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. Greg Justice, CEO
Medical Behavioral Hospital of Indianapolis
1167 Wilson Dr.
Greenwood, IN 46143

RE: **Determination re: Filing Requirements**
Medical Behavioral Hospital of Indianapolis (Provider Number 15-4068)
Appealed Period: FFY 2023
Case Number: 25-4060

Dear Mr. Justice:

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

BACKGROUND:

On March 24, 2025, the Provider filed the above-captioned appeal request relating to the Quality Reporting Program with a sole issue in dispute: 2% APU Reduction. (The Board notes that the Provider entered the Issue Title as, "never received final determination letter".)

The Board further notes that the final determination date was entered into OH CDMS as January 5, 2025. However, the support document uploaded for the final determination is a letter dated March 24, 2025 and states, in part, "No final determination letter was received but we have received a reduction of 2% Medicare reduction."

RULES/REGULATIONS:

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

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing in the manner prescribed by the Board, and the request must include the elements described in paragraphs (b)(1) through (4) of this section. If the provider submits a hearing request that does not meet the

> requirements of paragraph (b)(1), (2), or (3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.
>
> ***
>
> (3) A copy of the final contractor or Secretary determination under appeal . . .

Board Rule 4.1, listed below, addresses the filing requirements for an appeal:

> **Board Rule 4.1 General Requirements**
>
> See 42 C.F.R. §§ 405.1835 - 405.1840.
>
> **The Board will dismiss appeals that fail to meet the timely filing requirements and/or jurisdictional requirements.** A jurisdictional challenge (see Rule 44.4) may be raised at any time during the appeal; however, for judicial economy, the Board strongly encourages filing any challenges as soon as possible. The Board may review jurisdiction on its own motion at any time. The parties cannot waive jurisdictional requirements.

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

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

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

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

7.1.2 Additional Requirements for Specific Determination Types

*** * ***

7.1.2.4 Quality Reporting Payment Reduction Decision

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

<u>BOARD DETERMINATION:</u>

The Board has determined that the subject appeal, as filed, is jurisdictionally deficient and does not meet the regulatory requirements for filing since the Provider failed to submit the ***final determination*****,** dated January 5, 2025, on which the Provider has indicated the appeal is based. The Board notes that the Provider has indicated, on several occasions, that it never received a final determination. In addition, it is noted that the Provider did not supply any proof that a reconsideration request was ever filed with the Medicare Contractor ("MAC"), which is required to get a final determination letter. Lastly, the Board notes that the support document filed as the final determination for the subject appeal identified a different provider and case number (Provider Number 15-4061, Case Number 25-1491).

By omitting the final determination in the appeal request,[1] the Board has determined that the Provider failed to meet the minimum filing requirements as set forth in 42 C.F.R. §§ 405.1835 - 405.1840 and the Board Rules cited above. As a result, the Board hereby dismisses case number 25-4060, in its entirety, and removes it from its docket.

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

[1] The Board notes that it is unclear if the final determination was ever requested by the Provider from the Medicare Contractor upon realization that a 2% reduction was applied.

Board Members:

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

FOR THE BOARD:

7/1/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-8)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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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: 15-3341G - *HRS 2013 Outlier Threshold Payments 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]

The parties have filed preliminary position papers in this case,[2] but no Final Position Papers have been filed.

On **June 5, 2025**, the Providers filed a request for Expedited Judicial Review ("EJR")

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.[3] 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] These predetermined, standardized amounts are calculated by the Secretary first determining a

[1] Group Issue Statement at 1 (Sep. 16, 2015).
[2] The Preliminary Position Papers in this case were filed in 2016 and, based on Board Rule 25.3 (2015), only the cover page and preliminary documentation list was filed with the Board.
[3] *See* 42 U.S.C. § 1395f(b)(1).
[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*

nationwide average allowable cost per discharge,[6] which is then further adjusted based on a wage index specific to the locality of the hospital.[7] Each discharge is also adjusted based on the severity of illness, which are classified as distinct diagnosis-related groups ("DRGs").[8] 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."[9]

While the IPPS provides a fixed amount of reimbursement per patient regardless of actual costs incurred in rendering services,[10] Congress also authorized supplemental "outlier payments," or additional reimbursement for patients' care if the cost was atypically high.[11] 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."[12]

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.[13] 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."[14] This amount essentially makes a hospital responsible for a portion of the treatment's excessive costs.[15] 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.[16] The sum of the DRG rate plus the fixed loss threshold is known as the "outlier threshold."[17] Hospitals are typically paid 80% of the costs above the applicable outlier threshold.[18]

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.'"[19] To combat turbo-charging, the Secretary began using more recent data and also reserved the right to

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[6] 42 U.S.C. § 1395ww(d)(2)(A)-(C).
[7] 42 U.S.C. § 1395ww(d)(2)(H).
[8] 42 U.S.C. § 1395ww(d)(4).
[9] *See Cape Cod Hosp. v. Sebelius*, 630F.3d 203, 205-206 (D.C. Cir. 2011).
[10] *See Sebelius v. Auburn Reg'l Med. Ctr.*, 133 S.Ct. 817, 822 (2013).
[11] *See County of L.A. v. Shalala*, 192 F.3d 1005, 1009 (1999); 42 U.S.C. § 1395ww(d)(5)(A).
[12] 42 U.S.C. § 1395ww(d)(5)(A)(ii).
[13] *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).
[14] *See Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d at 50.
[15] *See Boca Raton Comm. Hosp., Inc. v. Tenet Health Care Corp.*, 582 F.3d 1227, 1229 (11th Cir. 2009).
[16] 42 U.S.C. § 1395ww(d)(5)(A)(iv).
[17] *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).
[18] 42 C.F.R. § 412.84(k).
[19] *Billings Clinic v. Azar*, 901 F.3d 301, 306 (D.C. Cir. 2018) (citing *Banner Health v. Price*, 87 F.3d at 1333).

recalculate a hospital's eligibility for outlier payments using actual cost data at the time of settlement, a process known as reconciliation.[20]

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.[21] 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.

The Request for EJR also explains that "[t]he Hospitals contend that the outlier thresholds applicable to the Hospitals' FYE 2013 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 2013 IPPS discharges to redetermine amounts the Hospitals are owed."[22]

On **June 18, 2025**, the Board issued a Scheduling Order explaining:

> On June 12, 2025, the Medicare Contractor's designated representative, Federal Specialized Services ("FSS") filed a timely response "to advise that a jurisdictional challenge will be filed for provider 12-0001[Queen's Medical Center] as the appeal is untimely." The Board also notes that the Medicare Contractor noted a jurisdictional impediment for Queen's Medical Center on February 6, 2017 after reviewing the Final Schedule of Providers pursuant to Board Rule 22. The Medicare Contractor noted at that time that this provider "based their appeal on a failure to issue a timely NPR; however, the Provider filed an amended cost report extending the MAC's length of time to issue a NPR" and that "[a] Jurisdictional Challenge will be filed with the Board" for this and several other Providers.

The Board ordered the Medicare Contractor to file any Jurisdictional Challenge in this case no later than Wednesday, June 25, 2025. Neither the Medicare Contractor nor its designated representative, Federal Specialized Services ("FSS"), filed any such challenge.

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[20] *Id.* (citing 68 Fed. Reg. 34494, 34499 (June 9, 2003)).
[21] 5 U.S.C. § 706(2).
[22] Request for Expedited Judicial Review at 2 (June 5, 2025).

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]

The Providers' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[25] The Providers have also all made timely appeals from original NPRs or the failure of the Medicare Contractor to issue a timely final determination.[26]

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[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] *See* 42 C.F.R. § 405.1837(a)(3).
[26] The regulation at 42 C.F.R. § 405.1835(c) permits a provider to file an appeal with the Board where:

> (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) . . .

While there are allegations that an amended cost report was accepted for provider 12-0001 (Queen's Medical Center) or that its appeal was otherwise untimely, no formal challenge was ever filed and the record does not contain any evidence to support this contention.

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 could 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.*[27] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, "does not, by itself, bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. 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."[28]

On August 21, 2008, new regulations governing the Board were effective.[29] 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*").[30] 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.[31]

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

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[27] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R ("[i]n self-disallowing an item, the provider submits a cost report that complies with Medicare payment policy for the item and then appeals the item to the [Board]; the contractor's NPR would not include any disallowance for the item, and the provider would effectively self- disallow the item.").
[28] *Bethesda* at 1258-59.
[29] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[30] 201 F. Supp. 3d 131 (D.D.C. 2016).
[31] *Id.* at 142.

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) It has jurisdiction over the matter for the subject years and that the participants in Case 15-3341G 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

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' EJR Request for the issue and the subject year for Case No. 15-3341G. 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 Case No. 15-3341G, 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
Ratina Kelly, CPA
Nicola E. Musgrave, Esq.
Shakeba DuBose, Esq.

FOR THE BOARD:

7/1/2025

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Blvd.
Suite 700
Los Angeles, CA 90064-1582

RE: ***Expedited Judicial Review Determination***
Penobscot Bay Medical Center (Provider Number 20-0063)
FYE: 3/31/2009
Case Number: 25-0771

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's Petition for Expedited Judicial Review ("EJR") filed on June 12, 2025 in the above-referenced appeal. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

On November 15, 2024, the Board received a request for hearing for Penobscot Bay Medical Center ("Provider"). The Provider is appealing from a revised Notice of Program Reimbursement ("RNPR") dated May 29, 2024, which implements the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Provider's FYE 3/31/2009.

The issue in this appeal 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 CMS Ruling 1739-F. The Provider 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 Provider is 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] Statement of Statement at 1, ¶ 2 (Nov. 15, 2024).
[3] *Id.*

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]

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]

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[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.l06(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.)
[12] 42 C.F.R. § 412.106(b)(2)-(3).

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 Secretary[15] 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 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]

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[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(4).
[15] of Health and Human Services.
[16] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).

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:

> *. . . 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*

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[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).

> *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.

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

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[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).
[28] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[29] 746 F. 3d 1102 (D.C. Cir. 2014).

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]

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

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[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.
[39] 85 Fed. Reg. 47723 (Aug. 6, 2020).

> 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":

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]

[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).
[43] 88 Fed. Reg. at 37774-75 (emphasis added).

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 <u>after receiving NPRs and revised NPRs</u> that reflect the interpretation adopted in this final action <u>retain appeals rights</u> and <u>can challenge</u> the reasonableness of the Secretary's interpretation set forth in <u>this final action</u>**."[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 <u>appealing</u> those NPRs and revised NPRs***. While some providers have already received reopening 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.

<u>Provider's Position</u>:

A. Provider's Appeal Request

The Provider's appeal request argues that Medicare Part C days "should be reflected in the Medicaid percentage rather than the Medicare/SSI Fraction."[47] It seeks to invalidate the Final

[44] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[45] *Id.* at 37788 (emphasis added).
[46] *Id.* (emphasis added).
[47] Statement of Issue at 1.

Rule published on June 9, 2023 and the SSI Ratio published thereafter to implement the Final Rule.[48] The Provider argues that the Final Rule is contrary the statutory language of 42 U.S.C. § 1395ww(d)(5)(F)(vi) and that Secretary's interpretation of this statute deserves no deference following the Supreme Court's decision in *Loper Bright.*[49]

The Provider recounts how, prior to 2004, CMS did not include Part C Days in the SSI Ratio, along with the subsequent rulemaking and litigation which can be outlined 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.

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.

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 is "improper under law," "improperly retroactive," "contrary to the spirit and policy of the rulemaking authority under the Administrative Procedures Act," "arbitrary and capricious," and "*per se* unreasonable."[50]

B. Provider's Petition for EJR

The Provider has requested EJR of its challenge to CMS 1739F, the post-*Allina* retroactive Part C policy issue outlined above. It argues that it filed its appeal within 180 days of the issuance of its RNPR; that the amount in controversy exceeds $10,000; that it challenges the validity of the June 2023 Final Rule; and that the Board cannot grant this relief because it is bound by the policy.[51] It notes that the June 2023 Final Rule affords appeal rights from RNPRs implementing the retroactive Part C Days policy even if a Provider's SSI Ratio does not change numerically.[52]

On June 19, 2025, the Medicare Contractor's representative, Federal Specialized Services, filed a response to the Request for EJR simply advising that "a jurisdictional challenge will not be filed.

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[48] *Id.* at ¶ 3.
[49] *Id.* at ¶¶ 4-5 (citing *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024)).
[50] *Id.* at ¶¶ 6-18.
[51] Provider's Petition for Expedited Judicial Review at 1-4 (June 12, 2025).
[52] *Id.* at 11.

A substantive claim challenge will not be filed. The MAC will not challenge Provider's request for expedited judicial review."[53]

Decision of the Board:

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

A. Jurisdiction

A 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;[54] and
- The amount in controversy is $10,000 or more.[55]

For this individual appeal request, the provider appealed from a revised NPR which implements the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. The Provider appealed within 180 days of the issuance of its NPR and the amount in controversy exceeds $10,000.

The Board finds that the Provider has filed a timely appeal from its revised NPR concerning the 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 NPRs. The Board also finds that the amount in controversy $10,000 as required by 42 C.F.R. § 405.1839(a)(1). 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.

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[53] Response to Provider's Request for Expedited Judicial Review (Jun. 19, 2025).
[54] 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).
[55] 42 U.S.C. § 1395oo(a)(2); 42 C.F.R. §§ 405.1835 – 1840.

B. Board's Decision Regarding the EJR 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 year in this case and that the Provider is entitled to a hearing before the Board;

2) Based upon the Provider's 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

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 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 adopted in the June 9, 2023 Final Rule, 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 the subject year.

The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since two additional issues remain in this case, it will remain open on the Board's docket.

Board Members Participating:

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

FOR THE BOARD:

7/1/2025

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)
Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Heather Mogden
Hall, Render, Killian, Heath & Lyman, P.C.
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Milwaukee, WI 53202

RE: **Notice of Dismissal**
Hall Render DSH Dual Eligible Days RNPR CIRP and Optional Groups
Case Numbers: 25-1736GC *et al.* (18 Cases – *See* **Appendix A**)

Dear Ms. Mogden:

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the Common Interest Related Party ("CIRP") and Optional Group cases listed in **Appendix A**. The groups are appealing a Dual Eligible Days issue from Revised Notices of Program Reimbursement ("RNPRs"). The decision of the Board to ***dismiss*** the appeals is set forth below.

Procedural history:

The Providers in these groups are appealing from RNPRs. The Providers acknowledge the RNPRs were "issued as a result of the June 9, 2023 Final Rule (88 Fed. Reg. 37772) and Change Request 13294 (Feb. 21, 2024)."[1]

The Group Issue in these cases is related to "DSH SSI Ratio Dual Eligible Days" and is described as follows:

> Providers assert their Medicare Disproportionate Share Hospital (DSH) calculation was understated in the RNPRs because, in implementing the Final Rule described above, the Centers for Medicare & Medicaid Services (CMS) and the Medicare Administrative Contractor (MAC) failed to include, in the numerator of the Medicare Fraction, all days for patients who were eligible for and enrolled in the Supplemental Security Income (SSI) program but did not receive an SSI stipend for the month in which they received services from the Provider(s) ("SSI Eligible Days), as required by 42 U.S.C. § 1395ww(d)(5)(F).[2]

[1] *See, e.g.*, Case 25-1736GC, Provider Number 36-0084, Provider's Memorandum Regarding Notice of Reopening (Jan. 27, 2025).
[2] *E.g.*, Case 25-1736GC, Statement of the Issue – Part C Days Retroactive Rulemaking - Impact on SSI Eligible Days at 1 (Jan. 27, 2025).

The Providers cite to the Supreme Court's decision in *Becerra v. Empire Health Foundation,* 597 U.S. 424 (2022), and argue that "CMS and the MAC are required to count all SSI enrollees who meet basic SSI program eligibility requirements regardless of whether they received a monthly SSI stipend."[3] The Provider then quotes *Empire*, which states "individuals 'entitled to [Medicare Part A] benefits' are all those qualifying for the program, regardless of whether they are receiving Medicare payments for part or all of a hospital stay") and ("the stoppage of payment for any given service cannot be thought to affect the broader statutory entitlement…."). The Providers also "contend the same holds true with respect to entitlement to SSI benefits, and SSI Eligible Days should be included in the Medicare Fraction numerator."[4]

Relevant Law:

A. RNPR Appeals

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2023), 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. § 405.1889 (2023)[5] 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.

[3] *Id.* at 3.
[4] *Id.*
[5] *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).

> (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[.]"[6]

B. Retroactive Part C Rule, Resulting RNPRs, and Associated Appeal Rights

i. 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").[7] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[8]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[9] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[10]

A hospital may qualify for a DSH adjustment 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 DPP is defined as the sum of two fractions expressed as percentages.[13] 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

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[6] 42 C.F.R. § 405.1889(b)(1).
[7] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[8] *Id.*
[9] *See* 42 U.S.C. § 1395ww(d)(5).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[12] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[13] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).

> 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 . . . .[14]

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.[15]

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.[16]

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.[17]

ii. *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 an 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 Secretary[18] 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

[14] (Emphasis added.)
[15] 42 C.F.R. § 412.106(b)(2)-(3).
[16] (Emphasis added.)
[17] 42 C.F.R. § 412.106(b)(4).
[18] of Health and Human Services.

> 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 included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that are associated with Medicare patients. Therefore, since that time we have been including HMO days in SSI/Medicare percentage [of the DSH adjustment].[19]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[20]

With the creation of Medicare Part C in 1997,[21] 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.[22] 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."[23] 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.[24]

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

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[19] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[20] *Id.*
[21] 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 has 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.
[22] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[23] *Id.*
[24] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).

proposal in the FY 2005 IPPS final rule.[25] 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."[26] In response to a comment regarding this change, the Secretary explained that:

> *. . . 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.*[27]

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.[28] 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).[29] 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."[30]

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[25] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[26] 69 Fed Reg. 48916, 49099 (Aug. 11, 2004).
[27] *Id.* (emphasis added).
[28] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[29] *Id*. at 47411.
[30] 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

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.

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.[31] In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[32] 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.[33] 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.[34] 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.[35] 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.[36] A number of hospitals appealed this action.[37] In *Azar v. Allina Health Services* ("*Allina II*"),[38] 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.[39] There was no rule to vacate in this instance, and

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§ 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).

[31] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).

[32] 746 F. 3d 1102 (D.C. Cir. 2014).

[33] *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.").

[34] *Id.* at 2011.

[35] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).

[36] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).

[37] 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)).

[38] 139 S. Ct. 1804 (2019).

[39] *Id.* at 1817.

the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[40] 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.[41]

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.[42] 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.[43]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[44] 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

[40] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[41] 139 S. Ct. at 1814.
[42] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[43] CMS Ruling 1739-R at 1-2.
[44] 88 Fed. Reg. 37772 (June 9, 2023).

