § 1395oo(a)(1)(A)(ii).

⁴³ See 42 U.S.C. § 1395oo(b); 42 C.F.R. § 405.1837(a)(3).

B. Appeals Not Timely Filed

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 were 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.⁴⁴ Given the nature of the Groups' 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 5 and 14, 2025, nearly two weeks or more 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.

1. Providers Not Timely Directly Added to Appeals

Additionally, in these groups currently before the Board, there are Providers in each group⁴⁵ that were directly added to the groups on February 13, 2025 and February 14, 2025, which is 184 and 185 days, respectively, from the August 13, 2024 Transmittal date. Even if the Board were to have found that the Transmittal is an appealable final determination, the Board would find that the Providers listed in Appendix B did not timely file their appeals.

42 C.F.R. § 405.1835(a)(3) indicates that, "[u]nless the provider qualifies for a good cause extension", the Board must receive a Provider's hearing request "***no later than 180 days after the date of receipt by the Provider of the final contractor or Secretary determination.***"⁴⁶

Board Rule 4.3, Commencement of Appeal Period, specifies various types of final determinations and states:

4.3.1 Contractor/CMS/Secretary Final Determination

Final Determinations include:

- Notices of Program Reimbursement;
- Revised Notices of Program Reimbursement;
- Exception Determinations;

⁴⁴ See also 42 C.F.R. § 405.1835(a)(3)

⁴⁵ Providers are listed in Appendix B.

⁴⁶ Emphasis added.

- Quality Reporting Program Payment Reduction Determinations; and
- Other determinations issued by CMS or its *contractors with regard to the amount of total reimbursement due the provider.*

The date of receipt of a contractor/CMS/Secretary final determination is presumed to be five (5) days after the date of issuance. This presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date. *See* 42 C.F.R. § 405.1801(a)(1)(iii).⁴⁷

This rule also goes on to explain that there is no five (5) day mailing presumption for appeals from Federal Register Notices:

4.3.2 Federal Register Notice

The date of receipt of a Federal Register Notice is the date the Federal Register is *published*. The appeal period begins on the *date of publication* and ends 180 days from that date.⁴⁸

Board Rule 4.5, Date of Receipt by the Board, states that “[t]he timeliness of a filing is determined based on the date of receipt by the Board,” and “[t]he date of receipt is presumed to be [] the date of filing in OH CDMS as evidenced by the Confirmation of Correspondence generated by the system.”⁴⁹

Here, the Board finds that the Transmittal, if it were an appealable final determination, is akin to a Federal Register Notice appeal, thus there is no 5-day mailing presumption. If that is the case, then the Providers that were directly added to the group appeals on February 13, 2025 and February 14, 2025, which is 184 and 185 days from the August 13, 2024 Transmittal date, were not timely filed.

2. Providers Did Not Timely File Individual Appeal Requests

There are a number of Providers in each of these group appeals that filed individual appeal requests and then requested to transfer the SSI Statutory and Systemic Errors issue to group appeals. These Providers, listed in Appendix C, below, did not timely file their individual appeal requests as they were filed between February 12 – 14, 2025, which is between 183 and 185 days from the August 13, 2024 Transmittal date. Thus, even if the Board were to have found that the Transmittal is an appealable final determination, the Board would find that the Providers did not

⁴⁷ Emphasis added.

⁴⁸ Emphasis added.

⁴⁹ *See also* 42 C.F.R. § 405.1801(a)(2)(iii).

timely file their individual appeal requests and would **deny** the requests to transfer the issue to these various group appeals. Further, although the individual appeals have already been closed as the transfers were processed in OH CDMS, these appeals would remain closed as they were not timely filed in accordance with 42 C.F.R. § 405.1835(a)(3) and Board Rules 4.3 and 4.5.

C. RNPR Appeal in Case No. 25-1971G

Provider No. 39-0009, St. Vincent Hospital, FYE 6/30/2007 in Case No. 25-1971G filed an appeal from a revised NPR issued on September 11, 2024. The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885, which provides in relevant part:

(a) General. (1) A Secretary determination, a contractor determination, or a decision by a reviewing entity (as described in § 405.1801(a)) may be reopened, with respect to specific findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the contractor (with respect to contractor determinations), or by the reviewing entity that made the decision. . . .