> the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[45]

Finally, the following excerpts from the June 9, 2023 Final Rule discuss a hospital's right to challenge the Part C days policy adopted therein:

1. "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**."[46]

2. "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***."[47]

3. "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 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.**"[48]

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[45] 88 Fed. Reg. at 37788 (bold emphasis added).
[46] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[47] *Id.* at 37788 (emphasis added).
[48] *Id.* (emphasis added).

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.

Decision of the Board:

42 C.F.R. § 405.1889 governs the scope of appeals once a contractor determination is "reopened as provided in § 405.1885[.]" In this circumstance, Providers have *limited* appeal rights and are only able to appeal issues or matters that were "specifically revised" in the RNPRs.

The appeal rights detailed in the June 9, 2023 Final Rule specifically limit a provider's appeal rights to specific matters related to the actual RNPR (*i.e.*, the Part C Days policy). First, the Secretary made clear that the Part C Days rule could be appealed following the issuance of a new NPR or RNPR "***even if the Medicare fraction or DSH payment does not change numerically.***"[49] Thus, the new rule could be appealed even if the treatment of Part C Days was not "specifically revised."

The appeal rights, however, are strictly limited to the policy related to the treatment of Part C days. Following the issuance of a RNPR, the Secretary stated that Providers "***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***[,]" "**will be able to challenge the agency's interpretation** [of the treatment of Part C days in this final action] by appealing those NPRs and revised NPRs[,]" and further stated that they "**can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[50]

Conclusion:

The issue being appealed in the eighteen (18) cases listed in **Appendix A** is related to Dual Eligible Days in the Medicare Fraction. The appeals were taken from RNPRs that were issued specifically to reflect and implement the treatment of Part C days as set forth in the June 23, 2023 Final Rule, but the Providers have not briefed any Part C Days issues. The RNPRs make no changes at all to the Provider's payment or cost report related to Dual Eligible Days in the Medicare Fraction. The Board finds that (1) the RNPRs did not "specifically revise" Dual Eligible Days and thus, pursuant to 42 C.F.R. § 405.1889(b)(1), that issue is beyond the scope of any appeal from the RNPRs, and (2) the only appeal rights afforded from the RNPRs as set forth in the June 23, 2023 Final Rule are to challenge the treatment of Part C Days in the RNPRs. Based on the foregoing, the Board hereby ***dismisses*** the eighteen (18) CIRP and optional group appeals listed in **Appendix A** and removes them from the Board's docket.

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

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[49] *Id.* (emphasis added).
[50] *Id.* at 37787-88 (emphasis added).

Board Members:

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

For the Board:

7/1/2025

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
Cecile Huggins, Palmetto GBA (J-J)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Judith Cummings, CGS Administrators (J-15)
Pamela VanArsdale, National Government Services, Inc. (J-6)
Byron Lamprecht, WPS Government Health Administrators (J-8)

Appendix A
(18 Cases)

Case No.	Case Name	MAC
25-1736GC	Aultman Health CY 2010 DSH Dual Eligible Days RNPR CIRP Group	CGS Admin (J-15)
25-1753GC	Ascension Health CY 2008 DSH Dual Eligible Days RNPR CIRP Group	Palmetto GBA (J-J)
25-1785GC	Ascension Health CY 2009 DSH SSI Dual Eligible Days RNPR CIRP Group	Palmetto GBA (J-J)
25-1792GC	Ascension Health CY 2013 DSH SSI Dual Eligible Days RNPR CIRP Group	Novitas Solutions (J-H)
25-1810GC	Premier Health Partners CY 2013 DSH SSI Dual Eligible Days RNPR CIRP Group	CGS Admin (J-15)
25-1836GC	Valley Health CY 2008 DSH SSI Dual Eligible Days RNPR CIRP Group	Palmetto GBA c/o NGSs (J-M)
25-2127GC	ScionHealth CY 2011 DSH SSI Dual Eligible Days RNPR CIRP Group	Novitas Solutions (J-H)
25-2183GC	Aultman Health CY 2013 DSH SSI Dual Eligible Days RNPR CIRP Group	CGS Admin (J-15)
25-2379GC	Aultman Health CY 2008 DSH SSI Dual Eligible Days RNPR CIRP Group	CGS Admin (J-15)
25-2933GC	ScionHealth CY 2013 DSH SSI Dual Eligible Days RNPR CIRP Group	Novitas Solutions (J-H)
25-2955GC	Franciscan Alliance CY 2010 DSH SSI Dual Eligible Days RNPR CIRP Group	WPS (J-8)
25-3389GC	LifePoint Health CY 2008 DSH SSI Days Dual Eligible RNPR CIRP Group	Novitas Solutions (J-H)
25-3513GC	Ascension Health CY 2007 DSH SSI Dual Eligible Days RNPR CIRP Group	NGS, Inc. (J-6)
25-3637GC	ScionHealth CY 2010 DSH SSI Dual Eligible Days RNPR CIRP Group	Novitas Solutions (J-H)
25-3960G	Hall Render CY 2013 DSH SSI Dual Eligible Days RNPR Group	Palmetto GBA (J-J)
25-4103G	Hall Render CY 2010 DSH SSI Dual Eligible Days RNPR Group	Palmetto GBA (J-J)
25-4275GC	St. Elizabeth Healthcare CY 2011 DSH SSI Dual Eligible Days RNPR CIRP Group	CGS Admin (J-15)
25-4282GC	Aultman Health CY 2007 DSH SSI Dual Eligible Days RNPR CIRP Group	CGS Admin (J-15)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Nathan Summar
Community Health Systems, Inc.
4000 Meridian Boulevard
Franklin, TN 37067

Byron Lamprecht
WPS Government Health Administrators
1000 N 90th Street, Suite 302
Omaha, NE 68114

RE: ***Board Decision* – DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**
Tennova Healthcare – Volunteer Martin (Provider No. 44-0061)
FYE 05/31/2018
Case No. 22-0178

Dear Mr. Summar 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. 22-0178*

On **June 4, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2018.

On **November 23, 2021**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained three (3) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – Medicaid Eligible Days

The Provider is commonly owned/controlled by Community Health Systems, Inc. ("CHS") and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **June 10, 2022**, the Provider transferred Issue 2 to a CHS group. 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 **November 23, 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:

[1] On June 10, 2022, this issue was transferred to PRRB Case No. 21-1206GC.

> 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.[2]

On **July 6, 2022**, the Provider timely filed its preliminary position paper.

On **August 30, 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 **October 25, 2022**, the MAC timely filed its preliminary position paper.

On **January 12, 2023**, the MAC requested from the Provider all documentation necessary to resolve Issue 3 (DSH Payment – Medicaid Eligible Days).

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 21-1206GC

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 CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[3]

Here it is important to note that the amount in controversy listed for both Issues 1 (Provider Specific) and Issue 2 (Systemic Errors) in the Provider's individual appeal request is $1,685.

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[2] (Emphasis added).
[3] Issue Statement at 1 (Nov. 23, 2021).

The DSH/SSI Systemic Errors Group Issue Statement in Case No. 21-1206GC, CHS CY 2018 DSH SSI Percentage CIRP Group, to which the Provider transferred Issue 2 (Systemic Errors), reads, in part:

Statement of the Issue:

> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 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.[4]

On July 6, 2022, the Provider filed its Preliminary Position Paper ("PPP"). 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

[4] Group Issue Statement, Case No. 21-1206GC.

were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (January 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 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).[5]

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,

[5] Provider's Preliminary Position Paper at 8-9 (Jul. 6, 2022).

> unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 5,22,S-D
>
> Estimated Reimbursement Amount: $24,925[6]

Regarding the Medicaid eligible days issue, in its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[7] 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]

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. Further, the MAC argues that 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.[9] 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."[10]

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

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 Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed.

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[6] Appeal Request at Issue 3.
[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 7-8.
[9] Medicare Contractor's Jurisdictional Challenge at 6-7 (Aug. 30, 2022).
[10] *Id*. at 8-9 (Emphasis added).

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 Nos. 1 and 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 percentage, and 2) the Provider's preservation of 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. 21-1206GC.

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."[11] 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)."[12] 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."[13]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 21-1206GC 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.[14] Rather, it applies to all SSI calculations. To this end,

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

the 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."[15] 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, 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.[16]

In its PPP (filed July 6, 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 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*

[15] 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.

[16] (Emphasis added).

> *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.[17]

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."[18] The Provider's appeal is relative to FYE 2018.

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 2018 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. 21-1206GC.

Accordingly, *based on the record before it*, the Board finds that the SSI Provider Specific issue in the instant appeal and the group issue from Group Case 21-1206GC are the same issue.[19] 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

[17] Last accessed August 14, 2024.
[18] Emphasis added.
[19] 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).

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 to indicate 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

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider states Issue 3 as:

> **Statement of the 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.[20]

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

[20] Individual Appeal Request, Issue 3.

> 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(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*.[21]

Similarly, with regard to position papers,[22] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[23] This

[21] (Emphasis added).
[22] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[23] (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 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.[24]

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 23, 2021 (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.[25] ***To-date, no listing has been provided—even after the MAC requested the listing***. 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.[26] Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and

[24] (Emphasis added).
[25] Provider's Preliminary Position Paper at 8.
[26] *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.

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. The Board takes administrative notice that it has made similar dismissal in other cases involving CHS providers.[27]

****

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. 21-1206GC 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. 22-0178 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:

7/3/2025

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

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

[27] An example of a CHS individual provider case in which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Baltimore, MD 21244
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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
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WPS Government Health Administrators
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RE: ***Board Decision* – DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**
Gateway Regional Medical Center (Provider No. 14-0125)
FYE 12/31/2017
Case No. 22-0596

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. 22-0596*

On **August 10, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2017.

On **January 31, 2022**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained three (3) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – Medicaid Eligible Days

The Provider is commonly owned/controlled by Quorum Health and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **August 15, 2022**, the Provider transferred Issue 2 to a Quorum Health group. 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 **January 31, 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:

[1] On August 15, 2022, this issue was transferred to PRRB Case No. 20-1339GC.

> 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.[2]

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

On **December 22, 2022**, the Medicare Administrative Contractor ("MAC") timely filed its preliminary position paper.

On **January 4, 2023**, 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. 20-1339GC

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 CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[3]

Here it is important to note that the amount in controversy listed for both Issues 1 (Provider Specific) and Issue 2 (Systemic Errors) in the Provider's individual appeal request is $19,724.

The DSH/SSI Systemic Errors Group Issue Statement in Case No. 20-1339GC, Quorum Health CY 2017 DSH SSI Percentage CIRP Group, to which the Provider transferred Issue 2 (Systemic Errors) reads, in part:

---

[2] (Emphasis added).
[3] Issue Statement at 1 (Jan. 31, 2022).

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.[4]

On September 27, 2022, the Provider filed its Preliminary Position Paper ("PPP"). 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 their calculation based on the Provider's Fiscal Year End (December 31).

[4] Group Issue Statement, Case No. 20-1339GC.

> 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).[5]

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.

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

Audit Adjustment Number(s): 5,29,32,S-D

Estimated Reimbursement Amount: $38,243[6]

Regarding the Medicaid eligible days issue, in its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[7] 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]

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. Further, the MAC argues that 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.[9] 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."[10]

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

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 Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed.

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[6] Appeal Request at Issue 3.
[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 7-8.
[9] Medicare Contractor's Jurisdictional Challenge at 6-7 (Jan. 4, 2023).
[10] *Id*. at 7.

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 Nos. 1 and 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 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. 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."[11] 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)."[12] 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."[13]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-1339GC 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. 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***.

[11] Issue Statement at 1.
[12] *Id.*
[13] *Id.*

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."[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, 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.[15]

In its PPP (filed September 27, 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 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*

[14] 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.

[15] (Emphasis added).

> ***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 2022*** and instructs providers to send a request via email to access their DSH data."[17] 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 2018 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. 20-1339GC.

Accordingly, *based on the record before it*, the Board finds that the SSI Provider Specific issue in the instant appeal and the group issue from Group Case 20-1339GC 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.

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[16] Last accessed August 14, 2024.
[17] Emphasis added.
[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 Quorum Health CIRP group per 42 C.F.R. § 405.1837(b)(1).

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 to indicate 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

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider states Issue 3 as:

> **Statement of the 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.[19]

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:

[19] Individual Appeal Request, Issue 3.

> 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(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*.[20]

[20] (Emphasis added).

Similarly, with regard to position papers,[21] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[22] 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.[23]

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 January 31, 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.[24] ***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

[21] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[22] (Emphasis added).
[23] (Emphasis added).
[24] Provider's Preliminary Position Paper at 8.

Board Rules.[25] 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. 20-1339GC 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. 22-0596 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:

7/3/2025

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

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

[25] *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

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Quality Reimbursement Services, Inc.
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RE: ***Board Decision* – DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**
AllianceHealth Durant (Provider No. 37-0014)
FYE 09/30/2017
Case No. 22-0911

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. 22-0911*

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

On **March 1, 2022**, 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)
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]

The Provider is commonly owned/controlled by Community Health Systems, Inc. ("CHS") and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For

[1] On September 8, 2022, this issue was transferred to PRRB Case No. 20-0997GC.
[2] On September 8, 2022, this issue was transferred to PRRB Case No. 19-2620GC.
[3] On September 8, 2022, this issue was transferred to PRRB Case No. 20-1383GC.

that reason, on **September 7, 2022**, the Provider transferred Issues 2, 4 and 5 to CHS 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 **March 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.[4]

On **October 24, 2022**, the Provider timely filed its preliminary position paper.

On **January 25, 2023**, the Medicare Administrative Contractor ("MAC") filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 3. The Provider filed a Jurisdictional Response on **March 14, 2023**.[5]

On **January 30, 2023**, the MAC timely filed its preliminary position paper.

On **February 28, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

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

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

[4] (Emphasis added).
[5] The Jurisdictional Response was not timely filed.

> 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]

Here, it is important to note that the amount in controversy listed for both Issues 1 (Provider Specific) and Issue 2 (Systemic Errors) in the Provider's individual appeal request is $19,724. $29,387.

The DSH/SSI Systemic Errors Group Issue Statement in Case No. 20-0997GC, CHS CY 2017 DSH SSI Percentage CIRP Group, to which the Provider transferred Issue 2 (Systemic Errors) reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 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 (Mar. 1, 2022).
[7] Group Issue Statement, Case No. 20-0997GC.

On October 24, 2022, the Provider filed its Preliminary Position Paper ("PPP"). 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 Oklahoma and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Oklahoma 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"), 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**

[8] Provider's Preliminary Position Paper at 8-9 (Oct. 24, 2022).

> 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): 5,17,18,S-D
>
> Estimated Reimbursement Amount: $61,061[9]

Regarding the Medicaid eligible days issue, in its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[10] 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 because it failed to brief the issue in its PPP.[12] Second, the MAC questions the Provider's preservation realignment rights when the Provider's cost reporting year end is identical to the federal fiscal year end. Third, notwithstanding the foregoing, the MAC argues the realignment sub-issue is premature because the hospital has yet to formally request realignment of its SSI percentage, and such an election is not a final intermediary determination ripe for appeal.[13]

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC contends that the Provider failed to properly develop its arguments within its preliminary position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25. The

[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 6-7 (Jan. 25, 2023).
[13] *Id*. at 7.

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

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. 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 January 25, 2023. The Provider filed a response on March 14, 2023, after the February 24, 2023 deadline. As a result of the late filing, the Board will not consider the Provider's Jurisdictional 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 Nos. 1 and 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 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. 20-0997GC.

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."[14] 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)."[15] The Provider argues that "its'[sic] SSI

[14] Issue Statement at 1.
[15] *Id.*

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.”[16]

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).

The Board has previously noted that CMS’ regulation interpretation for the SSI percentage is clearly not “specific” to a single provider.[17] 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.”[18] 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, 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.

---

[16] *Id.*

[17] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

[18] It is also not clear whether this is a systemic issue for CHS providers in the same state subject to the CIRP rules or something that is provider specific because, if it was a common systemic issue, it was required to be transferred to a CIRP group “no later than the filing of the preliminary position paper” in this case per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

> Once the documents become available, promptly forward them to the Board and the opposing party.[19]

In its PPP (filed on October 24, 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:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[20]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[21] 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

[19] (Emphasis added).
[20] Last accessed August 14, 2024.
[21] Emphasis added.

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. 20-0997GC.

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 20-0997GC are the same issue.[22] 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 a conduit for the MAC (the intermediary) nor for CMS. In fact, the Provider's cost reporting period is September 30, 2017, therefore it is *already* on the Federal FYE. 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 states Issue 3 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**

[22] 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).

> 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.[23]

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(b) addresses position papers and specifies in pertinent part:

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[23] Individual Appeal Request, Issue 3.

> (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*.[24]

Similarly, with regard to position papers,[25] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[26] 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.[27]

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);

[24] (Emphasis added).
[25] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[26] (Emphasis added).
[27] (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 March 1, 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.[28] ***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.[29] 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. 20-0997GC 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. 22-0778 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.

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

[29] *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:

7/3/2025

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

cc: 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
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RE: ***Notice of Dismissal***
Tennova Healthcare - Lebanon, Prov. No. 44-0193, FYE 10/31/2017
Case No. 21-0174

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 21-0174. 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. 21-0174*

On **February 25, 2020**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end October 31, 2017.

On **August 7, 2020**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained eight (8) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – SSI Fraction/Medicare Managed Care Part C Days[2]
4. DSH Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[3]
5. DSH Payment – Medicaid Eligible Days
6. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days[4]
7. DSH Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[5]
8. 2 Midnight Census IPPS Payment Reduction[6]

[1] On March 23, 2021, this issue was transferred to PRRB Case No. 20-1332GC. **Note:** PRRB Case No. 20-1332GC was subsequently consolidated into PRRB Case No. 20-0997GC.
[2] On March 23, 2021, this issue was transferred to PRRB Case No. 20-1333GC.
[3] On March 23, 2021, this issue was transferred to PRRB Case No. 20-1334GC.
[4] On March 23, 2021, this issue was transferred to PRRB Case No. 20-1335GC.
[5] On March 23, 2021, this issue was transferred to PRRB Case No. 20-1336GC.
[6] This issue was withdrawn on March 29, 2021.

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). For that reason, on **March 23, 2021**, the Provider transferred Issues 2, 3, 4, 6 and 7 to Community Health groups.

After the withdrawal of Issue 8, there are two (2) remaining issues in this appeal: Issue 1 (DSH Payment/SSI Percentage (Provider Specific)) and Issue 5 (DSH Payment – Medicaid Eligible Days).

On **November 5, 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.[7]

On **February 3, 2021**, the Medicare Contractor requested that duplicative issues be removed from the Provider' individuals appeals.

On **March 29, 2021**, the Provider timely filed its preliminary position paper. With respect to Issue 5, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2017 cost report does not reflect an accurate number of Medicaid eligible days." As a result, the Provider included, as an Exhibit, the original "estimated impact" for this issue of $49,600 based on an *estimated* 100 days.

On **June 18, 2021**, the Medicare Contractor 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.

On **July 14, 2021**, the Medicare Contractor filed its preliminary position paper. With regard to Issue 5, the Medicare Contractor's position paper noted that: (1) the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation

[7] (Emphasis added.)

necessary to support its position; and (2) the Provider had failed to respond to any of the Medicare Contractor's requests for that Medicaid eligible days listing.

On **January 6, 2023**, the Medicare Contractor filed its 2nd and Final Request for DSH Package in connection with Issue 5. In this filing, the Medicare Contractor noted that, on February 3, 2021 (1st request), it had previously requested that the Provider send it a DSH package to resolve Issue 5. As no response was received, the Medicare Contractor formally filed the 2nd and Final Request for DSH Package to formally request that a listing of the Medicaid eligible days at issue plus supporting documentation be provided to the Medicare Contractor on or before February 5, 2023 (*i.e.*, within 30 days). Notwithstanding the formal request, the Provider failed to file any response to the Medicare Contractor.

As no response was received from the Provider, on **July 27, 2023**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to furnish documentation in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); (2) the Provider failed to furnish the Medicaid eligible days listing with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2; and (3) the Provider has effectively abandoned Issue 5. Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** timely respond to that Motion.

On **July 31, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **November 24, 2023**, nearly 3 months after the deadline for responding to the Motion to Dismiss Issue 5, 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 6 pages with roughly 970 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 970 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 970 included in this belated listing is *significantly* 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. 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.

[8] (Emphasis added.)

> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).[9]

The Group issue Statement in Case No. 20-0997GC, in which the Provider is a participant, 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.[10]

On March 29, 2021, the Board received the Provider's preliminary position paper in 21-0174. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

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[9] Issue Statement at 1 (Aug. 7, 2020).
[10] Group Appeal Issue Statement in Case No. 20-0997GC.

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 their calculation based on the Provider's Fiscal Year End (October 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 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 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 $23,000.

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2. The portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[12]

Issue 3 – DSH Payment – Medicaid Eligible Days

[11] Provider's Preliminary Position Paper at 8-9 (Mar. 29, 2021).
[12] Medicare Contractor's Jurisdictional Challenge at 6-7 (Jun. 18, 2021).

The MAC contends that the Provider failed to properly develop its arguments within its preliminary position paper in accordance with Board Rules 7, 25.2.1 and 25.2.2. The MAC argues the Provider has not submitted a Medicaid eligible days listing and therefore, requests the Board dismiss the issue.

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[13] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Similarly, the Provider's response to the Motion to Dismiss was due within 30 days but the Provider failed to timely file a response. In this regard, Board Rule 44.3[14] specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Decision of the Board

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

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.

[13] Board Rule 44.4.3, v. 2.0 (Aug. 2018).
[14] Board Rules, v. 3.1 (Nov. 2021).

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[15] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[16] The Provider argues in its issue statement, which was included in the appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[17]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 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. 21-0704 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[18], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[19] Accordingly, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 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.[20] Moreover, the Board

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[15] Issue Statement at 1.
[16] *Id.*
[17] *Id.*
[18] PRRB Rules v. 2.0 (Aug. 2018).
[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

finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Aug. 29, 2018), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[21]

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") as explained on the following webpage:

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

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

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.

[21] (Italics and underline emphasis added.)

[22] Last accessed Oct. 15, 2024.

[23] (Emphasis added).

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 20-0997GC.

Accordingly, *based on the record before it*,[24] the Board finds that the SSI Provider Specific issue in Case No. 21-0704 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:

> 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.

[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.

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.

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

> **Rule 25 Preliminary Position Papers**[26]
>
> **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**

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

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

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on November 5, 2020 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.[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 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.

[27] (Emphasis added.)

On March 29, 2021, 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 $49,600 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 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.

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

In its Motion to Dismiss, the Medicare Contractor asserts that the Provider has failed to submit a list of additional Medicaid eligible days and neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Medicare Contractor sent two (2) separate requests for the Provider's list of Medicaid Eligible days (and also discussed the lack of the listing in the Medicare Contractor's own position paper filing). The first notice was sent to the Provider on February 3, 2021 and the second, final request was sent to the Provider on January 6, 2023. The Medicare Contractor also informed the Provider in its final request for information that the deadline to respond was February 5, 2023. The Provider failed to file any response to the 2nd and final request.

Due to the non-responsiveness of the Provider, on **July 27, 2023**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish the list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2 (or when requested by the Medicare Contractor 2 separate times after that). The Medicare Contractor thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the Board Rules.[29]

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 August 26, 2023 filing deadline (*i.e.*, 30 days after July 27, 2023).

However, on November 24, 2023 (nearly 3 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 970 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 970 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 970 included in this belated listing is *exponentially* larger than the original estimate of 100 days included with the appeal request. Regardless, this filing was nearly 3 months past the deadline for responding to the Motion to Dismiss *and, more importantly,* ***was roughly 2½ years past the deadline for including it with its preliminary position paper*** since the position paper deadline was April 4, 2021.

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

[29] *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.

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 over 3 months after the Provider changed its designated representative to QRS does not excuse the Provider for its failure to include the information with its preliminary position paper or its failure to timely respond to the 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 24, 2023 filing as a "Supplement to Position Paper" and does not accept that filing because:

1. The alleged "Supplement" was filed ***roughly 2½ years*** *after the deadline* for that exhibit to be included with its preliminary position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)). Indeed, the Provider failed to timely reply to the Medicare Contractor's Motion to Dismiss Issue 5 and the alleged "Supplement" was filed ***nearly 3 months*** *after the deadline* for filing a response to the Motion to Dismiss Issue 5.

2. The alleged "Supplement" fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the roughly 970 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 3 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 November 5, 2020 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* 970 days listed in the

> alleged "Supplement" is, without explanation, *significantly* larger than the original estimated 100 days included with the appeal request).[30]

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"[31] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provider the § 412.106(b)(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.[32]

* * * * *

Based on the foregoing, the Board has dismissed the two (2) remaining issues in this case – (Issues 1 and 5). As no issues remain, the Board hereby closes Case No. 21-0174 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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[30] *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."

[31] (Emphasis added.)

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

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

Board Members Participating:

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

For the Board:

7/7/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Stormont Vail Hospital, Prov. No. 17-0086, FYE 09/30/2018
Case No. 23-0603

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0603. 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. 23-0603*

On **August 1, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2018.

On **January 24, 2023**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained one (1) issue:

1. DSH Payment – Medicaid Eligible Days

On **January 25, 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]

[1] (Emphasis added.)

Attached to the individual appeal request was a calculation support document, which showed an additional 1,055 Medicaid Eligible Days in dispute, with an amount in controversy of $762,325.

On **September 19, 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 239 days and a redacted list of 1115 waiver days including 4,229 days. The position paper included no explanation as to the difference in the number of days.

On **November 14, 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 an unredacted 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 2, 2024**, the Medicare Contractor timely filed a Jurisdictional Challenge[3] with the Board requesting that the Board dismiss the remaining 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 a timely response. A response was not filed until June 14, 2025, 17 months after the deadline to respond.

On **January 12, 2024**, the Medicare Contractor filed its preliminary position paper. 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 1,055 additional days in the Appeal Request and the 239 days included in the redacted listing submitted as an exhibit with the Provider's Preliminary Position Paper.

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[2] Note: 45 days from November 14, 2023 is Friday, December 29, 2023.

[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).

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 did not file a response until June 14, 2025, *17 months* after the due date. 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.

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:

> 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**

[4] Board Rule 44.4.3, v. 3.2 (Dec. 2023).

> **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:

> **Rule 25 Preliminary Position Papers**[6]
>
> **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:

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

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
B. For ***each*** issue that has not been fully resolved, 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 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 25, 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.

[7] (Emphasis added.)

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 19, 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 239 days with zero explanation of the discrepancy between this number and the 1,055 days in the individual appeal request. The Provider's complete briefing of this issue in its position paper is as follows:

> **Issue #1: Medicaid Eligible Days**
>
> 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

[8] Provider's Preliminary Position Paper at 8 (Sept. 19, 2023).

> 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 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, including Section 1115 waiver days, 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.

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). *See* CMS Manual Instructions System, Change Request 12669, Transmittal No. 11912 (March 16, 2023) ("Transmittal 11912"), attached as Exhibit P-3.

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]

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.

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[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 appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

The appeal was filed with the Board in 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.

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**

[11] 42 C.F.R. § 405.1835(b).

> 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:

> (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

[12] (Bold and italic emphasis added).
[13] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[14] 65 FR 47054, 47087 (Aug. 1, 2000).

> **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] 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

[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 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).

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. As no issues remain, the Board hereby closes Case No. 23-0603 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:

7/7/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[17] *Id*. at *11.
[18] *Id.*
[19] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

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

RE: ***Board Decision***
HRS Crossover Bad Debt – Billed/Unbilled Groups
Case Numbers: 14-0069G, *et al*. (*See* Appendix A for listing of cases)

Dear Ms. Goron,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above referenced group appeals. Set forth below is the decision of the Board to dismiss the group appeals, as set forth below.

Background:

A. *Consolidated Case History*

The issue statements in the eleven (11) cases are substantively identical. Case Nos. 14-0069G, 13-3906G, 13-3908G, and 14-3238G describe the issue as:

> **MEDICARE GROUP ISSUE: CROSSOVER BAD DEBTS**
>
> **Description of the Issue**
>
> Whether the MAC properly determined the Provider's Medicare Reimbursement for all allowable Inpatient and Outpatient crossover bad debts.
>
> **Statement of the Legal Basis**
>
> The Providers contend that [the] MAC did not determine Medicare reimbursement for allowable bad debts in accordance with the Statutory instruction at 42 U.S.C. § 1395x(v). Specifically, the Provider disagrees with the MAC's instruction that it could not claim bad debts for all indigent/crossover Inpatients and Outpatient unless those crossover patients were billed to the Medicaid program.

> The Providers contend that the MAC advised that the Provider could only claim these crossover bad debts if they could show proof in the form of a denial on a remittance advice. The Provider contends that this is inconsistent with the Regulations and Instructions per 42 C.F.R. § 413.80 and the Provider Reimbursement Manual ("PRM"), Part 1, § 308.

The remaining cases describe the issue as:

> **Group Issue: Medicare Crossover Bad Debts**
>
> **Statement of Issue**
>
> Whether the Medicare Administrative Contractor ("MAC") properly determined the Providers' Medicare reimbursement for allowable Crossover Bad Debts.
>
> **Statement of the Legal Basis**
>
> The Providers contend that the Lead 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 Providers disagree with the Lead MAC's failure to include all possible Bad Debts associated with Medicaid Crossovers. This action was contrary to the criteria set forth at 42 C.F.R. § 413.89 of the Secretary's regulations and the Provider Reimbursement Manual ("PRM"), Part 1, § 322.

In the lead case, Case No. 14-0069G, the Board issued a Notice of Hearing on July 27, 2020 setting a hearing date on April 14, 2021. Subsequently, there were a number of motions with requests to consolidate hearings and requests to postpone:

- On September 3, 2020, HRS filed a Request for a Consolidated Hearing for Case Nos. 14-0069G, 13-3906G, 13-3908G and 14-0165G on April 14, 2021.
- On January 12, 2021, HRS filed a Request for a Consolidated Hearing to include the cases consolidated on September 3, 2020 and adding Case Nos. 14-3761G and 14-3238G. The Board effectively granted this on April 12, 2021, by rescheduling the hearing date in the cases to October 15, 2021.
- On September 14, 2021, HRS filed a Request for Postponement of Hearing until May 15, 2022. The Board granted this on September 20, 2021, by rescheduling the hearing date in the cases to May 16, 2022.
- On April 20, 2022, HRS filed a SECOND Request for Postponement of Hearing until May 15, 2023. The Board granted this on May 6, 2022, by rescheduling the hearing date in the cases to May 15, 2023.

- On January 19, 2023, HRS filed a THIRD Request for Postponement of Hearing until May 15, 2024. The Board granted this on February 6, 2023, by rescheduling the hearing date in the cases to May 15, 2024.
- HRS filed a Request for Consolidated Hearing on January 11, 2024, to include the cases consolidated on April 12, 2021 and adding Case Nos. 15-2662G, 16-0683G, 17-1235G, 19-1457G and 22-0259G. HRS represented that all 11 cases have the same issue. The request included the request to reschedule the cases for hearing on July 11, 1014 [sic][1]. The Board granted this on February 28, 2024, by rescheduling the hearing date in the cases to July 11, 2024.

On May 29, 2024, HRS submitted a FOURTH Request for Postponement in the instant cases. It read:

> Healthcare Reimbursement Services, Inc. ("HRS") as designated Group representative hereby requests to postpone the above-referenced cases, which are currently scheduled for July 11, 2024.
>
> 1. The parties are not ready for a hearing due to the pending final outcome of the Mercy General Hospital, et al v. Xavier Becerra 0:2023cvus05013 litigation. On September 18, 2020, CMS issued a final rule that made extensive changes to CMS' bad debt policy and addressed, among other aspects of the previous policy, the documentation requirements related to the demonstration of entitlement to Medicare reimbursement for the bad debts of dual-eligible patients. On March 29, 2024 (Exhibit P-1), the judge ordered the case to be returned to the court's active docket along with a briefing schedule.
> 2. We believe that, considering the new final rule and pending litigation, these group appeals may be resolvable with the MAC without the need for a hearing. Alternatively, if the new policy documentation requirements cannot be reasonably met, the group appeals will likely depend upon the final outcome of the Mercy Hospital litigation.
> 3. The MAC does not have any objection to the Provider requesting a postponement. (Exhibit P-2)
> 4. The Provider would like to request a new hearing date of July 11, 2025.

On June 12, 2024, the Board postponed the consolidated hearing to July 15, 2025.[2]

The next filing in the instant appeals was May 29, 2025. In it, HRS filed another (FIFTH) Request for Postponement and requested a new hearing date of May 29, 2026. The motion read:

---

[1] Note: This typo was interpreted as requesting the hearing date of July 11, 2024.
[2] Request for Postponement at 1 (May 29, 2024).

> Healthcare Reimbursement Services, Inc. ("HRS") as designated Group representative hereby requests to postpone the above-referenced cases, which are currently scheduled for July 11, 2024.[3]
>
> 1. The parties are not ready for a hearing due to the pending final outcome of the Mercy General Hospital, et al v. Xavier Becerra 0:2023cvus05013 litigation. *We believe there has been a settlement in Mercy General case, but we have no details on the details. We have been discussing this with our attorneys and are seeking advice on how to proceed.*
> 2. We believe that, considering the new final rule and pending litigation, these group appeals may be resolvable with the MAC without the need for a hearing. Alternatively, if the new policy documentation requirements cannot be reasonably met, the group appeals will likely depend upon the final settlement of the Mercy Hospital litigation *and we may be requesting EJR on our groups.*
> 3. The MAC does not have any objection to the Provider requesting a postponement. (Exhibit P-1)
> 4. The Provider would like to request a new hearing date of May 29, 2026.[4]

On June 26, 2025, the Board denied postponement of the hearing. The Board cited five prior postponements in the lead case. In addition, the Board cited the voluntary dismissal over a year ago by the Plaintiff in the Mercy Hospital litigation cited by HRS. As witness lists had not been submitted timely, the hearing was scheduled to proceed on July 15, 2025, and would be limited to oral argument.[5]

On June 27, 2025, HRS submitted a request for expedited judicial review ("EJR") in the instant cases. In sum, HRS' justification for EJR is:

> Because the Board does not have the authority to disregard or overturn the FY 2021 IPPS Rule's requirement that a provider must bill the State even if it has documentation alternative to the remittance advice (see 42 C.F.R. § 405.1867), and because the Providers have not billed the State for all of the bad debts at issue in this case, the Providers believe they are entitled to a grant of EJR.[6]

---

[3] Note: At the time of this motion, the hearing was scheduled for July 15, 2025. The Board notes this was likely missed from the template of the prior year's request for postponement. The Board further notes that the 2025 letter was almost an exact duplicate of the 2024 letter, with only slight changes made (noted in italics in the above quote).
[4] Request for Postponement at 1 (May 29, 2025) (italics emphasis added).
[5] Postponement Denial Letter at 1 (June 26, 2025).
[6] Request for EJR at 2 (June 27, 2025).

A separate filing, made the same day by HRS, is titled "Notice of Filing Requests for Expedited Judicial Review and Request to Vacate Hearing and Associated Case Deadlines." The body of the letter includes no legal reasoning, justification, or citation to Board Rules for the Request to Vacate, indeed, the phrase "Request to Vacate" *only* appears in the letter's title.

Amount in Controversy:

A. Relevant Law

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.

Pursuant to 42 C.F.R. § 405.1840(b), the Board has jurisdiction over specific matters at issue from final determinations for a group of providers if the requirements of 42 C.F.R. § 405.1837 have been met. The criteria set forth at 42 C.F.R. § 405.1837 for a group of Providers to have a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports are:

- The Providers must be dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider must be 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; [7]
- The matter at issue must involve 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 must be, in the aggregate, $50,000 or more***.[8]

Pursuant to Board Rule 4.1 (2023), "[t]he Board may review jurisdiction on its own motion at any time,"[9] regardless of whether a challenge has been made or filed by the Medicare Contractor or its representative. Rule 4.1 also specifies that "[t]he parties cannot waive jurisdictional requirements."[10] Additionally, pursuant to 42 C.F.R. §§ 405.1842(b)(1), (e)(2)(ii), and (e)(3)(ii), the Board specifically finding jurisdiction over a provider's appeal is also a ***mandatory*** prerequisite to consideration of an EJR request.

[7] 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).
[8] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[9] Board Rule 4.1 (v. 3.2) (Dec. 15, 2023).
[10] *Id.*

The regulation governing the amount in controversy requirement ***specifically divests*** the Board of jurisdiction if the amount in controversy changes to an amount less than the requisite amount due to "[a] more accurate assessment of the amount in controversy."[11] The Providers in a group appeal have an affirmative, ***mandatory***[12] obligation to ***demonstrate*** that the amount in controversy has been met. Demonstrating that this requirement has been met requires a good faith pleading of the amount in controversy.[13] If a Request for EJR is filed and the Board determines that the amount in controversy has not been satisfied, the Board lacks jurisdiction and is ***required*** to deny the request.[14]

B. Positions of the Parties:

Each of the Providers in each group case claims it had bad debts for indigent, crossover dual-eligible patients. They "request the MAC to sample the listings as soon as practicable"[15] and also claim they "have not submitted alternative documentation (documentation other than a remittance advice from the Medicaid State Agency) with this Final Position Paper because they are unsure whether the MAC will accept such alternative documentation."[16] But the exhibits submitted with each Final Position Paper are limited to one provision of the Provider Reimbursement Manual and a copy of the Schedule of Providers.