Additionally, 42 C.F.R. § 405.1889⁵⁰ explains the effect of a cost report revision:

(a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.

(b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

As outlined above, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to “[o]nly those matters that are specifically revised[.]”⁵¹

⁵⁰ See also *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

⁵¹ 42 C.F.R. § 405.1889(b)(1).

Here, the Provider appealed from a revised NPR that only included adjustments to clear Level I or HCRIS consistency edits and to include the most recent settlement data. Additionally, the Provider included the Notice of Intent to Reopen Medicare Cost Report which stated:

This Notice of Intent to Reopen is issued in accordance with 42 CFR 405.1885, 405.1887. This rule states that where material information is discovered, the provider must be informed of the Medicare Administrative Contractor's intention to reopen the previous determination (Notice of Program Reimbursement). Saint Vincent Health Center for the fiscal year ended 6/30/2007 is reopened per Provider Reimbursement Manual 15-1 Section 2931.2.

This Notice of Intent to Reopen is issued based on the following statement: In the event of an unfavorable final non-appealable decision in *Allina Health Services v. Sebelius*, the cost report will be reopened to adjust the Disproportionate Share payment calculation.⁵²

It is unclear whether this Provider was unintentionally added to this group, considering all of the other providers are appealing from the Transmittal. Regardless, the Board finds that it does not have jurisdiction over this Provider as it appealed from a revised NPR that did not specifically adjust the SSI percentage as required by the regulations. Based on the Notice of Reopening that the Provider submitted with its direct add, the cost report was reopened for Part C days (i.e. *Allina*). Further, there is no SSI adjustment on the audit adjustment report, therefore the Board finds that it does not have jurisdiction over this provider as a participant in the group.

Conclusion

The Board finds that it does not have jurisdiction over the revised NPR appeal Provider No. 39-0009, St. Vincent Hospital, FYE 6/30/2007 in Case No. 25-1971G and dismisses the Provider from that group. 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 25 group appeals and removes them from the Board's docket.

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

⁵² Notice of Intent to Reopen Medicare Cost Report at 1 (Aug. 26, 2014).

Board Members:

Kevin D. Smith, CPA

Ratina Kelly, CPA

Nicole E. Musgrave, Esq.

Shakeba DuBose, Esq.

FOR THE BOARD:

8/27/2025

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

Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators

Enclosures: Appendix A – Listing of Cases

Appendix B – Listing of Providers that did not timely direct add to group

Appendix C – Listing of Providers that did not timely file appeal requests

Appendix A

Listing of 25 Cases

25-1952G	QRS CY 1988 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-1953G	QRS CY 1989 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-1954G	QRS CY 1990 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-1956G	QRS CY 1992 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-1957G	QRS CY 1993 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-1958G	QRS CY 1994 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-1959G	QRS CY 1995 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-1960G	QRS CY 1996 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-1961G	QRS CY 1997 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-1962G	QRS CY 1998 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-1963G	QRS CY 1999 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-1964G	QRS CY 2000 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-1965G	QRS CY 2001 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-1966G	QRS CY 2002 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-1967G	QRS CY 2003 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-1968G	QRS CY 2004 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-1969G	QRS CY 2005 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-1970G	QRS CY 2006 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-1971G	QRS CY 2007 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-1972G	QRS CY 2008 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-1973G	QRS CY 2009 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-1974G	QRS CY 2010 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-1975G	QRS CY 2011 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-1976G	QRS CY 2012 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-1977G	QRS CY 2013 Medicare Fraction (SSI) - Statutory & Systemic Errors Group