C. Decision of the Board

To date, HRS has failed to submit a listing of the bad debts for indigent, crossover dual-eligible patients for pre-hearing Medicare Contractor review or as an exhibit for the hearing before the Board. In each of the final position papers, the group participants state they have not submitted alternative documentation other than a remittance advice from the Medicaid State Agency for the Medicare Contractor's review because they are uncertain if the Medicare Contractor will accept the documentation. HRS made no mention of any attempts to confer with the MAC to determine whether such alterative documentation is acceptable. Accordingly, the Board finds the Providers' silence on the matter is indicative of its failure to confer with the Medicare Contractor as to acceptable documentation, which clearly demonstrates a lack of diligence to pursue the appeals in good faith. Additionally, while claiming that the Providers have submitted no alternative documentation as they are unsure of whether the alternative documentation will be accepted for review, the respective final position papers conclude with a request that the Medicare Contractor sample certain "listings as soon as practicable." Here, too, such a request demonstrates the Providers' lack of diligence in pursuing their cases in good faith. The Medicare Contractor

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[11] 42 C.F.R. §405.1839(c)(5)(B).
[12] "In order to satisfy the amount in controversy requirement . . . the group ***must demonstrate*** that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal would increase, in the aggregate, by at least $50,000." 42 C.F.R. § 405.1839(b)(1) (emphasis added).
[13] *See, e.g. Infinity Care of Tulsa v. Sebelius*, 2011 WL 778111 at *3 (N.D. OK 2011).
[14] 42 C.F.R. § 405.1842(f)(2)(i); *see also Affinity Healthcare Svcs. v. Sebelius*, 746 F.Supp.2d 106, 116 (D.D.C. 2010).
[15] *See e.g.* Case No. 14-0069G, *et al*. Providers' Consolidated Final Position Paper at 8 (Feb. 14, 2024). Note: This is repeated in the Final Position Paper for all of the groups herein.
[16] *See e.g. id.* at 5. Note: This is repeated in the Final Position Paper for all of the groups herein.

cannot sample any listing that it has yet to receive.

Providers' lack of diligence in preparing for its July 15, 2025 hearing is further evidenced by its May 29, 2025 request for postponement and its untimely filing of its witness list. Prior to May 29, 2025, the Providers requested and were granted a number of postponements. In the request for postponement filed on May 29, 2024, HRS stated that a new final rule and pending litigation may impact the outcome of the matter.[17] One year later, in the May 29, 2025 postponement request, the Providers based their request on a purported belief that a settlement had been reached in the pending litigation which had been cited as pending in their requests since 2021.[18] Indeed, the pending litigation on which they have relied in their many postponement requests was voluntarily dismissed with prejudice by the Plaintiffs on May 30, 2024 (which was just one day after the Providers' 2024 postponement request). But now, the Group Participants contend that the details of an undisclosed settlement that it only believes occurred may impact its cases. Considering that the details of settlement agreements are not typically disclosed to non-parties nor are they binding precedent for non-parties, if disclosed, Providers' readiness for the hearing cannot rely on such undisclosable terms.

Board Rule 30.3 provides in pertinent part:

> The Board expects the parties to be ready for hearing. The representation that a settlement is imminent or probable will not guarantee a postponement. . . The Board expects the parties to be diligent in planning and preparing for hearing and disfavors last minute postponement requests.
>
> . . .
>
> NOTE: A motion for postponement pending before the Board that has not yet been completed or ruled upon will not suspend either the hearing date or any pre-hearing filing deadlines (e.g., position papers, witness lists). If a motion for postponement is not complete or has not been ruled on, the parties must proceed as if it will not occur (or will not be granted) and comply with the hearing date and all filing deadlines.

Accordingly, on June 26, 2025, the Board denied the Providers' request for postponement and reminded the Providers that the hearing was set for July 15, 2025 and would be limited to oral arguments considering that the Providers, in their ***untimely filed witness list***, stated they would not present any witnesses.

As relates to the submission of exhibits for the hearing, Providers' exhibits were due with their Final Position Paper.[19] The Board's *Notice of Hearing and Critical Due Dates* clearly stated,

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[17] *See e.g.* Case No. 14-0069G, *et al*. Request for Postponement at 1 (May 29, 2024).
[18] *See e.g.* Case No. 14-0069G, *et al*. Request for Postponement at 1 (May 29, 2025).
[19] *See* Board Rules 25.2, 27 and 35.3.

"This filing [the Final Position Paper] must also include any exhibits the Group will use to support its position" and cites Board Rule 27 for content requirements. On February 14, 2024, the Group filed their Final Position Paper including only two exhibits: Exhibit P-1, a Schedule of Providers and Exhibit P-2, Part I, Section 322 of the Provider Reimbursement Manual; neither of which can be construed as the documentation HRS avers may serve as an alternative to a Medicaid remittance advice. Further, there is no listing of claims/bad debts in contention included with this Final Position Paper. The Board finds that the failure of the Providers to submit any documentary evidence to support the appeal is yet another instance of its lack of diligence in pursuing its appeal before the Board.

Here, the Board emphasizes that in its May 29, 2024 and May 29, 2025 requests for postponement, HRS acknowledged that they believed these matters to be resolvable with the Medicare Contractor without proceeding to hearing – yet, as of the filings of the Final Position Papers in 2024, HRS maintained that they were uncertain of whether their alternative documentation was acceptable to the Medicare Contractor, and thus had not submitted it for the review that they specifically requested or as an exhibit for the impending hearing.

Demonstrating that the amount in controversy requirement has been met requires a good faith pleading of the amount in controversy, and not merely a bald allegation or list of a dollar amount in an appeal request.[20] The Board reviewed the records in these cases and could not identify any listings to illustrate which, if any, bad debts were claimed and/or disallowed; if they concerned patients that were, in fact, Medicaid eligible, and were for the correct time period. The Board's review notes that the amounts in controversy claimed by each provider and listed in the Schedules of Providers appear to be arbitrary percentages applied to **total** Medicare deductibles and coinsurance amounts for the years in question. Not all disallowed bad debts for coinsurance and deductible amounts would be relevant to this appeal. The Medicare Contractor could have disallowed these bad debts for a myriad of reasons: perhaps they were not related to Medicare Crossover patients; perhaps they were applicable to a different cost reporting period; perhaps the amounts claimed contained inaccuracies due to errors in accounting. The Board finds that assuming a general, blanket percentage (which appears to be identical to each provider) of ***all*** coinsurance and deductible amounts, without any justification as to how or why that percentage was applied, does not constitute a good faith estimate of a real amount in controversy that is specific to the issue under appeal. The calculations appear to have been made in a manner that was convenient, but arbitrary. Alleging a convenient, but arbitrary, amount in controversy does not satisfy the Providers' obligation to demonstrate that it has pled this jurisdictional requirement in good faith.

Since the Board finds that the amounts in controversy were not made in good faith, but rather calculated in an arbitrary manner, the Board finds that the Providers have failed to affirmatively demonstrate that the amount in controversy requirement has been met in each of these cases as required by 42 C.F.R. § 405.1839(b)(1). Since demonstrating the amount in controversy has been met is a requirement for the Board's jurisdiction, and since a finding of jurisdiction is a prerequisite to granting a request for EJR, the Board hereby ***denies*** the requests for EJR in the

[20] *See, e.g. Infinity Care of Tulsa v. Sebelius*, 2011 WL 778111 at *3 (N.D. OK 2011).

eleven (11) cases listed in **Appendix A**. Additionally, since the Board is unable to establish it has jurisdiction over these appeals, the Board also hereby ***dismisses*** the cases and will remove them from the Board's docket.

As an additional basis for denying EJR, the Board notes there are a number of factual disputes remaining in these cases. Board Rule 42.3 (2023) requires that an EJR Request "demonstrates that there are no factual issues in dispute." The Providers' Final Position Papers also state "the Providers request the MAC to sample the listings as soon as practicable."[21] They also claim they "have not submitted alternative documentation (documentation other than a remittance advice from the Medicaid State Agency) with this Final Position Paper because they are unsure whether the MAC will accept such alternative documentation."[22] The records in these cases, however, do not contain any listings of bad debts, or any documentation whatsoever, let alone any evidence that the patients in question were dually eligible for Medicare and Medicaid or applicable to the cost reporting periods under appeal.

Even assuming the Board had jurisdiction in these cases, it would require a resolution to these factual disputes before granting EJR pursuant to Board Rule 42.3.[23]

Conclusion:

The Board dismisses the instant appeals, pursuant to 42 C.F.R. § 405.1868 and Board Rules 4.1 and 41.2, as the Providers failed to comply with Board procedures.

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 upon final disposition of the appeals.

Board Members Participating:

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

For the Board:

7/8/2025

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)

[21] *Supra* n.15.
[22] *Supra* n.16.
[23] Even if the Board were to find that it has jurisdiction over these cases and providers *with regard to the AIC*, it must still "find that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question." *See* 42 C.F.R. § 405.1842(b)(1). There are jurisdictional challenges in ten (10) of the eleven (11) cases in the EJR Request, many of which are substantively identical.

Appendix A
(List of Eleven Cases Subject to Dismissal)

14-0069G	*HRS 2006 Crossover Bad Debt – Billed/Unbilled Group*
13-3906G	*HRS 2007 Crossover Bad Debt – Billed/Unbilled Group*
13-3908G	*HRS 2008 Crossover Bad Debt – Billed/Unbilled Group*
14-0165G	*HRS 2009 Crossover Bad Debt – Billed/Unbilled Group*
14-3761G	*HRS 2010 Crossover Bad Debts Billed/Unbilled Group*
14-3238G	*HRS 2011 Crossover Bad Debts Billed/Unbilled Group*
15-2662G	*HRS 2012 Crossover Bad Debts Billed/Unbilled Group*
16-0683G	*HRS 2013 Crossover Bad Debts Billed/Unbilled Group*
17-1235G	*HRS 2014 Crossover Bad Debt Billed/Unbilled Group*
19-1457G	*HRS CY 2015 Crossover Bad Debt Billed/Unbilled Group*
22-0259G	*HRS CY 2016 Crossover Bad Debt Billed/Unbilled Group*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Corinna Goron
Healthcare Reimbursement Services, Inc.
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Plano, TX 75075

RE: **EJR Determination**
Case Number: 15-0570G - *HRS 2012 Outlier Threshold Payments Group*

Dear Ms. Goron:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Request for Expedited Judicial Review ("EJR") filed June 16, 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

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 for the fiscal year 2004 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 for federal fiscal year 2004. 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]

The Board notes that the issue statement ***incorrectly*** asserts that the Providers are appealing their outlier threshold payments for ***fiscal year 2004***, though the case actually concerns fiscal years ending in 2012. The parties have filed preliminary position papers in this case,[2] but no Final Position Papers have been filed.

On **June 5, 2025**, the Providers filed a request for EJR.

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.[3] 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]

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[1] Group Issue Statement at 1 (Nov. 28, 2014).
[2] The Preliminary Position Papers in this case were filed in 2016 and thus, based on Board Rule 25.3 (2015), only the cover page and preliminary documentation list was filed with the Board.
[3] *See* 42 U.S.C. § 1395f(b)(1).
[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*

These predetermined, standardized amounts are calculated by the Secretary first determining a nationwide average allowable cost per discharge,[6] which is then further adjusted based on a wage index specific to the locality of the hospital.[7] Each discharge is also adjusted based on the severity of illness, which are classified as distinct diagnosis-related groups ("DRGs").[8] 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."[9]

While the IPPS provides a fixed amount of reimbursement per patient regardless of actual costs incurred in rendering services,[10] Congress also authorized supplemental "outlier payments," or additional reimbursement for patients' care if the cost was atypically high.[11] 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."[12]

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.[13] 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."[14] This amount essentially makes a hospital responsible for a portion of the treatment's excessive costs.[15] 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.[16] The sum of the DRG rate plus the fixed loss threshold is known as the "outlier threshold."[17] Hospitals are typically paid 80% of the costs above the applicable outlier threshold.[18]

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.'"[19] To combat turbo-charging, the Secretary began using more recent data and also reserved the right to

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[6] 42 U.S.C. § 1395ww(d)(2)(A)-(C).
[7] 42 U.S.C. § 1395ww(d)(2)(H).
[8] 42 U.S.C. § 1395ww(d)(4).
[9] *See Cape Cod Hosp. v. Sebelius*, 630F.3d 203, 205-206 (D.C. Cir. 2011).
[10] *See Sebelius v. Auburn Reg'l Med. Ctr.*, 133 S.Ct. 817, 822 (2013).
[11] *See County of L.A. v. Shalala*, 192 F.3d 1005, 1009 (1999); 42 U.S.C. § 1395ww(d)(5)(A).
[12] 42 U.S.C. § 1395ww(d)(5)(A)(ii).
[13] *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).
[14] *See Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d at 50.
[15] *See Boca Raton Comm. Hosp., Inc. v. Tenet Health Care Corp.*, 582 F.3d 1227, 1229 (11th Cir. 2009).
[16] 42 U.S.C. § 1395ww(d)(5)(A)(iv).
[17] *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).
[18] 42 C.F.R. § 412.84(k).
[19] *Billings Clinic v. Azar*, 901 F.3d 301, 306 (D.C. Cir. 2018) (citing *Banner Health v. Price*, 87 F.3d at 1333).

recalculate a hospital's eligibility for outlier payments using actual cost data at the time of settlement, a process known as reconciliation.[20]

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.[21] 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 16, 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.[22]

On **June 23, 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 there is a pending jurisdictional challenge in this matter (filed 5/21/18). Beyond the pending jurisdictional challenge, FSS does not take any issue with the Provider's request for expedited judicial review.[23]

Though the date cited by FSS is incorrect, the Board should note that a Jurisdictional Challenge was filed on **October 3, 2016**. The challenge first argues that the Providers were required to file the outlier threshold reimbursement issue under protest on their cost reports and notes several Providers which either did not claim any protested items or only claimed unrelated items.[24] The Medicare Contractor also argues that two Providers have filed untimely appeals. It notes that Lima Memorial Health System (Provider Number 36-0009) and MetroHealth System (Provider Number 36-0059) appealed from the failure to issue a timely NPR, but that their appeal was filed more than 180 days after the deadline for the NPR. They also note that the Board Rules presume

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[20] *Id.* (citing 68 Fed. Reg. 34494, 34499 (June 9, 2003)).
[21] 5 U.S.C. § 706(2).
[22] Request for Expedited Judicial Review at 2 (June 16, 2025).
[23] Response to Provider's Request for Expedited Judicial Review at 1 (June 23, 2025).
[24] Jurisdictional Review Letter at 1 (Oct. 3, 2016).

5 days of mailing time for NPRs, but that "Providers not appealing an NPR are not afforded this 5-day mailing time."[25]

The Providers filed a Jurisdictional Response on **October 28, 2016**. They articulate several arguments against the requirement to file this issue under protest, but do not mention or counter the arguments made about Lima Memorial Health System's (Prov. No. 36-0009) and MetroHealth System's (Prov. No. 36-0059) untimely appeals.

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; [26]
- 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.[27]

The regulation at 42 C.F.R. § 405.1835(c) permits a provider to file an appeal with the Board where:

> (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

[25] *Id.* at 2.
[26] 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).
[27] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.

> § 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) . . .

Board Rule 4.3 (2013) dictates that "[t]he date of receipt of a final determination is presumed to be 5 days after the date of issuance."

The Final Schedule of Providers ("SOP") and accompanying jurisdictional documentation shows that Lima Memorial Health System's (Prov. No. 36-0009) cost report was received by the Medicare Contractor on May 30, 2013, so the NPR should have been issued by May 30, 2014. The appeal taken from the failure to issue a timely final determination, however, was not received by the Board until December 1, 2014, which was 185 days after the due date for the NPR's issuance. Thus, the Board finds that this appeal was untimely. The same Provider, however, did file a timely appeal from its NPR once it was issued, so it will remain in the appeal based on that request for a hearing.

Similarly, the Final SOP and accompanying jurisdictional documentation shows MetroHealth System's (Prov. No. 36-0059) cost report was received by the Medicare Contractor on May 29, 2013, so the NPR should have been issued by May 29, 2014. The appeal taken from the failure to issue a timely final determination, however, was not received by the Board until November 26, 2014, which was 181 days after the due date for the NPR's issuance. Thus, the Board finds that this appeal was untimely. The same Provider, however, did file a timely appeal from its NPR once it was issued, so it will remain in the appeal based on that request for a hearing.

The Board also notes that the Final SOP filed on **June 16, 2025** with the Request for EJR listed these two Providers' appeals from the failure to issue timely NPRs, and while they were not officially withdrawn, an updated SOP filed on **June 18, 2025** omitted them.

The remainder 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

[28] *See* 42 C.F.R. § 405.1837(a)(3).

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, by itself, bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. 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]

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.

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[29] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R ("[i]n 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 contractor's NPR would not include any disallowance for the item, and the provider would effectively self-disallow the item.").
[30] *Bethesda* at 1258-59.
[31] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[32] 201 F. Supp. 3d 131 (D.D.C. 2016).
[33] *Id.* at 142.

V. Board's Decision Regarding the EJR Request

The Board finds that:

1) ***Except for*** Lima Memorial Health System's (Prov. No. 36-0009) and MetroHealth System's (Prov. No. 36-0059) appeals taken from the failure of the Medicare Contractor to issue a timely final determination, it has jurisdiction over the matter for the subject years and that the participants in Case 15-0570G are entitled to a hearing before the Board;

2) Lima Memorial Health System's (Prov. No. 36-0009) and MetroHealth System's (Prov. No. 36-0059) appeals taken from the failure of the Medicare Contractor to issue a timely final determination were untimely and are hereby dismissed from this appeal;

3) 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;

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 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' EJR Request for the issue and the subject year for Case No. 15-0570G ***except for*** Lima Memorial Health System's (Prov. No. 36-0009) and MetroHealth System's (Prov. No. 36-0059) appeals taken from the failure of the Medicare Contractor to issue a timely final determination. The remainder of 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 Case No. 15-0570G, 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
Ratina Kelly, CPA
Nicola E. Musgrave, Esq.
Shakeba DuBose, Esq.

FOR THE BOARD:

7/9/2025

X Kevin D. Smith, CPA

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

cc: Judith Cummings, CGS Administrators (J-15)
Scott Berends, Esq., FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Mr. Donald Anderson, Jr.
Director, Reimbursement Administration
Providence Health & Services
2001 Lind Ave., SW
Renton, WA 98057

RE: **Determination re: Controversy Amount Threshold**
Providence Regional Medical Center Everett (50-0014)
Appealed Period: 12/31/2005
PRRB Case No.: 25-4855

Dear Mr. Anderson:

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 June 27, 2025, the Provider filed an appeal request based on a *Revised Notice of Program Reimbursement ("RNPR")* dated December 24, 2024. The appeal identified a sole issue in dispute: Post Allina II DSH Part C Days.

Upon review of the appeal request and the supporting jurisdictional documentation, the Board notes that the Provider has stated the amount in controversy as $2,148. The Provider offered no further documentation or calculation as to the lack of the required $10,000 controversy amount threshold.

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 $2,148 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 25-4855, in its entirety, for failure to meet the minimum filing requirements pursuant to 42 C.F.R. § 405.1835(b) or (d) and Board Rule 6.1.1 and Board Rule 6.4.

Board Members:

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

FOR THE BOARD:

7/11/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

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. Donald Anderson, Jr.
Director, Reimbursement Administration
Providence Health & Services
2001 Lind Ave., SW
Renton, WA 98057

RE: **Determination re: Filing Requirements**
Providence St. Peter Hospital (50-0024)
Appealed Period: 12/31/2004
PRRB Case No.: 25-4885

Dear Mr. Anderson:

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 July 1, 2025, the Provider filed an appeal request based on a *Revised Notice of Program Reimbursement ("RNPR")* dated January 2, 2025. The appeal identified a sole issue in dispute: Post Allina II DSH Part C Days.

Upon review of the appeal request and the supporting jurisdictional documentation, the Board notes that the Provider has stated the amount in controversy as $9,573. The Provider offered no further documentation or calculation as to the lack of the required $10,000 controversy amount threshold.

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 $9,573 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 25-4885, 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.

Board Members:

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

FOR THE BOARD:

7/11/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Ms. Nicole Stoychev
Reimbursement Manager
West Virginia University Health System
One Medical Center Drive
P.O. Box 8261
Morgantown, WV 26506

RE: **Determination re: Filing Requirements**
Braxton County Memorial Hospital (51-1308)
Appealed Period: 12/31/2020
PRRB Case No.: 25-4867

Dear Ms. Stoychev:

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 June 30, 2025, West Virginia University Health System (hereafter "WVU Health") filed an appeal, on behalf of the above referenced Provider, for Fiscal Year End ("FYE") 12/31/2020. The proceedings for the appeal indicate that the Provider is filing the appeal based on a **Notice of Program Reimbursement** ("NPR") dated August 25, 20**23**. The sole issue in dispute in the subject individual appeal was stated as Material Errors.

The Board notes that although the Provider has indicated that the appeal is based on a NPR dated August 25, 2023, it did not upload a copy of that final determination. In lieu of the NPR, the Provider filed various worksheets and audit adjustment pages dated August 23, 2023.

In addition, the Board notes that the Provider failed to file a Representation Letter in accordance with Board Rule 5.4. In lieu of the Representation Letter, the Provider filed a Modification Request letter addressed to the Medicare Contractor ("MAC").

As set forth below, the appeal was untimely filed since it was filed on the 675th day past the final determination date of August 25, 2023.

RULES/REGULATIONS:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is

dissatisfied with the contractor's final determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and ***the request for a hearing is filed within 180 days of receipt of the final determination***.

Board Rule 4.4.1. states:

> **Due Dates for New Appeals** New appeals must be received by the Board ***no later than 180 days*** from the commencement of the appeal period as specified in Rule 4.3. See Rule 2.1.4 for instructions on requesting an extension under 42 C.F.R. § 405.1836 "due to extraordinary circumstance beyond [the party's] control."

Board Rule 4.4.3 states:

> **Due Date Exceptions** If the due date falls on a Saturday, a Sunday, a federal legal holiday, (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the Board is unable to conduct business in the usual manner (e.g., "if OH CDMS were down for the entire last day of a deadline" (85 Fed. Reg. 58432, 58987 (Sept. 18, 2020))), the deadline becomes the next day that is not one of the aforementioned days. *See* 42 C.F.R. § 405.1801(d)(3).

Board Rule 4.5 states:

> **Date of Receipt by the Board** The timeliness of a filing is determined based on the date of receipt by the Board. The date of receipt is presumed to be:
> A. The date of filing in OH CDMS as evidenced by the Confirmation of Correspondence generated by the system; or
> B. If the filing is permitted pursuant to an exemption under Rule 2.1.2, the date of receipt is:
> • The date of delivery to the Board as evidenced by the courier's tracking bill for documents transmitted by a nationally recognized next-day courier. It is the responsibility of the provider to maintain a record of the delivery. See 42 C.F.R. § 405.1801(a)(2)(i).
> • The date stamped "received" by the Board on documents submitted by regular mail, hand delivery, or couriers not recognized as a national next-day courier. This provision also applies if the party is unable to supply the next-day courier's tracking bill as noted above. See 42 C.F.R. § 405.1801(a)(2)(ii).

Per PRRB Rule 6.1, the Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b). (Emphasis added.)

BOARD DETERMINATION:

As noted in the facts above, the appeal request states that the subject appeal is based on a **Notice of Program Reimbursement** dated August 25, 20**23**. Allowing for the 180-day appeal period and a five-day presumption for mailing, the 185th day fell on February 24, 2024 (since this date was a Saturday, the Provider had until the following business day, February 26, 2024 to file the appeal). The date of delivery to the Board, as evidenced by the Confirmation of Correspondence generated by OH CDMS, is June 30, 2025. The subject appeal request was filed 675 days past the final determination date of August 25, 2023 and was, therefore, untimely filed.

In addition, the Board notes that the Provider failed to meet the minimum filing requirements by omitting the NPR and a Letter of Representation from the appeal request.

As a result, the Board hereby dismisses case number 25-4867, in its entirety, since it failed to meet the minimum filing requirements pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 and Board Rules 4.4.1, 4.4.3 and 4.4.5.

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

Board Members:

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

FOR THE BOARD:

7/14/2025

X Nicole E. Musgrave

Nicole E. Musgrave, Esq.
Board Member
Signed by: Nicole Musgrave-burdette -A

cc: Wilson C. Leong, Federal Specialized Services
Dana Johnson, Palmetto GBA c/o National Government Services, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Ms. Nicole Stoychev
Reimbursement Manager
West Virginia University Health System
One Medical Center Drive
P.O. Box 8261
Morgantown, WV 26506

RE: **Determination re: Filing Requirements**
Braxton County Memorial Hospital (51-1308)
Appealed Period: 12/31/2021
PRRB Case No.: 25-4868

Dear Ms. Stoychev:

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 June 30, 2025, West Virginia University Health System (hereafter "WVU Health") filed an appeal, on behalf of the above referenced Provider, for Fiscal Year End ("FYE") 12/31/2021. The proceedings for the appeal indicate that the Provider is filing the appeal based on a **Notice of Program Reimbursement** ("NPR") dated June 26, 20**24**. The sole issue in dispute in the subject individual appeal was stated as Material Errors.

The Board notes that although the Provider has indicated that the appeal is based on a NPR dated June 26, 2024, it did not upload a copy of that final determination. In lieu of the NPR, the Provider filed various worksheets and audit adjustment pages dated June 20, 2024.

In addition, the Board notes that the Provider failed to file a Representation Letter in accordance with Board Rule 5.4. In lieu of the Representation Letter, the Provider filed a Modification Request letter addressed to the Medicare Contractor ("MAC") dated June 27, 2025.

As set forth below, the appeal was untimely filed since it was filed on the 369th day past the final determination date of June 26, 2024.

RULES/REGULATIONS:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is

dissatisfied with the contractor's final determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and ***the request for a hearing is filed within 180 days of receipt of the final determination***.

Board Rule 4.4.1. states:

> **Due Dates for New Appeals** New appeals must be received by the Board ***no later than 180 days*** from the commencement of the appeal period as specified in Rule 4.3. See Rule 2.1.4 for instructions on requesting an extension under 42 C.F.R. § 405.1836 "due to extraordinary circumstance beyond [the party's] control."

Board Rule 4.4.3 states:

> **Due Date Exceptions** If the due date falls on a Saturday, a Sunday, a federal legal holiday, (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the Board is unable to conduct business in the usual manner (e.g., "if OH CDMS were down for the entire last day of a deadline" (85 Fed. Reg. 58432, 58987 (Sept. 18, 2020))), the deadline becomes the next day that is not one of the aforementioned days. See 42 C.F.R. § 405.1801(d)(3).

Board Rule 4.5 states:

> **Date of Receipt by the Board** The timeliness of a filing is determined based on the date of receipt by the Board. The date of receipt is presumed to be:
>
> A. The date of filing in OH CDMS as evidenced by the Confirmation of Correspondence generated by the system; or
>
> B. If the filing is permitted pursuant to an exemption under Rule 2.1.2, the date of receipt is:
>
> • The date of delivery to the Board as evidenced by the courier's tracking bill for documents transmitted by a nationally recognized next-day courier. It is the responsibility of the provider to maintain a record of the delivery. See 42 C.F.R. § 405.1801(a)(2)(i).
>
> • The date stamped "received" by the Board on documents submitted by regular mail, hand delivery, or couriers not recognized as a national next-day courier. This provision also applies if the party is unable to supply the next-day courier's tracking bill as noted above. See 42 C.F.R. § 405.1801(a)(2)(ii).

Per PRRB Rule 6.1, the Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b). (Emphasis added.)

BOARD DETERMINATION:

As noted in the facts above, the appeal request states that the subject appeal is based on a **Notice of Program Reimbursement** dated June 26, 20**24**. Allowing for the 180-day appeal period and a five-day presumption for mailing, the 185th day fell on December 28, 2024 (since this date was a Saturday, the Provider had until the following business day, December 30, 2024 to file the appeal). The date of delivery to the Board, as evidenced by the Confirmation of Correspondence generated

by OH CDMS, is June 30, 2025. The subject appeal request was filed 369 days past the final determination date of June 26, 2024 and was, therefore, untimely filed.

In addition, the Board notes that the Provider failed to meet the minimum filing requirements by omitting the NPR and a Letter of Representation from the appeal request.

As a result, the Board hereby dismisses case number 25-4868, in its entirety, since it failed to meet the minimum filing requirements pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 and Board Rules 4.4.1, 4.4.3 and 4.4.5.

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

Board Members:

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

FOR THE BOARD:

7/14/2025

X Nicole E. Musgrave

Nicole E. Musgrave, Esq.
Board Member
Signed by: Nicole Musgrave-burdette -A

cc: Wilson C. Leong, Federal Specialized Services
Dana Johnson, Palmetto GBA c/o National Government Services, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Regional Hospital of Jackson, Prov. No. 44-0189, FYE 09/30/2017, Case No. 21-0140

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 21-0140. 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. 21-0140*

On **January 23, 2020**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2017.

On **July 7, 2020**, the Board received the Provider's individual appeal request. The Individual Appeal Request included four (4) issues:

1. SSI Percentage (Provider Specific)[1]
2. SSI Percentage[2]
3. Medicaid Eligible Days
4. 2 Midnight Census IPPS Payment Reduction[3]

On **October 29, 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***

[1] On June 24, 2025, the SSI Percentage (Provider Specific) issue was withdrawn from the appeal.
[2] On February 23, 2021, this issue was transferred to PRRB Case No. 20-0997GC.
[3] On February 25, 2021, this issue was withdrawn in the cover letter to the preliminary position paper.

> ***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]

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). For that reason, on **February 23, 2021**, the Provider transferred the SSI Percentage Issue (# 2) to a CHS CIRP group under Case No. 20-0997GC.

On **February 25, 2021**, the Provider filed its preliminary position paper. The following are excerpts from the Provider's position on Issue 3 set forth therein:

> The Provider contends that the MAC's determination for Medicare reimbursement for Disproportionate Share Payments was not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(i). The amount at issue is $59,000.
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 CFR § 412.106 (b)(4) of the Secretary's Regulations.
>
> * * *
>
> 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 required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[5]

On **May 19, 2021**, the MAC filed a jurisdictional challenge over Issue 1 in the appeal, to which the Representative responded on **January 28, 2021**. ***The SSI Provider Specific issue was subsequently withdrawn from the appeal on March 28, 2025***.

On **June 25, 2021**, the Medicare Contractor ("MAC") filed its preliminary position paper.

On **November 14, 2022**, the MAC filed a global jurisdictional challenge in various cases, including the subject case, in which it challenged jurisdiction over the Medicaid Eligible days issue. On **December 14, 2022**. CHS filed a responsive brief.

On **December 16, 2022**, Quality Reimbursement Services, Inc. ("QRS") became the designated representative of the individual appeal.

---

[4] (Emphasis added).
[5] Provider's Preliminary Position Paper at 8 (February 25, 2021).

On **December 28, 2022**, the MAC filed a Motion to Dismiss in response to the Provider's responsive brief, reiterating its request to dismiss the Medicaid Eligible days issue.

On **December 23, 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*** *include* ***any exhibits*** *the Provider will use to support its position*. *See* Board Rule 27 for more specific content requirements.[6]

On **May 6, 2025**, the Provider timely filed its final position paper. The following is the Provider's ***complete*** position on Issue 3 set forth therein:

> Specifically, the Provider disagrees with the MAC's calculation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp., Inc. v. Secretary of Health and Human Servs.* 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits…
>
> CMS acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> 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**

[6] (Emphasis added).

> **waiver days, which are paid under the authority of section 1115 of the Social Security Act and regarded 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 2017 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.[7]

On **May 30, 2025**, the MAC timely filed its final position paper.

On **June 2, 2025**, the MAC filed another jurisdictional challenge, again requesting dismissal of the Medicaid Eligible days Issue (#3).[8]

On **June 24, 2025**, QRS filed a response to the MAC's jurisdictional challenge.

---

[7] Provider's Final Position Paper at 8-9 (May 6, 2025) (emphasis added).

[8] The Jurisdiction Challenge revised and replaced the two prior challenges filed by the Medicare Contractor on May 19, 2021 and November 14, 2022 which also included a challenge over Issue #1 (SSI Provider Specific) but that issue was subsequently withdrawn.

MAC's Jurisdictional Challenge

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC contends that this issue should be dismissed because the Provider failed to file complete preliminary or final position papers including all supporting exhibits to document the merits of its argument in accordance with 42 C.F.R. §405.1853(b)(2) and Board Rule 25 and 27.

"In addition, the Provider untimely and improperly added the issue of Section 1115 Waiver Days via its final position paper."[9]

Specifically, the MAC argues:

> . . . that the Provider was in violation of 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 or 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.[10]

The MAC contends that Provider has never submitted a complete, unredacted list of additional Medicaid eligible days with either its preliminary or final position papers, nor has it submitted such list under separate cover. Only a redacted listing has been filed with its final position paper.[11]

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 final position paper on May 6, 2025. The MAC issued the Provider's NPR on January 23, 2020. In accordance with 42 C.F.R. § 415.1835(e), the deadline for adding issues to the appeal was September 24, 2020. The issue was informally added through the final position paper filed on May 6, 2025, which was 1690 days after issuance of the NPR.[12]

The MAC maintains that the Section 1115 waiver days issue is one component of the DSH issue that must be appealed as a separate issue. The MAC notes that Board Rule 8 explains that one issue can have multiple components. Within Board Rule 8, some of the disproportionate share hospital (DSH) components are identified. Specifically, the Board identifies Section 1115 waiver days as a distinct DSH component that the Provider must separately appeal.[13]

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[9] Medicare Contractor's jurisdictional challenge at 2 (June 2, 2025).
[10] Medicare Contractor's jurisdictional challenge at 11 (June 2, 2025).
[11] Medicare Contractor's jurisdictional challenge at 18 (June 2, 2025).
[12] Medicare Contractor's jurisdictional challenge at 14-15 (June 2, 2025).
[13] Medicare Contractor's jurisdictional challenge at 16 (June 2, 2025)

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 appealed all Medicaid eligible days, including section 1115 waiver days. By definition, section 1115 waiver days are Medicaid eligible days."[14]

Further, the Provider argues that:

> . . . whereas the Medicare Contractor states that it 'contends 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. . . Both a June 25, 2004 proposed rule (69 *Fed. Reg.* 35716) and a May 23, 2008 final rule (73 *Fed. Reg.* 30190) indicate that an "issue" is encapsulated by a specific cost report adjustment. They do not slice and dice an "issue" into component parts, including the specific reason why Medicaid eligible days were not counted in the numerator of the Medicaid Fraction of the Disproportionate Payment Percentage. [15]

The Provider maintains that the version of Board Rule 8 (July 1, 2015) that was in effect when the Provider filed its appeal, makes no mention of "section 1115 waiver days" nor even "Medicaid eligible days." Therefore, 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. [16]

Finally, the Provider contends that 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 MAC 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 has the duty to accept the Provider's listing of Section 1115 waiver days and audit them. The Provider states that it

[14] Provider's jurisdictional response at 2 (June 24, 2025)
[15] Provider's jurisdictional response at 2 (June 24, 2025)
[16] Provider's jurisdictional response at 3 (June 24, 2025)

submitted a redacted listing of section 1115 waiver days as an Exhibit to its final position paper on June 24, 2024, and an unredacted listing to the MAC.[17]

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. *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 either the initial appeal or the preliminary position papers.

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

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

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

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

[17] Provider's jurisdictional response at 4-5 (June 24, 2025).

> 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.[18]

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

Rule 25 Preliminary Position Papers[19]

> **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, state the material facts that support the provider's claim.

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

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

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on October 29, 2020 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.[20]

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 February 25, 2021, the Provider filed its preliminary position paper. Significantly, Exhibit 2 included with the position paper is a copy of the calculation support included with the appeal

[20] (Emphasis added.)

request in which the Provider indicates it is seeking reimbursement for 50 additional Secondary Medicaid eligible days with an estimated impact of $31,309.[21]

On May 6, 2025, the Provider filed its final position paper. Attached as Exhibit P-1 was a statement as follows: "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 redacted listing titled "1115 Waiver and Additional ME Days Consolidated" was also included. The 4-page redacted listing showed 615 days. The Provider did not explain why the listing of days was being submitted at this late date, ***more than 7 years after the fiscal year at issue had closed***. NOTE—the 615 days included in this belated listing is *exponentially* larger than the original estimate of 50 days included with the appeal request. Regardless, this filing, *importantly,* ***was more than 3 years past the deadline for including it with its preliminary position paper*** since the position paper deadline was March 4, 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 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"[22] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to submit a finalized listing of Medicaid eligible days, notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.[23]

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.[24]

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[21] Provider's Preliminary Position Paper Exhibit 2. (February 25, 2021).
[22] (Emphasis added.)
[23] Again, the exhibit of "1115Waiver and Additional ME Days Consolidated" includes the statement "Listing pending finalization upon receipt of State eligibility data."
[24] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

2. *Section 1115 Waiver Days*

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

The appeal was filed with the Board in July 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, 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…[25]

Board Rule 7.2.1 (2018) elaborated on this regulatory requirement instructing providers:

> The following information and supporting document must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
> - the adjustment, including the adjustment number,
> - the controlling authority,

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.

[25] 42 C.F.R. § 405.1835(b).