Appendix B

Providers that Did Not Timely Direct Add Issue to Group

01	25-1952G QRS CY 1988 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
06-0022	Memorial Hospital Central	12/31/1988	02/13/2025	08/13/2024
26-0040	Cox Medical Centers	09/20/1988	02/13/2025	08/13/2024
45-0231	BSA Hospital	12/31/1988	02/13/2025	08/13/2024
02	25-1953G QRS CY 1989 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
05-0360	Marinhealth Medical Center	06/30/1989	02/14/2025	08/13/2024
06-0022	Memorial Hospital Central	12/31/1989	02/13/2025	08/13/2024
24-0036	St Cloud Hospital	06/30/1989	02/14/2025	08/13/2024
26-0040	Cox Medical Centers	09/20/1989	02/13/2025	08/13/2024
45-0231	BSA Hospital	12/31/1989	02/13/2025	08/13/2024
03	25-1954G QRS CY 1990 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
05-0360	Marinhealth Medical Center	06/30/1990	02/14/2025	08/13/2024
06-0022	Memorial Hospital Central	12/31/1990	02/13/2025	08/13/2024
24-0036	St Cloud Hospital	06/30/1990	02/14/2025	08/13/2024
26-0040	Cox Medical Centers	09/20/1990	02/13/2025	08/13/2024
45-0231	BSA Hospital	12/31/1990	02/13/2025	08/13/2024

05	25-1956G QRS CY 1992 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
05-0360	Marinhealth Medical Center	12/31/1992	02/14/2025	08/13/2024
06-0022	Memorial Hospital Central	12/31/1992	02/13/2025	08/13/2024
07-0016	St. Mary's Hospital, Inc.	09/30/1992	02/14/2025	08/13/2024
24-0036	St Cloud Hospital	06/30/1992	02/14/2025	08/13/2024
26-0040	Cox Medical Centers	09/20/1992	02/13/2025	08/13/2024
45-0231	BSA Hospital	12/31/1992	02/13/2025	08/13/2024
06	25-1957G QRS CY 1993 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
05-0360	Marinhealth Medical Center	12/31/1993	02/14/2025	08/13/2024
06-0022	Memorial Hospital Central	12/31/1993	02/13/2025	08/13/2024
07-0016	St. Mary's Hospital, Inc.	09/30/1993	02/14/2025	08/13/2024
24-0036	St Cloud Hospital	06/30/1993	02/14/2025	08/13/2024
26-0040	Cox Medical Centers	09/20/1993	02/13/2025	08/13/2024
45-0231	BSA Hospital	12/31/1993	02/13/2025	08/13/2024
07	25-1958G QRS CY 1994 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
05-0360	Marinhealth Medical Center	12/31/1994	02/14/2025	08/13/2024
06-0022	Memorial Hospital Central	12/31/1994	02/13/2025	08/13/2024
07-0016	St. Mary's Hospital, Inc.	09/30/1994	02/14/2025	08/13/2024
24-0036	St Cloud Hospital	06/30/1994	02/14/2025	08/13/2024
26-0040	Cox Medical Centers	09/20/1994	02/13/2025	08/13/2024
45-0231	BSA Hospital	12/31/1994	02/13/2025	08/13/2024

08	25-1959G QRS CY 1995 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
05-0360	Marinhealth Medical Center	12/31/1995	02/14/2025	08/13/2024
06-0022	Memorial Hospital Central	12/31/1995	02/13/2025	08/13/2024
07-0016	St. Mary's Hospital, Inc.	09/30/1995	02/14/2025	08/13/2024
24-0036	St Cloud Hospital	06/30/1995	02/14/2025	08/13/2024
26-0040	Cox Medical Centers	09/20/1995	02/13/2025	08/13/2024
45-0231	BSA Hospital	12/31/1995	02/13/2025	08/13/2024
09	25-1960G QRS CY 1996 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
05-0360	Marinhealth Medical Center	12/31/1996	02/14/2025	08/13/2024
06-0022	Memorial Hospital Central	12/31/1996	02/13/2025	08/13/2024
07-0016	St. Mary's Hospital, Inc.	09/30/1996	02/14/2025	08/13/2024
24-0036	St Cloud Hospital	06/30/1996	02/14/2025	08/13/2024
26-0040	Cox Medical Centers	09/20/1996	02/13/2025	08/13/2024
45-0231	BSA Hospital	12/31/1996	02/13/2025	08/13/2024
10	25-1961G QRS CY 1997 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
05-0360	Marinhealth Medical Center	12/31/1997	02/14/2025	08/13/2024
06-0022	Memorial Hospital Central	12/31/1997	02/13/2025	08/13/2024
24-0036	St Cloud Hospital	06/30/1997	02/14/2025	08/13/2024
26-0040	Cox Medical Centers	09/20/1997	02/13/2025	08/13/2024
45-0231	BSA Hospital	12/31/1997	02/13/2025	08/13/2024