- why the adjustment is incorrect,
- how the payment should be determined differently,
- the reimbursement effect, and
- the basis for jurisdiction before the Board.[26]

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

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

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.[28]

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

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

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

In this regard, the Board notes that Section 1115 waiver days are not traditional Medicaid Eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.[29] 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

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[26] v. 2.0 (Aug. 2018).
[27] (Bold and italic emphasis added).
[28] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[29] 65 FR 47054, 47087 (Aug. 1, 2000).

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.[20] In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act**.
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

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 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 position paper filings. First, the Provider's preliminary position paper does not even mention Section 1115 waiver days (much less even identify the specific 1115 waiver day program(s) at issue) notwithstanding its obligations to do so pursuant to

42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (2018). 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 perfunctory conclusions.[30] 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 (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 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*.[31] 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 . . ."[32] 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."[33] 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.[34] 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 sub-issue consistent with 42 C.F.R. §§ 405.1835(b)(2)-(3), 412.106(b)(4)(iii), and

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

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

[32] *Id*. at *11.

[33] *Id.*

[34] *Id.*

405.1871(a)(3) and Board Rules 7.1, 8, 25, and 27.2.[35] 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.

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Based on the foregoing, the Board dismisses the sole remaining issue in this case – (Issue 3- DSH Payment – Medicaid Eligible Days. As no issues remain, the Board hereby closes Case No. 21-0140 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:

7/15/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[35] 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 – 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).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Nathan Summar
Community Health Systems, Inc.
4000 Meridian Boulevard
Franklin, TN 37067

RE: ***Board Jurisdiction Determination - in Whole***
Alliance Health Woodward (Prov. No. 37-0002), FYE 05/31/2018
PRRB Case No. 22-0026

Dear Mr. Summar:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-0026. Set forth below is the decision of the Board to dismiss the two (2) remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Payment/SSI % (Provider Specific) and DSH Payment - Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 22-0026*

On **May 6, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2018.

On **October 12, 2021**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained three (3) issues:

1. DSH Payment/SSI % (Provider Specific)
2. DSH Payment/SSI % (Systemic Errors)
3. DSH Payment – Medicaid Eligible Days

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). For that reason, on **May 9, 2022**, the Provider transferred Issue 2 to a CHS group, Case No. 21-1206GC.

As a result, there are two (2) remaining issues in this appeal: Issue 1 (SSI % (Provider Specific)) and Issue 3 (Medicaid Eligible Days).

On **October 13, 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.[1]

On **May 25, 2022**, the Provider timely filed its preliminary position paper.

On **July 21, 2022**, the Medicare Contractor ("MAC") filed a copy of its request to the Provider for a DSH package needed in order to administratively resolve the appeal.

On **September 8, 2022**, the MAC filed a Jurisdictional Challenge over the last two issues: SSI % (Provider Specific) and Medicaid Eligible Days. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. To date there has been no response from the Provider.

On **September 23, 2022**, the MAC filed its preliminary position paper. The Medicare Contractor again noted the jurisdictional impediments over the SSI % (Provider Specific) issue and Medicaid Eligible days issues. With regard to Issue 3, the Medicare Contractor's position paper noted that it had not yet received a listing of Medicaid eligible days although the Provider's preliminary position paper suggested one would be sent under separate cover.

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

[1] (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).[2]

The Group issue Statement in Case No. 21-1206GC, to which the Provider transferred Issue No. 2, reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[3]

On May 25, 2022, the Board received the Provider's preliminary position paper in Case No. 22-0026. 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

[2] Issue Statement at 1 (Oct. 12, 2021).
[3] Group Appeal Issue Statement in Case No. 21-1206GC.

> 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 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).[4]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $7,271.

MAC's Contentions

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

In its jurisdictional challenge, the MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue, which 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 component 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.[5]

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."[6] The MAC suggests that the Provider "failed to properly sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its Preliminary Position Paper."[7]

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[4] Provider's Preliminary Position Paper at 8-9 (Dec. 1, 2021).
[5] MAC's Jurisdictional Challenge at 5-7 (Sept. 8, 2022).
[6] *Id*. at 7-9 (Emphasis added).
[7] *Id*. at 9.

Issue 3 – DSH Payment – Medicaid Eligible Days

With regard to the Medicaid Eligible Days issue, the MAC contends that the Provider failed to include a list of additional Medicaid eligible days they expect to be included with their appeal or their preliminary position paper (even though the Provider advised that it would send a listing of additional Medicaid eligible days under separate cover.)[8] In addition, the MAC argues the Provider has abandoned this issue because it failed to sufficiently develop and set forth the relevant facts and arguments in its preliminary position paper and because it neglected to include all supporting documentation.[9]

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.[10] The Provider failed to file a timely 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. 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 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.

[8] In addition, the Provider failed to submit such a list, even after the MAC requested one by letter dated July 21, 2022.
[9] MAC's Jurisdictional Challenge at 11 (Sept. 8, 2022).
[10] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

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."[11] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI % (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)."[12] 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."[13]

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 % (Provider Specific) issue in Case No. 22-0026 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 21-1206GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[14], the Board dismisses this aspect of the 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.[15] 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. 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.[16] Moreover, the Board

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[11] Issue Statement at 1.
[12] *Id.*
[13] *Id.*
[14] PRRB Rules v. 2.0 (Aug. 2018).
[15] 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).
[16] 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

finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Aug. 29, 2018), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of the any alleged "errors" and include *all* exhibits.

Furthermore, 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.[17]

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[18]

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."[19]

Provider failed 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.

[17] (Italics and underline emphasis added.)

[18] Last accessed June 17, 2025.

[19] (Emphasis added).

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs, or is waiting on, or claims that it should have access to, or why this is not a common issue already covered by the CIRP group under Case No. 21-1206GC.

Accordingly, *based on the record before it*,[20] the Board finds that the SSI Provider Specific issue in Case No. 22-0026 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 SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

The second aspect of the 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 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. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding an 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 states Issue 3 as:

> **Statement of the 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

[20] Again, the Board notes that the Provider failed to timely respond to the Jurisdictional Challenge so the Board must make its determination based on the record before it.

> 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.[21]

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*

[21] Individual Appeal Request, Issue 3.

> *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]

Similarly, with regard to position papers,[23] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[24] 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,* 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]

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 12, 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 separate cover.[26] ***To-date, no listing has been provided—even after the MAC requested***

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[22] (Emphasis added).
[23] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[24] (Emphasis added).
[25] (Emphasis added).
[26] Provider's Preliminary Position Paper at 8.

the listing on July 21, 2022. 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.[27] 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. The Board takes administrative notice that it has made similar dismissals in other cases involving CHS providers.[28]

****

In summary, the Board hereby dismisses the DSH Payment/SSI % (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 21-1206GC 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. 22-0026 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:

7/15/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[27] *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.

[28] An example of a CHS individual provider case in which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nathan Summar
Community Health Systems, Inc.
4000 Meridian Boulevard
Franklin, TN 37067

RE: ***Notice of Dismissal***
Lake Wales Medical Center, Prov. No. 10-0099, FYE 12/31/2017
Case No. 21-0262

Dear Mr. Summar:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 21-0262. 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 issues.

Background:

A. ***Procedural History for Case No. 21-0262***

On **March 26, 2020**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2017. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **September 18, 2020**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained four (4) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – Medicaid Eligible Days
4. 2 Midnight Census IPPS Payment Reduction[2]

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **April 27, 2021**, the Provider transferred Issue 2 to a CHS group.

As a result of the case transfer, and after the withdrawal of Issue 4, 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).

[1] On April 27, 2021, this issue was transferred to PRRB Case No. 20-0997GC.
[2] This issue was withdrawn on April 22, 2021.

On **November 23, 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.[3]

On **May 10, 2021**, the Provider timely filed its preliminary position paper.

On **June 21, 2021**, the Medicare Contractor 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.

On **July 26, 2021**, the Medicare Contractor requested from the Provider all documentation necessary to resolve Issue 3 (DSH Payment – Medicaid Eligible Days).

On **August 31, 2021**, the Medicare Contractor timely filed its preliminary position paper.

On **January 12, 2023,** the Medicare Contractor requested for the 2nd, and final, time from the Provider all documentation necessary to resolve Issue 3 (DSH Payment – Medicaid Eligible Days).

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

In their Individual Appeal Request, Provider summarizes its DSH Payment/SSI Percentage (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.
>
> . . .

[3] (Emphasis added).

> 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.[4]

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 [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.[5]

On May 10, 2021, the Board received the Provider's preliminary position paper in 21-0262. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

---

[4] Issue Statement at 1 (Sept. 18, 2020).
[5] Group Issue Statement, Case No. 20-0997GC.

> **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 (December 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 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]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $20,000.

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**

[6] Provider's Preliminary Position Paper at 8-9 (May 10, 2021).

> 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): 5,6,30,S-D
>
> Estimated Reimbursement Amount: $23,000[7]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the *Jewish Hospital* case[8] 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.[9]

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]

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.[11] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board

[7] Appeal Request at Issue 3.
[8] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[9] Provider's Preliminary Position Paper at 7-8.
[10] Medicare Contractor's Jurisdictional Challenge at 6-7 (Jun. 21, 2021).
[11] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

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.

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 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 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."[12] 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)."[13] 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."[14]

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,

[12] Issue Statement at 1.
[13] *Id.*
[14] *Id.*

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. 21-0262 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[15], 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, 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 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 Preliminary Position Paper 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 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper 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**
>
> **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.

[15] PRRB Rules v. 2.0 (Aug. 2018).
[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).

> Once the documents become available, promptly forward them to the Board and the opposing party.[17]

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[18]

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."[19]

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*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 20-0997GC are the same issue.[20] 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.

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[17] (Italics and underline emphasis added.)
[18] Last accessed August 14, 2024.
[19] Emphasis added.
[20] 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 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

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider states Issue 3 as:

> **Statement of the 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.[21]

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:

[21] Individual Appeal Request, Issue 3.

> 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*.[22]

[22] (Emphasis added).

Similarly, with regard to position papers,[23] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[24] 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.[25]

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 September 18, 2020 (over 4.5 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.[26] ***To-date, no listing has been provided—even after the MAC requested the listing on two (2) occasions***. Accordingly, the Provider has abandoned the issue by failing to properly develop its arguments and provide supporting documents, and by failing to explain why

[23] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[24] (Emphasis added).
[25] (Emphasis added).
[26] Provider's Preliminary Position Paper at 8.

it cannot produce those documents, as required by the regulations and the Board Rules.[27] 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. The Board takes administrative notice that it has made similar dismissal in other cases involving CHS providers.[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. 21-0262 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:

7/16/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Chair
Signed by: PIV

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

[27] *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.

[28] An example of a CHS individual provider case in which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
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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

RE: ***Board Decision* – DSH Payment – Medicaid Eligible Days Issue**
Covenant Medical Center (Provider No. 16-0067)
FYE 06/30/2017
Case No. 20-1857

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. 20-1857*

On **January 10, 2020**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2017.

On **July 7, 2020**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained eight (8) issues:

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

[1] This issue was withdrawn on June 16, 2025.
[2] On October 27, 2020, this issue was transferred to PRRB Case No. 21-0130G.
[3] On October 27, 2020, this issue was transferred to PRRB Case No. 21-0131G.
[4] On October 27, 2020, this issue was transferred to PRRB Case No. 21-0132G.
[5] On October 27, 2020, this issue was transferred to PRRB Case No. 21-0133G.
[6] On October 27, 2020, this issue was transferred to PRRB Case No. 21-0134G.

8. Standardized Payment Amount[7]

The Provider transferred Issues 3, 4, 5, 6, 7 and 8 to optional groups. As a result, there is one (1) remaining issues in this appeal: Issue 2 (DSH Payment – Medicaid Eligible Days).

On **July 8, 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.[8]

On **March 4, 2021**, the Provider timely filed its preliminary position paper.

On **June 2, 2021**, the Medicare Contractor filed a Substantive Claim Challenge[9] relative to Issues 1 and 2 requesting that the Board find that there is not an appropriate cost report claim for these issues per 42 C.F.R. § 413.24(j) and that these items are not reimbursable, regardless of whether the Board were to issue a favorable final hearing decision under 42 C.F.R. § 405.1871(a). Significantly, under Board Rule 44.5.1, the Provider had 30 days to respond to the Substantive Claim Challenge. However, the Provider ***failed*** to file any response.

On **June 25, 2021**, the Medicare Contractor timely filed its preliminary position paper.

On **December 6, 2024**, the Board issued the Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

> Provider's Final Position Paper – *For each remaining issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying***

[7] On October 27, 2020, this issue was transferred to PRRB Case No. 21-0135G.
[8] (Emphasis added).
[9] As explained at Board Rule 44.5, "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."

> ***the material facts*** to the controlling authorities. This filing ***must*** *also include* ***any exhibits*** *the Provider will use to support to support its position*. *See* Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.[10]

On **May 6, 2025**, the Provider timely filed its final position paper.

On **May 21, 2025**, the Medicare Contractor timely filed its final position paper.

On **June 24, 2025**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of the DSH Payment – Medicaid Eligible Days because: (1) the Provider failed to furnish documentation in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); (2) the Provider failed to furnish the Medicaid eligible days listing with its preliminary and final position papers in violation of Board Rules 7, 25.2.1, 25.2.2 and 27.2; and (3) the Provider has effectively abandoned Issue 2. The Provider filed a timely response on **July 14, 2025**.

B. Description of Issue 2 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 2 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] (Emphasis added.)

Audit Adjustment Number(s): 9,10,28,S-D

Estimated Reimbursement Amount: $137,093[11]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the Jewish Hospital case[12] 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.[13]

MAC's Contentions

Issue 2 – DSH Payment – Medicaid Eligible Days

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

a. That the Provider has failed to timely furnish documentation in support of its claim for additional Medicaid Eligible Days in a timely manner.
b. That the Provider has made affirmative statements in its preliminary and final papers that it was submitting such supporting documentation to the MAC.
c. That the Provider's failure to furnish such documentation (or describe why such documentation is unavailable) is in violation of PRRB Rules 7, 25.2.1, 25.2.2 and 27.2.
d. That the Provider has effectively abandoned its claim for additional Medicaid Eligible Days.[14]

Provider's Response

The Provider responded by providing the following information:

> The Provider – Covenant Medical Center has gone through two changes of ownership and now Provider Number 16-0067 is called Mercyone Waterloo Medical Center. Due to the disruptions with personnel and Provider Systems, the Provider Representative had to maneuver through this difficult process and was able to complete the work and send a listing of additional Medicaid eligible days to Mr. Saadat on June 27, 2025.[15]

[11] Appeal Request at Issue 2.
[12] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[13] Provider's Preliminary Position Paper at 7-8 (Mar. 4, 2021).
[14] Medicare Contractor's Motion to Dismiss at 4 (Jun. 24, 2025).
[15] Provider's Response to Motion to Dismiss at 1 (Jul. 14, 2025).

In addition, the Provider requests that the Board rule on a Postponement Request filed on June 18, 2025, to "give the parties to time to finalize the administrative resolution."[16]

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 No. 2.

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider states Issue 2 as:

> **Statement of the 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]

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

[16] *Id*.
[17] Individual Appeal Request, Issue 2.

> 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(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*.[18]

[18] (Emphasis added).

Similarly, with regard to position papers,[19] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[20] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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

Rule 25 Preliminary Position Papers[21]

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

25.1 Content of Position Paper Narrative

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

25.1.1 The Provider's Position Paper

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
B. For *each* issue that has not been fully resolved, state the 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

[19] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[20] (Emphasis added).
[21] (Underline emphasis added to these excerpts and all other emphasis in original.)

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on July 8, 2020 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 2, 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.[22]

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

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

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

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

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board 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 4, 2021, 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.[23] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $137,093 based on an estimated 337 days). The Provider's complete briefing of this issue in its position paper is as follows:

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[22] (Emphasis added.)
[23] Provider's Preliminary Position Paper at 13 (March 4, 2021).

Calculation of Medicaid Eligible Days

Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.

The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).

The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:

> [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.

Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2017 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[24]

In its Motion to Dismiss, the Medicare Contractor asserts that the Provider has failed to submit a list of additional Medicaid eligible days and neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

[24] *Id.* at 7-8.

On **June 24, 2025**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish the list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2. The Medicare Contractor thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the regulations and the Board Rules.[25]

Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. On July 14, 2025, the Provider filed a document entitled "Response to Motion to Dismiss." The Provider indicated that it submitted a listing of days to the Medicare Contractor on ***June 25, 2025***, and requested a postponement of the upcoming hearing date.

This filing briefly mentioned that the provider "has gone through two changes of ownership. . . Due to the disruptions with personnel and Provider Systems, the Provider representative had to maneuver through this difficult process and was able to complete the work and send a listing of additional Medicaid eligible days…"[26] QRS' filing did not explain when these changes of ownership occurred, or why that meant that the Provider could not submit a listing of days until ***8 years after the fiscal year at issue had closed and more than 4 years past the deadline for including it with its preliminary position paper*** since the position paper deadline was March 4, 2021.

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

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[27] and, pursuant to Board Rule 25, the Provider

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[25] *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.
[26] Provider Response to Motion to Dismiss at 1.
[27] (Emphasis added.)

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 its position paper filings (much less provider the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

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

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In summary, the Board hereby 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. 20-1857 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.

[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.

Board Members Participating:

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

For the Board:

7/17/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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July 18, 2025

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RE: Determination re: Transfer Request
Griffin Hospital
Provider Number: 07-0031
Appealed Period: FYE 09/30/2010
PRRB Case Number: 25-0995

Dear Mr. Blumberg and Ms. Decker:

On July 11, 2025, Blumberg Ribner, Inc. requested that the CMS1739F Challenge: MCR Part C Days in the Medicare Fraction issue be transferred to group case number 25-3627G.

Upon review, it is noted that the subject individual appeal is for Fiscal Year End ("FYE") 09/30/2010 and the above referenced group appeal, case number 25-3627G, involves Calendar Year ("CY") 2003. Pursuant to Board Rule 12.5, "A group may cover only one calendar year unless the Board allows the group to be expanded. Specifically, providers in a group appeal must have final determinations for their cost reporting periods that end within the same calendar year. However, a group may submit a written request to include more than one calendar year if it cannot meet the minimum number of providers or the $50,000 amount in controversy requirements."

It is further noted that the Medicare Contractor ("MAC") filed an objection to the transfer request by letter dated July 15, 2025.

The Board notes that there is currently a group pending for this issue for CY 2010, Blumberg Ribner CY 2010 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction Group, CN: 25-1241G.

As a result, the request to transfer the CMS1739F Challenge: MCR Part C Days in the Medicare Fraction issue from the subject appeal to group case number 25-3627G is denied. The Board will modify the system to reflect that this issue is still pending in the subject individual appeal.

If the original transfer request was entered into the wrong case number in error, a request should be made, notifying the Board, in writing, to rescind the original transfer request and then Blumberg may submit the proper transfer by utilizing the Transfer Request button in OH CDMS with the correct group case number for CY 2010, case number 25-1241G.