11	25-1962G QRS CY 1998 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
05-0360	Marinhealth Medical Center	12/31/1998	02/14/2025	08/13/2024
06-0022	Memorial Hospital Central	12/31/1998	02/13/2025	08/13/2024
24-0036	St Cloud Hospital	06/30/1998	02/14/2025	08/13/2024
26-0040	Cox Medical Centers	09/20/1998	02/13/2025	08/13/2024
45-0231	BSA Hospital	12/31/1998	02/13/2025	08/13/2024
12	25-1963G QRS CY 1999 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
05-0360	Marinhealth Medical Center	12/31/1999	02/14/2025	08/13/2024
06-0022	Memorial Hospital Central	12/31/1999	02/13/2025	08/13/2024
24-0036	St Cloud Hospital	06/30/1999	02/14/2025	08/13/2024
26-0040	Cox Medical Centers	09/20/1999	02/13/2025	08/13/2024
45-0231	BSA Hospital	12/31/1999	02/13/2025	08/13/2024
13	25-1964G QRS CY 2000 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
05-0360	Marinhealth Medical Center	12/31/2000	02/14/2025	08/13/2024
24-0036	St Cloud Hospital	06/30/2000	02/14/2025	08/13/2024
26-0040	Cox Medical Centers	09/20/2000	02/13/2025	08/13/2024
45-0231	BSA Hospital	12/31/2000	02/13/2025	08/13/2024

14	25-1965G QRS CY 2001 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
05-0360	Marinhealth Medical Center	12/31/2001	02/14/2025	08/13/2024
24-0036	St Cloud Hospital	06/30/2001	02/14/2025	08/13/2024
26-0040	Cox Medical Centers	09/20/2001	02/13/2025	08/13/2024
45-0231	BSA Hospital	12/31/2001	02/13/2025	08/13/2024
15	25-1966G QRS CY 2002 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
05-0360	Marinhealth Medical Center	12/31/2002	02/14/2025	08/13/2024
07-0016	Saint Mary's Hospital, Inc.	09/30/2002	02/14/2025	08/13/2024
24-0036	St Cloud Hospital	06/30/2002	02/14/2025	08/13/2024
26-0040	Cox Medical Centers	09/20/2002	02/13/2025	08/13/2024
45-0231	BSA Hospital	12/31/2002	02/13/2025	08/13/2024
16	25-1967G QRS CY 2003 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
05-0360	Marinhealth Medical Center	12/31/2003	02/14/2025	08/13/2024
07-0016	Saint Mary's Hospital, Inc.	09/30/2003	02/14/2025	08/13/2024
24-0036	St Cloud Hospital	06/30/2003	02/14/2025	08/13/2024
26-0040	Cox Medical Centers	09/20/2003	02/13/2025	08/13/2024
45-0231	BSA Hospital	12/31/2003	02/13/2025	08/13/2024

17	25-1968G QRS CY 2004 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
05-0360	Marinhealth Medical Center	12/31/2004	02/14/2025	08/13/2024
07-0005	Waterbury Hospital.	09/30/2004	02/10/2025	08/13/2024
24-0036	St Cloud Hospital	06/30/2004	02/14/2025	08/13/2024
26-0040	Cox Medical Centers	09/20/2004	02/13/2025	08/13/2024
28-0032	Mary Lanning Healthcare	12/31/2004	02/13/2025	08/13/2024
45-0231	BSA Hospital	12/31/2004	02/13/2025	08/13/2024
18	25-1969G QRS CY 2005 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
05-0360	Marinhealth Medical Center	12/31/2005	02/14/2025	08/13/2024
07-0005	Waterbury Hospital.	09/30/2005	02/10/2025	08/13/2024
24-0036	St Cloud Hospital	06/30/2005	02/14/2025	08/13/2024
26-0040	Cox Medical Centers	09/20/2005	02/13/2025	08/13/2024
28-0032	Mary Lanning Healthcare	12/31/2005	02/13/2025	08/13/2024
45-0231	BSA Hospital	12/31/2005	02/13/2025	08/13/2024
19	25-1970G QRS CY 2006 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
05-0360	Marinhealth Medical Center	12/31/2006	02/14/2025	08/13/2024
07-0005	Waterbury Hospital.	09/30/2006	02/10/2025	08/13/2024
24-0036	St Cloud Hospital	06/30/2006	02/14/2025	08/13/2024
26-0040	Cox Medical Centers	09/20/2006	02/13/2025	08/13/2024
28-0032	Mary Lanning Healthcare	12/31/2006	02/13/2025	08/13/2024
45-0231	BSA Hospital	12/31/2006	02/13/2025	08/13/2024