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

FOR THE BOARD:

Kevin D. Smith, CPA
PRRB Chair

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Expedited Judicial Review Determination***
PRRB Cases 24-1588GC *et al*. - *FFY 2024 Area Unlawful Rural Floor and Rural Floor Budget Groups* (9 cases – *See* Appendix A)

Dear Mr. Robertson:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' consolidated Request for Expedited Judicial Review ("EJR") filed on May 20, 2025, in the nine (9) above-referenced group appeals. The Board's decision on jurisdiction and EJR for the nine (9) above-referenced group appeals are set forth below.

Issue:

The issue for which EJR has been requested is:

> [Whether each Providers'] Federal Fiscal Year 2024 ("FFY 2024") wage indexes and associated Medicare reimbursement were improperly calculated and are lower than required because the Secretary ("Secretary") of the United States Department of Health and Human Services' ("HHS") unlawful interpretation and application of the Rural Floor and the Rural Floor Budget Neutrality Factor ("RFBNF").[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 rates[2] 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").

[1] Request for Expedited Judicial Review at 1 (May 20, 2025).
[2] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).

The base payment rate is comprised of a standardized amount[3] for all subsection (d) hospitals located in an "urban" or "rural" area.[4]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[5] 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.

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts.[6]

A. Rural Floor; Rural Floor Budget Neutrality Factor

Though the general rule is that a hospital's payment rate is adjusted based on its geographical area, whether it be an "urban" or "rural" area,[7] Congress has made an exception to ensure that even hospitals in a low-wage urban area receive at least the wage index applicable to the rural hospitals in that state.[8] This minimum wage index is known as the "rural floor." To offset this increase in payment to urban hospitals, however, Congress also enacted a budget neutrality adjustment which decreased payments to other hospitals,[9] namely rural hospitals and high-wage

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[3] The standardized amount is based on per discharge averages from a base period and is updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994). Section 1395ww(d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).
[4] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[5] of the Department of Health and Human Services.
[6] *See* https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index (last visited July 18, 2025).
[7] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[8] *See* Balanced Budget Act of 1997 ("BBA 1997"), Pub. L. No. 105-33, § 4410(a), 111 Stat. 251, 402.
[9] BBA 1997, § 4410(b).

urban hospitals.[10] To implement this budget neutrality adjustment, the Secretary adopted an "iterative method."

First, the rural floor is applied to raise low-wage urban hospitals' wage indices to match the rural hospitals, which *raises* the overall Medicare payments for the CBSA. Second, to make these adjustments budget-neutral, the Secretary applies an overall downward adjustment to rural and high-wage urban hospitals. A downward adjustment to the rural hospitals lowers the rural floor, which allows the low-wage urban hospitals' wage indices to be decreased, which *lowers* the overall Medicare payments for the CBSA. To make these new adjustments budget neutral, the Secretary applies an overall upward adjustment to rural and high-wage urban hospitals, again altering the rural floor, requiring the low-wage urban hospitals' wage index to be increased again. The process repeats until the wage indices stabilize in a budget neutral manner.[11]

The Secretary has simplified the iterative method by "simply adjusting all area wage indices by a uniform percentage."[12] In this simplified method, low-wage urban hospitals' wage indices are raised to the rural floor, then a uniform percentage is applied to decrease the wage indices of all hospitals to achieve budget neutrality.[13] The process of applying the budget neutrality adjustment to all hospitals' wage indices continues to be applied in setting the current annual wage indices.[14]

Providers' Position:

The Providers filed a consolidated Request for EJR on May 20, 2025, arguing that the wage indices and associated Medicare reimbursement for FFY 2024 were improperly calculated and lower than required. They argue that the Secretary has unlawfully interpreted and applied the rural floor and rural floor budget neutrality factor.[15] The Providers recount how BBA 1997 § 4410 establishes a rural floor to increase low-wage urban hospitals' wage indices to at least equal the wage index of the rural areas in a particular area.[16] They also explain how other hospitals – the rural and high-wage urban hospitals – would have their wage indices reduced to achieve budget neutrality in light of those increases to low-wage urban hospitals.[17] They argue that the simplified "iterative method", wherein a uniform percentage is applied to decrease the wage indices of all hospitals to achieve budge neutrality, is unlawful. They posit that this uniform decrease lowers the wage indices of low-wage urban hospitals, which are supposed to be exempt from the budget neutrality adjustments.[18] The Providers claim that once the rural floor is set, low wage urban hospitals that receive the rural floor cannot have their wage indices reduced pursuant to BBA 1997 § 4410(b).[19]

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[10] 72 Fed. Reg. 47130, 47325 (Aug. 22, 2007).
[11] *See id.* at 47325-47329; *see also St. Mary Med. Ctr. v. Becerra*, 581 F.Supp.3d 119, 127 (D.D.C. 2022).
[12] 72 Fed. Reg. at 47325.
[13] *Id.*; *see also St. Mary Med Ctr. v. Becerra*, 581 F.Supp.3d at 138.
[14] *See* 89 Fed. Reg. 68986, 69299 (Aug. 28, 2025).
[15] Request for Expedited Judicial Review at 1.
[16] *Id.* at 3-4.
[17] *Id.* at 4.
[18] *Id.* at 4-5.
[19] *Id.* at 7.

The Providers ask the Board to grant EJR because it has jurisdiction over these appeals. The appeals were all filed withing 180 days of the publication of the FFY 2024 Final Rule and the Providers are dissatisfied with the calculation of their appliable wage indices as published therein. The reimbursement impact in each group case exceeds the $50,000 threshold to establish the Board's jurisdiction.[20] The Board, however, lacks the authority to grant the relief sought: to hold CMS' policy and calculation of the rural floor budget neutrality factor and the related decrease to their wage indices unlawful under the Medicare statute.[21]

Medicare Contractor's Position:

On **May 28, 2025**, the Medicare Contractor's Representative, Federal Specialized Services ("FSS"), filed a Response to the Request for EJR. The Response did not address the actual request but instead made a timely[22] certification that it would be filing Substantive Claim Challenges in eight (8) cases. On **May 21, 2025**, National Government Services, the Medicare Contractor in Case 24-1567GC, also filed a separate, timely certification that a Substantive Claim Challenge was forthcoming in that case.

Decision of the Board:

The participants that comprise the group appeals within this EJR request have filed an appeal involving FFY 2024 based on their appeals from the FFY 2024 IPPS Final Rule.

A. Jurisdiction and Request for EJR

All of the participants in all of the nine (9) group cases at issue appealed from the FFY 2024 IPPS Final Rule.[23] The Board has determined that (1) the participants' documentation in each of the group appeals shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal;[24] (2) the appeals were timely filed; and (3) Board review of the matter in these appeals is not precluded by statute or regulation. In finding that the groups meet the $50,000 amount in controversy, the Board recognizes that the Group Representative has explained that the amount in controversy ("AiC") calculation is simply based on the estimated IPPS payments for the

[20] *Id.* at 10.
[21] *Id.* at 9-11.
[22] Board Rule 44.6 (2023) governs the timing of Substantive Claim Challenges in cases where a Request for EJR is filed less than sixty (60) days from the filing of a Final Schedule of Providers (or Board Rule 20 Certification filed in lieu of a Final SOP which certifies that the group is complete and fully populated in OH CDMS). In such instances, Board Rule 44.6 requires any party questioning the Board's jurisdiction or whether an appropriate cost report claim was made to file the challenge, or a certification that a challenge is forthcoming, within five (5) business days of the date the EJR Request was filed. The Request for EJR in these cases was filed on May 20, 2025, so any challenges (or certification that a challenge was forthcoming) were due no later than close of business May 28, 2025, noting that May 26, 2025 was a federal holiday and not a business day.
[23] The CMS Administrator confirmed that, consistent with the D.C. Circuit's decision in *Washington Hosp. Ctr. v. Bowen*, 795 F.3d 139 (D.C. Cir. 1986, a wage index notice published in the Federal Register is a final determination from which a provider may appeal to the Board within the meaning of 42 U.S.C. § 1395oo(a)(1)(A)(ii). *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993*)*, *rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015); 42 C.F.R. § 405.1837.
[24] *See* 42 C.F.R. § 405.1837.

period at issue if the rural floor budget neutral factor were removed for the FFY and this AiC unmistakably demonstrates each of the groups more than clears the minimum $50,000 AiC hurdle. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractors for the actual final amounts in each case.

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.[25]

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

[25] (Bold and underline emphasis added.)

> 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 report included an appropriate claim for the specific item, **must not be included in such jurisdictional dismissal decision**.[26]

These regulations are applicable to the cost reporting periods in these group cases.

2. Appropriate Cost Report Claims: Findings of Fact and Conclusions of Law

As explained above, at issue in this appeal are cost reports beginning after January 1, 2016, which are subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[27] 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))"[28] 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 findings as to whether an appropriate claim was included.

First, the Board notes that, when the participants in a group have not filed their cost report, then § 405.1873(b) would not be triggered because the issue of whether the relevant participants' cost reports included an appropriate claim for the specific item under appeal would not yet be ripe.[29] Section 405.1873(b) sets forth the procedures for Board review of Substantive Claim Challenges:

> The Board must give the parties an adequate opportunity to submit factual evidence and legal argument regarding the question of whether the provider's cost report included an appropriate claim for the specific item under appeal. Upon receipt of timely submitted factual evidence or legal argument (if any), the Board must review such 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, for the specific item under appeal, the cost report claim requirements prescribed in § 413.24(j) of this chapter.

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[26] (Bold and underline emphasis added.)
[27] 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").
[28] (Emphasis added.)
[29] The preamble to the final rule that adopted the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1973 responded to a comment about appeals from the Federal Register and confirmed that the substantive claim regulations applied to them. 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015). However, this preamble discussion does not address the manner in which they apply. Rather, the response concludes with the following directive in § 405.1873(a)-(b): "if a party to an appeal questions whether there was an appropriate cost report claim for a specific PPS item, the Board must take evidence and argument on that question; issue findings of fact and conclusions of law on such matter; and include those findings and conclusions in both the administrative record and certain types of overall Board decisions." *Id.* at 70570.

Significantly, the regulation simply directs the Board to give an adequate opportunity to take in evidence and argument and does not discuss staying appeals based on the Federal Register to allow future review and consideration of Substantive Claim Challenges. In this regard, the fact that a cost report has not been filed would not stop or delay the Board proceedings as set forth in § 405.1873(b). Accordingly, it is the Board's position that in these instances, any Substantive Claim Challenge would be premature.

That said, *if subsequent to the Federal Register appeal being filed*, one or more participants files its cost report, then any party may raise a Substantive Claim Challenge regarding those participants and submit argument and evidence supporting their position. In this case, all of the participants in the above-referenced group cases are appealing the FFY 2024 Federal Register Notice and the cost reports impacted by such notice for at least some Providers appear to have not yet been filed to trigger the general substantive claim payment requirement for cost reports under § 413.24(j).[30] Accordingly, the Board is not obligated under 42 C.F.R. § 405.1873 to include findings on substantive claim challenges in these cases for any participants which have not yet filed their cost reports.

Finally, the Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[31] 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.[32] As outlined below, the Medicare Contractor has questioned whether there was an appropriate claim made for some of the Providers in each of these nine (9) cases. All of the Providers for which a Substantive Claim Challenge was made shall be collectively referred to as "the Challenged Providers." Any Providers for which no Substantive Claim Challenge was made shall be collectively referred to as "the Non-Challenged Providers."

a. Case 24-1641GC

FSS makes the following allegations to support the argument that the following two Providers failed to include an appropriate claim on their respective cost reports for the disputed issue, Rural Floor Budget Neutrality Factor ("RFBNA"):[33]

- Bayfront Health Seven Rivers (Provider No. 10-0249; FYE 11/30/2023)
  - The cost report was filed noting $1,972,879 in Part A Protested Amounts, but the accompanying Protest Narrative and Calculation does not list the RFBNA issue[34]
- Northwest Health-Starke (Provider No. 15-0102; FYE 12/31/2023)

[30] *See* 80 Fed. Reg. at 70556, 70569-70.
[31] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[32] *See* 42 C.F.R. § 405.1873(a),
[33] PRRB Case 24-1641GC, Medicare Administrative Contractor's Substantive Claim Challenge at 2 (June 5, 2025).
[34] *Id.* at 5-6.

- The cost report was filed noting $172,578 in Part A Protested Amounts, but the accompanying Protest Narrative and Calculation does not list the RFBNA issue[35]

The Providers filed a Response to the MAC's Substantive Claim Challenge. They allege that the "Substantive Claim Regulations" are unlawful and with to have EJR granted with respect to the validity of those regulations, as well as the RFBNA issue.[36] They also claim that Northwest Health-Starke (Provider No. 15-0102; FYE 12/31/2023) ***did*** identify the RFBNA issue on its applicable cost report and has satisfied the Substantive Claim Regulations.[37] The Board concurs and notes that the Summary of Calculated Protest Amounts for this Provider includes a line for "Rural Floor" and lists $62,000 as the amount. The explanation of this protested item describes, in narrative form, how the calculation was made.

The Board finds that it is undisputed that Bayfront Health Seven Rivers (Provider No. 10-0249; FYE 11/30/2023) failed to make an appropriate claim on its cost report for the RFBNA issue.

The Board also finds that Northwest Health-Starke (Provider No. 15-0102; FYE 12/31/2023) did make an appropriate claim on its cost report for the RFBNA issue.

b. <u>Case 24-1588GC</u>

FSS makes the following allegations to support the argument that the following two Providers failed to include an appropriate claim on their respective cost reports for the disputed issue, RFNBA:[38]

- St. Mary Medical Center (Provider No. 05-0300; FYE 6/30/2024)
  - The cost report was filed noting $18,633,827 in protested amounts on Worksheet E, Part A, Line 75 and $888,085 on Worksheet E, Part B, Line 44, but the protested items schedule supporting the details of these amounts was not submitted with the cost report filing[39]
- Grace Medical Center (Provider No. 45-0162; FYE 12/31/2023)
  - The cost report was filed noting $0 in both Part A and Part B Protested Amounts[40]

The Providers filed a Response to the MAC's Substantive Claim Challenge. They allege that the "Substantive Claim Regulations" are unlawful and with to have EJR granted with respect to the validity of those regulations, as well as the RFBNA issue.[41] The Providers also included a copy of a document allegedly submitted with the cost report for St. Mary Medical Center (Provider No. 05-0300; FYE 6/30/2024), which reconciles to the protested amounts identified by the MAC in its challenge, to support that the RFBNA issue was included in its protest.[42]

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[35] *Id.* at 6.
[36] PRRB Case 24-1641GC, Providers' Response to the MAC's Substantive Claim Challenge at 1 (July 2, 2025).
[37] *Id.* at 3 (citing Ex. C-4 at C-0051).
[38] PRRB Case 24-1588GC, Medicare Administrative Contractor's Substantive Claim Challenge at 2 (June 6, 2025).
[39] *Id.* at 5.
[40] *Id.*
[41] PRRB Case 24-1588GC, Providers' Response to the MAC's Substantive Claim Challenge at 1 (July 2, 2025).
[42] *Id.* at 3 and Ex. P-3.

The Board concurs – the new evidence submitted with the Providers' Response to the Substantive Claim Challenge reflects $18,663,827 in total Part A protested amounts and $888,085 in Part B protested amounts. Within the newly submitted exhibit, protested item #45 describes a protested amount ($405,105 Part A and $108,571 Part B) associated with the improper calculation of the Provider's wage index based on the Rural Floor Budget Neutrality Factor.[43] Based on the foregoing, the Board finds that St. Mary Medical Center (Provider No. 05-0300; FYE 6/30/2024) did make an appropriate claim on its cost report for the RFBNA issue.

The Board also finds that it is undisputed that Grace Medical Center (Provider No. 45-0162; FYE 12/31/2023) failed to make an appropriate claim on its cost report for the RFBNA issue.

c. Case 24-1614GC

FSS makes the following allegations to support the argument that the following four Providers failed to include an appropriate claim on their respective cost reports for the disputed issue, RFBNA:[44]

- Hillcrest Hospital Claremore (Provider No. 37-0039; FYE 10/31/2024)
  - The cost report was filed identifying $562,606 in Part A protest amounts, but the Protested Items Summary includes a line for "RFBNF" stating "n/a for 10-31-2024."[45]
- Hillcrest Hospital Henryetta (Provider No. 37-0183; FYE 11/30/2024)
  - The cost report was filed identifying $295,479 in Part A protest amounts, but the accompanying Listing of Issues Filed Under Protest does not include the RBNA issue.[46]
- University of Texas Health Science Center at Tyler (Provider No. 45-0690; FYE 08/31/2024)
  - The cost report was filed identifying $77,189 in Part A protested amounts, but did not include a summary of specific items being protested or separate worksheets describing the calculation of the estimated reimbursement amount for each specific self-disallowed item.[47]
- East Texas Medical Center (Provider No. 45-0083; FYE 10/31/2023)
  - The cost report was filed identifying $17,954,866 in Part A protested amounts and the accompanying Protested Items Summary listed RFBNF with an amount of $476,520, but "the Provider did not include a separate work sheet explaining why the Provider self-disallowed this specific item and describing how the Provider calculated the estimated reimbursement amount for this specific self-disallowed item."[48]

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[43] Ex. P-3 at P-044.
[44] PRRB Case 24-1614GC, Medicare Administrative Contractor's Substantive Claim Challenge at 4-7 (June 6, 2025).
[45] *Id.* at 5.
[46] *Id.*
[47] *Id.* at 6.
[48] *Id.*

The Providers filed a Response to the MAC's Substantive Claim Challenge. They allege that the "Substantive Claim Regulations" are unlawful and with to have EJR granted with respect to the validity of those regulations, as well as the RFBNA issue.[49] They do not dispute any of the allegations raised by FSS in the Substantive Claim Challenge with regard to compliance with the requirements set forth in 42 C.F.R. § 413.24(j).