20	25-1971G QRS CY 2007 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
05-0360	Marinhealth Medical Center	12/31/2007	02/14/2025	08/13/2024
24-0036	St Cloud Hospital	06/30/2007	02/14/2025	08/13/2024
28-0032	Mary Lanning Healthcare	12/31/2007	02/13/2025	08/13/2024
45-0231	BSA Hospital	12/31/2007	02/13/2025	08/13/2024
21	25-1972G QRS CY 2008 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
05-0360	Marinhealth Medical Center	12/31/2008	02/14/2025	08/13/2024
24-0036	St Cloud Hospital	06/30/2008	02/14/2025	08/13/2024
28-0032	Mary Lanning Healthcare	12/31/2008	02/13/2025	08/13/2024
45-0231	BSA Hospital	12/31/2008	02/13/2025	08/13/2024
22	25-1973G QRS CY 2009 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
05-0360	Marinhealth Medical Center	12/31/2009	02/14/2025	08/13/2024
24-0036	St Cloud Hospital	06/30/2009	02/14/2025	08/13/2024
28-0032	Mary Lanning Healthcare	12/31/2009	02/13/2025	08/13/2024
45-0231	BSA Hospital	12/31/2009	02/13/2025	08/13/2024
23	25-1974G QRS CY 2010 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
05-0360	Marinhealth Medical Center	12/31/2010	02/14/2025	08/13/2024
24-0036	St Cloud Hospital	06/30/2010	02/15/2025	08/13/2024
28-0032	Mary Lanning Healthcare	12/31/2010	02/13/2025	08/13/2024
45-0231	BSA Hospital	12/31/2010	02/13/2025	08/13/2024

24	25-1975G QRS CY 2011 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
05-0360	Marinhealth Medical Center	12/31/2011	02/14/2025	08/13/2024
24-0036	St Cloud Hospital	06/30/2011	02/15/2025	08/13/2024
28-0032	Mary Lanning Healthcare	12/31/2011	02/13/2025	08/13/2024
45-0231	BSA Hospital	12/31/2011	02/13/2025	08/13/2024
25	25-1976G QRS CY 2012 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
05-0360	Marinhealth Medical Center	12/31/2012	02/14/2025	08/13/2024
24-0036	St Cloud Hospital	06/30/2012	02/15/2025	08/13/2024
28-0032	Mary Lanning Healthcare	12/31/2012	02/13/2025	08/13/2024
45-0231	BSA Hospital	12/31/2012	02/13/2025	08/13/2024
26	25-1977G QRS CY 2013 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
05-0360	Marinhealth Medical Center	12/31/2013	02/14/2025	08/13/2024
28-0032	Mary Lanning Healthcare	12/31/2013	02/13/2025	08/13/2024

Appendix C

Providers That Did Not Timely File Individual Appeal Requests

01	25-1952G QRS CY 1988 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Transmittal
45-0686	University Medical Ctr	25-2676	02/13/2025	08/13/2024
02	25-1953G QRS CY 1989 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Transmittal
17-0040	Univ. of Kansas Hosp.	25-2691	02/13/2025	08/13/2024
34-0030	Duke Univ. Health System	25-2595	02/12/2025	08/13/2024
45-0686	Univ. Medical Ctr.	25-2678	02/13/2025	08/13/2024
03	25-1954G QRS CY 1990 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Transmittal
34-0030	Duke Univ. Health System	25-2596	02/12/2025	08/13/2024
45-0686	Univ. Medical Center	25-2679	02/13/2025	08/13/2024
17-0040	Univ. of Kansas Hosp.	25-2693	02/13/2025	08/13/2024
05	25-1956G QRS CY 1992 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Transmittal
17-0040	Univ. of Kansas Hosp.	25-2696	02/13/2025	08/13/2024
34-0030	Duke Univ. Hosp.	25-2598	02/12/2025	08/13/2024
45-0686	Univ. Medical Ctr.	25-2683	02/13/2025	08/13/2024

06	25-1957G QRS CY 1993 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Transmittal
34-0030	Duke Univ. Hosp.	25-2599	02/12/2025	08/13/2024
45-0686	Univ. Medical Ctr.	25-2685	02/13/2025	08/13/2024
17-0040	Univ. of Kansas Hosp.	25-2697	02/13/2025	08/13/2024
07	25-1958G QRS CY 1994 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Transmittal
34-0030	Duke Univ. Hosp.	25-2600	02/12/2025	08/13/2024
45-0686	Univ. Med. Ctr.	25-2687	02/13/2025	08/13/2024
17-0040	Univ. of Kansas Hosp.	25-2698	02/13/2025	08/13/2024
08	25-1959G QRS CY 1995 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Transmittal
34-0030	Duke Univ. Health System	25-2601	02/12/2025	08/13/2024
45-0686	Univ. Medical Ctr.	25-2689	02/13/2025	08/13/2024
17-0040	Univ. of Kansas Hosp.	25-2699	02/13/2025	08/13/2024
09	25-1960G QRS CY 1996 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Transmittal
34-0030	Duke Univ. Health System	25-2602	02/12/2025	08/13/2024
17-0040	Univ. of Kansas Hosp.	25-2700	02/13/2025	08/13/2024
10	25-1961G QRS CY 1997 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Transmittal
17-0040	Univ. of Kansas Hosp.	25-2703	02/13/2025	08/13/2024

11	25-1962G QRS CY 1998 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Transmittal
17-0040	Univ. of Kansas Hosp. (6/30/98)	25-2707	02/13/2025	08/13/2024
17-0040	Univ. of Kansas Hosp. (9/30/98)	25-2709	02/13/2025	08/13/2024
06-0020	Parkview Medical Ctr.	25-2746	02/14/2025	08/13/2024
45-0058	Baptist Medical Ctr.	25-2584	02/12/2025	08/13/2024
12	25-1963G QRS CY 1999 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Transmittal
06-0020	Parkview Medical Ctr.	25-2747	02/14/2025	08/13/2024
17-0040	Univ. of Kansas Hosp.	25-2710	02/13/2025	08/13/2024
13	25-1964G QRS CY 2000 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Transmittal
06-0022	UCH-Memorial Health System	25-2695	02/13/2025	08/13/2024
17-0040	Univ. of Kansas Hosp.	25-2712	02/13/2025	08/13/2024
06-0020	Parkview Medical Ctr.	25-2748	02/14/2025	08/13/2024
14	25-1965G QRS CY 2001 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Transmittal
06-0022	UCH-Memorial Health System	25-2701	02/13/2025	08/13/2024
17-0040	Univ. of Kansas Hosp.	25-2714	02/13/2025	08/13/2024
06-0020	Parkview Medical Ctr.	25-2749	02/14/2025	08/13/2024

15	25-1966G QRS CY 2002 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Transmittal
45-0058	Baptist Medical Ctr.	25-2585	02/12/2025	08/13/2024
06-0022	UCH-Memorial Health System	25-2702	02/13/2025	08/13/2024
17-0040	Univ. of Kansas Hosp.	25-2716	02/13/2025	08/13/2024
06-0020	Parkview Medical Ctr.	25-2750	02/14/2025	08/13/2024
16	25-1967G QRS CY 2003 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Transmittal
45-0058	Baptist Medical Ctr.	25-2586	02/12/2025	08/13/2024
06-0022	UCH-Memorial Health System	25-2704	02/13/2025	08/13/2024
17-0040	Univ. of Kansas Hospital	25-2718	02/13/2025	08/13/2024
06-0020	Parkview Medical Ctr.	25-2751	02/14/2025	08/13/2024
17	25-1968G QRS CY 2004 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Determination
06-0022	UCH-Memorial Health System	25-2705	02/13/2025	08/13/2024
17-0040	Univ. of Kansas Hosp.	25-2719	02/13/2025	08/13/2024
06-0020	Parkview Medical Ctr.	25-2752	02/14/2025	08/13/2024
18	25-1969G QRS CY 2005 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Determination
06-0022	UCH-Memorial Health System	25-2706	02/13/2025	08/13/2024
17-0040	Univ. of Kansas Hosp.	25-2720	02/13/2025	08/13/2024
06-0020	Parkview Medical Ctr.	25-2753	02/14/2025	08/13/2024

19	25-1970G QRS CY 2006 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Determination
06-0020	Parkview Med. Ctr.	25-2754	02/14/2025	08/13/2024
06-0022	UCH-Memorial Health System	25-2708	02/13/2025	08/13/2024
17-0040	Univ. of Kansas Hosp.	25-2721	02/13/2025	08/13/2024
20	25-1971G QRS CY 2007 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Determination
06-0022	UCH-Memorial Health System	25-2711	02/13/2025	08/13/2024
17-0040	Univ. of Kansas Hosp.	25-2722	02/13/2025	08/13/2024
06-0020	Parkview Med. Ctr.	25-2756	02/14/2025	08/13/2024
26-0040	Cox Medical Ctrs.	25-2677	02/13/2025	08/13/2024
21	25-1972G QRS CY 2008 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Determination
26-0040	Cox Medical Ctrs.	25-2680	02/13/2025	08/13/2024
06-0022	UCH-Memorial Health System *	25-2713	02/13/2025	08/13/2024
06-0022	UCH-Memorial Health System *	25-2715	02/13/2025	08/13/2024
17-0040	Univ. of Kansas Hosp.	25-2723	02/13/2025	08/13/2024
06-0020	Parkview Medical Ctr.	25-2757	02/14/2025	08/13/2024

22	25-1973G QRS CY 2009 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Determination
26-0040	Cox Medical Ctrs.	25-2682	02/13/2025	08/13/2024
06-0022	UCH-Memorial Health System	25-2717	02/13/2025	08/13/2024
17-0040	Univ. of Kansas Hosp.	25-2724	02/13/2025	08/13/2024
06-0020	Parkview Medical Ctr.	25-2758	02/14/2025	08/13/2024
23	25-1974G QRS CY 2010 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Determination
17-0040	Univ. of Kansas Hosp.	25-2725	02/13/2025	08/13/2024
06-0020	Parkview Medical Ctr.	25-2759	02/14/2025	08/13/2024
24	25-1975G QRS CY 2011 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Determination
17-0040	Univ. of Kansas Hosp.	25-2726	02/13/2025	08/13/2024
06-0020	Parkview Medical Ctr.	25-2760	02/14/2025	08/13/2024
26-0040	Cox Medical Ctrs.	25-2684	02/13/2025	08/13/2024
25	25-1976G QRS CY 2012 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Determination
26-0040	Cox Medical Ctrs.	25-2686	02/13/2025	08/13/2024
17-0040	Univ. of Kansas Hosp.	25-2727	02/13/2025	08/13/2024
06-0020	Parkview Medical Ctr.	25-2761	02/14/2025	08/13/2024

26 25-1977G QRS CY 2013 Medicare Fraction (SSI) - Statutory & Systemic Errors Group				
Prov No.	Provider Name	Individual Appeal No.	Date of Appeal Request	Date of Determination
26-0040	Cox Medical Ctrs.	25-2688	02/13/2025	08/13/2024
17-0040	Univ. of Kansas Hosp.	25-2729	02/13/2025	08/13/2024
06-0020	Parkview Medical Ctr.	25-2762	02/14/2025	08/13/2024

* The Board notes that these two individual cases were filed on the same day, for the same provider, with the same fiscal year end, from the same “Other” determination dated 8/13/2024. It appears that duplicate cases were filed, both untimely.