The Board finds that it is undisputed that the four Challenged Providers in this case did not make an appropriate claim on their cost reports for the RFBNA issue.

d. Case 24-1640GC

FSS makes the following allegations to support the argument that the following one Provider failed to include an appropriate claim on its cost report for the disputed issue, RFBNA:[50]

- Cortland Regional Medical Center, Inc. (Provider No. 33-0175, FYE 06/30/2024)
  - The cost report was filed identifying $253,518 in Part A protested amounts, but the accompanying Summary of Protested Amounts attributed $0 to "Rural Floor Budget Neutrality Factor"[51]

The Providers filed a Response to the MAC's Substantive Claim Challenge. They allege that the "Substantive Claim Regulations" are unlawful and with to have EJR granted with respect to the validity of those regulations, as well as the RFBNA issue.[52] It also claims that the RFBNF issue *was* protested, but "there appears to have been an error in the Excel formula resulting in the amount being excluded. However, since that time, Provider 33-0175 Cortland Regional Medical Center has advised that it amended its June 30, 2024 Cost Report and it now includes all relevant materials."[53]

The exhibits support both parties' statements. The original Worksheet E, Part A was prepared on December 11, 2024,[54] and the accompanying Protested Items Support for the RFBNF issue displays errors "#DIV/0!" in the protested amount.[55] There is also a lengthy explanation describing the alleged flaws in calculating the wage index with regard to the RFBNF.[56] A new Worksheet E, Part A was prepared on May 30, 2025 and the accompanying Protested Items Support for the RFBNF issue now displays $123,257 for Part A.[57]

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[49] PRRB Case 24-1614GC, Providers' Response to the MAC's Substantive Claim Challenge at 1 (July 2, 2025).
[50] PRRB Case 24-1640GC, Medicare Administrative Contractor's Substantive Claim Challenge at 1 (June 6, 2025).
[51] *Id.* at 4.
[52] PRRB Case 24-1640GC, Providers' Response to the MAC's Substantive Claim Challenge at 1 (July 2, 2025).
[53] *Id.* at 2-3 and Ex. P-3.
[54] Ex. C-3.
[55] Ex. C-4 at 2.
[56] *Id.* at 3-5.
[57] PRRB Case 24-1640GC, Providers' Response to the AMC's Substantive Claim Challenge, Ex. P-3 at 1-3.

42 C.F.R. § 413.24(j)(2) explains that,

> 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.

It is undisputed that original cost report submission did not include an estimated reimbursement amount as required by 42 C.F.R. § 413.24(j)(2)(i). Thus, the original submission did not properly self-disallow the RFBNA issue. The Provider may, however, meet the requirements if their amended cost report self-disallows the specific item for which it seeks reimbursement,[58] **as long as the amended cost report is accepted by the Medicare Contractor**.[59] It appears that an amended cost report was prepared, but there is no evidence in the record that it has been ***accepted*** by the Medicare Contractor. If the amended cost report was not accepted, then "[w]hether the provider's cost report for its cost reporting period includes an appropriate claim for a specific item . . . must be determined by reference to the cost report that the provider submits originally to, and was accepted by, the contractor for such period[.]"[60]

The Board "will issue its findings and legal conclusions on the Substantive Claim Challenge **based on the record**[61] ***unless*** a party requests otherwise by motion (*e.g.*, requests additional time to submit evidence, requests a hearing to present argument and evidence) ***and*** the Board grants leave for additional filings and/or proceedings."[62]

Based on the record, there is nothing to show that the amended cost report has been accepted by the Medicare Contractor, and it is undisputed that the original submission did not include a protested amount for the RFBNA issue. In fact, the Provider only prepared this amended report on May 30, 2025 after it filed its Request for EJR on May 20 and after the Medicare Contractor attempted to confer with regard to the Substantive Claim Challenge on May 21.[63] Based on the

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[58] 42 C.F.R. § 413.24(j)(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), . . .") (emphasis added).
[59] 42 C.F.R. § 413.24(j)(3)(i) ("If the provider submits an amended cost report for its cost reporting period **and such amended cost report is accepted by the contractor**, then whether there is an appropriate cost report claim for the specific item must be determined by reference to such amended cost report, . . .") (emphasis added).
[60] 42 C.F.R. § 413.24(j)(3).
[61] (Emphasis added).
[62] Board Rule 44.5.2 (2023) (emphasis in original).
[63] *See* PRRB Case 24-1640GC, Medicare Administrative Contractor's Substantive Claim Challenge at 1 (indicating the Medicare Contractor attempted to confer with the Provider's Representative on May 21, 2025 but received no response).

foregoing, the Board finds that Cortland Regional Medical Center, Inc. (Provider No. 33-0175, FYE 06/30/2024) did not make an appropriate claim in compliance with 42 C.F.R. § 42.413(j).

e. Case 24-1642G

FSS makes the following allegations to support the argument that the following Provider failed to include an appropriate claim on its respective cost report for the disputed issue, RFBNA:[64]

- Jupiter Medical Center (Provider No. 10-0253; FYE 09/30/2024)
  - The cost report was filed identifying $11,291,070 in Part A Protested Amounts, but the accompanying list of protested items did not have an item for the RFNPA issue.[65] "Rural Floor" is listed as a protested issue, but there is no amount that was protested.[66]

The Providers filed a Response to the MAC's Substantive Claim Challenge. They allege that the "Substantive Claim Regulations" are unlawful and with to have EJR granted with respect to the validity of those regulations, as well as the RFBNA issue.[67] They do not dispute any of the allegations raised by FSS in the Substantive Claim Challenge with regard to compliance with the requirements set forth in 42 C.F.R. § 413.24(j).

The Board finds that it is undisputed that Jupiter Medical Center (Provider No. 10-0253; FYE 09/30/2024) did not make an appropriate claim on its cost report for the RFBNA issue.

f. Case 24-1618GC

FSS makes the following allegations to support the argument that the following four Providers failed to include an appropriate claim on its respective cost report for the disputed issue, RFBNA:[68]

- Holmes Regional Medical Center (Provider No. 10-0019; FYE 09/30/2024)
  - The cost report was filed identifying $13,424,159 in Part A protested amounts, but the accompanying Protested Amount Detail does not include an item for the RFBNA issue. While an issue was included labeled "Budget Neutrality Factor – 6% Under Payment", the detail of this item refers to the St. Francis Predicate Facts issue.[69]
- Cape Canaveral Hospital (Provider No. 10-0177; FYE 09/30/2024)
  - The cost report was filed identifying $3,792,177 in Part A protested amounts, but the accompanying Protested Amount Detail does not include an item for the RFBNA issue. While an issue was included labeled "Budget Neutrality Factor –

[64] PRRB Case 24-1642G, Medicare Administrative Contractor's Substantive Claim Challenge at 1 (June 6, 2025).
[65] *Id.* at 4.
[66] *Id.* at n.4 (citing Ex. C-3 at 9).
[67] PRRB Case 24-1642G, Providers' Response to the MAC's Substantive Claim Challenge at 1 (July 2, 2025).
[68] PRRB Case 24-1618GC, Medicare Administrative Contractor's Substantive Claim Challenge at 1 (June 5, 2025).
[69] *Id.* at 4.

6% Under Payment", the detail of this item refers to the St. Francis Predicate Facts issue.[70]

- Viera Hospital (Provider No. 10-0315; FYE 09/30/2024)
  - The cost report was filed identifying $671,328 in Part A protested amounts, but the accompanying Protested Amount Detail does not include an item for the RFBNA issue. While an issue was included labeled "Budget Neutrality", the detail of this item refers to the St. Francis Predicate Facts issue.[71]
- Palm Bay Hospital (Provider No. 10-0316; FYE 09/30/2024)
  - The cost report was filed identifying $3,297,545 in Part A protested amounts, but the accompanying Protested Amount Detail does not include an item for the RFBNA issue. While an issue was included labeled "Budget Neutrality Factor – 6% Under Payment", the detail of this item refers to the St. Francis Predicate Facts issue.[72]

The Providers filed a Response to the MAC's Substantive Claim Challenge. They allege that the "Substantive Claim Regulations" are unlawful and with to have EJR granted with respect to the validity of those regulations, as well as the RFBNA issue.[73] They do not dispute any of the allegations raised by FSS in the Substantive Claim Challenge with regard to compliance with the requirements set forth in 42 C.F.R. § 413.24(j).

The Board finds that it is undisputed that the four Challenged Providers in this case did not make an appropriate claim on their cost reports for the RFBNA issue.

g. Case 24-1577GC

FSS makes the following allegations to support the argument that the following two Providers failed to include an appropriate claim on their respective cost reports for the disputed issue, RFBNA:[74]

- ECU Health Medical Center f.k.a. Pitt County Memorial Hospital (Provider No. 34-0040, FYE 09/30/2024)
  - The cost report was filed identifying $5,120,382 in Part A Protested Amounts, but the accompanying Summary of Protested Amounts did not include a protested amount or supporting documentation for the RFNBA issue.[75]
- Vidant Edgecombe Hospital (Provider No. 34-0107, FYE 09/30/2024)
  - The cost report was filed identifying $0 in Part A protested amounts[76]

The Providers filed a Response to the MAC's Substantive Claim Challenge. They allege that the "Substantive Claim Regulations" are unlawful and with to have EJR granted with respect to the

[70] *Id.* at 5.
[71] *Id.* at 5-6.
[72] *Id.* at 6.
[73] PRRB Case 24-1618GC, Providers' Response to the MAC's Substantive Claim Challenge at 1 (July 2, 2025).
[74] PRRB Case 24-1577GC, Medicare Administrative Contractor's Substantive Claim Challenge at 1 (June 4, 2025).
[75] *Id.* at 4.
[76] *Id.*

validity of those regulations, as well as the RFBNA issue.[77] They do not dispute any of the allegations raised by FSS in the Substantive Claim Challenge with regard to compliance with the requirements set forth in 42 C.F.R. § 413.24(j).

The Board finds that it is undisputed that the two Challenged Providers in this case did not make an appropriate claim on their cost reports for the RFBNA issue.

h. Case 24-1579GC

FSS makes the following allegations to support the argument that the following one Provider failed to include an appropriate claim on its cost report for the disputed issue, RFBNA:[78]

- Centra Health-Lynchburg General Hospital (Provider No. 49-0021; FYE 12/31/2023)
  - The cost report was filed identifying $33,101,225 in Part A protested amounts and $10,633,779 in Part B protested amounts, but the accompanying Summary of Protested Amounts did not include an explanation or reimbursement calculation for the "RFBNF Protested Amount" item.[79]

The Providers filed a Response to the MAC's Substantive Claim Challenge. They allege that the "Substantive Claim Regulations" are unlawful and with to have EJR granted with respect to the validity of those regulations, as well as the RFBNA issue.[80] They argue that this Challenged Provider *did* identify the RFBNA issue on its cost report and included an amount at issue.[81]

The Board disagrees with the Provider. The Medicare Contractor's Exhibit C-3 does show a line for the RFBNF with a Protested Amount, but 42 C.F.R. § 413.24(j)(2) explains that,

> 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.**

The documentation in the record[82] shows work sheets and calculations for most of the protested items claimed on this Provider's cost report, but there is no work sheet or calculation for the

[77] PRRB Case 24-1577GC, Providers' Response to the MAC's Substantive Claim Challenge at 1 (July 2, 2025).
[78] PRRB Case 24-1579GC, Medicare Administrative Contractor's Substantive Claim Challenge at 1 (June 5, 2025).
[79] *Id.* at 4.
[80] PRRB Case 24-1579GC, Providers' Response to the MAC's Substantive Claim Challenge at 1 (July 2, 2025).
[81] *Id.* at 2 (citing Medicare Administrative Contractor's Substantive Claim Challenge, Ex. C-3).
[82] PRRB Case 24-1579GC, Medicare Administrative Contractor's Substantive Claim Challenge, Ex. C-3.

RFBNA issue. The Board finds that this Provider did not make an appropriate claim on their cost report for the RFBNA issue.

i. Case 24-1567GC

FSS makes the following allegations to support the argument that the following three Providers failed to include an appropriate claim on their respective cost reports for the disputed issue, RFBNA:[83]

- Geneva General Hospital (Provider No. 33-0058; FYE 12/31/2023)
  - The cost report was filed identifying $1,595,802 in Part A Protested Amounts, but the Provider did not include an amount, explanation, or reimbursement calculation for the RFBNA issue.[84]
- F.F. Thompson Hospital (Provider No. 33-0074; FYE 12/31/2023)
  - The cost report was filed identifying $2,138,410 in Part A Protested Amounts, but the Provider did not include an amount, explanation, or reimbursement calculation for the RFBNA issue.[85]
- Highland Hospital (Provider No. 33-0164, FYE 6/30/2024)
  - The Provider did not claim the full amount of reimbursement for the RFBNA issue. Additionally, the cost report claimed $5,446,304 in Part A protested amounts, while the summary of protested items totaled $5,487,804.[86] The Medicare Contractor notes that, based on the $41,500 variance, "[a]s the total protested amount on the summary does not trace to the CR/HCRIS data, and the amount claimed in the protested support is greater than the amount claimed on the cost report, a challenge is necessary."[87]

The Providers filed a Response to the MAC's Substantive Claim Challenge. They allege that the "Substantive Claim Regulations" are unlawful and with to have EJR granted with respect to the validity of those regulations, as well as the RFBNA issue.[88] They also argue that, for Highland Hospital (Provider No. 33-0164, FYE 6/30/2024), the Provider did identify the RFBNA issue and all supporting documentation including a calculation and narrative and note that "[a]ny minor error in the math totaling the protested item amount will be corrected by the Provider through amendment of its cost report."[89]

The Board concurs with the Provider. Highland Hospital (Provider No. 33-0164, FYE 6/30/2024) included a worksheet identifying $584,686 in protested amounts for the RFBNA issue, as well as a detailed narrative on the nature of the protest.[90] The variance of $41,500 is

[83] PRRB Case 24-1567GC, Medicare Administrative Contractor's Substantive Claim Challenge at 1 (June 5, 2025).
[84] *Id.* at 4.
[85] *Id.* at 4-5.
[86] *Id.* at 5.
[87] *Id.* at Ex. C-5 at 3.
[88] PRRB Case 24-1567GC, Providers' Response to the MAC's Substantive Claim Challenge at 1 (July 2, 2025).
[89] *Id.* at 2-3.
[90] PRRB Case 24-1567GC, Medicare Administrative Contractor's Substantive Claim Challenge, Ex. C-5 at 31-34.

immaterial to a total protested amount in excess of $5.4 million. This Provider protested the RFBNA issue, included a worksheet to calculate the reimbursement impact, and provided a detailed narrative on the issue with its cost report, thus meeting the requirements of 42 C.F.R. § 413.24(j).

For the other two Challenged Providers, the Board finds that it is undisputed that they did not make an appropriate claim on their cost reports for the RFBNA issue.

j. The Non-Challenged Providers

With regard to the Non-Challenged Providers, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[91] 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 for the non-challenged providers and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

C. Analysis Regarding Appealed Issue

The Board finds that the Secretary's determination to implement the rural floor budget neutrality adjustment was made through notice and comment in the form of an uncodified regulation[92] and that this policy continues to be applied in setting the current annual wage indices, including the FFY 2024 at issue in these appeals.[93] Therefore, the Board finds that this policy continues to be a binding but uncodified regulation for FFY 2024. 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 area wage indices, which incorporate this rural floor budget neutrality adjustment, and the Board does not have the authority to grant the relief sought by the Providers, namely to hold CMS' policy and calculation of the rural floor budget neutrality factor and the related decrease to their wage indices unlawful under the Medicare statute.[94] As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in these cases.

D. Board's Decision Regarding the EJR Request

The Board finds that:

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[91] 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."
[92] *See* 72 Fed. Reg. 47130, 47325-47330 (Aug. 22, 2007) "III. Changes to the Hospital Wage Index, G. Computation of the FY 2008 Unadjusted Wage Index, 4. Application of Rural Floor Budget Neutrality."
[93] *See* 89 Fed. Reg. 68986, 69299 (Aug. 28, 2025).
[94] Request for Expedited Judicial Review at 9-11.

1) It has jurisdiction over the rural floor budget neutrality factor issue for the subject year in these cases and that the Providers in these group appeals are entitled to a hearing before the Board;

2) The Challenged Providers listed in **Appendix B** failed to make an appropriate claim on their cost reports as required by 42 C.F.R. § 413.24(j) for the specific Rural Floor Budget Neutrality Adjustment issue under appeal;

3) The remaining Challenged Providers not listed in **Appendix B** did make an appropriate claim on their cost reports as required by 42 C.F.R. § 413.24(j) for the specific Rural Floor Budget Neutrality Adjustment issue under appeal;

4) While the Non-Challenged Providers appealed cost reporting periods beginning after January 1, 2016, no substantive claim challenges[95] have 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);

5) Based upon the Providers' assertions regarding the rural floor budget neutrality factor issue, there are no findings of fact for resolution by the Board;

6) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

7) It is without the authority to decide the legal questions of:

    a. Whether the calculation and application of the rural floor budget neutrality factor and the related decrease to the Providers' wage indices is valid; and
    b. Whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid for any Providers which the Board has specifically found failed to include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1).

Accordingly, the Board finds that the question of the validity of the application of the rural floor budget neutrality factor and the related decrease to the Providers' wage indices properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject years. For any Providers which the Board has specifically found failed to include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1), the Board also finds that the question of the validity of the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 falls

[95] 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."

within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the their requests 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 these cases.

Board Members Participating:

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

FOR THE BOARD:

7/18/2025

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)
Danelle Decker, National Government Services, Inc. (J-K)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)
Michael Redmond, Novitas Solutions c/o GuideWell Source (J-H)
Dean Wolfe, Noridian Healthcare Solutions (J-F)
Scott Berends, Esq., Federal Specialized Services

Appendix A

(9 Cases with Substantive Claim Challenges Encompassed in May 20, 2025 Consolidated EJR Request)

24-1641GC	*CHS FFY 2024 Unlawful Rural Floor & Rural Floor Budget Neutrality Factor CIRP Group*
24-1588GC	*Providence Health FFY 2024 Unlawful Rural Floor & Rural Floor Budget Neutrality Factor CIRP Group*
24-1614GC	*Ardent Health FFY 2024 Unlawful Rural Floor & Rural Floor Budget Neutrality Factor CIRP Group*
24-1640GC	*Guthrie Clinic FFY 2024 Unlawful Rural Floor & Rural Floor Budget Neutrality Factor CIRP Group*
24-1642G	*Greenbaum, Rowe, Smith FFY 2024 Unlawful Rural Floor & Rural Floor Budget Neutrality Factor Group*
24-1618GC	*Health First FFY 2024 Unlawful Rural Floor & Rural Floor Budget Neutrality Factor CIRP Group*
24-1577GC	*ECU Health FFY 2024 Unlawful Rural Floor & Rural Floor Budget Neutrality Factor CIRP Group*
24-1579GC	*Centra Health FFY 2024 Unlawful Rural Floor & Rural Floor Budget Neutrality Factor CIRP Group*
24-1567GC	*Univ of Rochester FFY 2024 Unlawful Rural Floor & Rural Floor Budget Neutrality Factor CIRP Group*

Appendix B

(Challenged Providers which the Board finds no appropriate claim was made as required by 42 C.F.R. § 413.24(j) for the Rural Budget Floor Neutrality Adjustment Issue)

1) Case 24-1641GC:
    a. Bayfront Health Seven Rivers (Provider No. 10-0249; FYE 11/30/2023)
2) Case 24-1588GC:
    a. Grace Medical Center (Provider No. 45-0162; FYE 12/31/2023)
3) Case 24-1614GC:
    a. Hillcrest Hospital Claremore (Provider No. 37-0039; FYE 10/31/2024)
    b. Hillcrest Hospital Henryetta (Provider No. 37-0183; FYE 11/30/2024)
    c. University of Texas Health Science Center at Tyler (Provider No. 45-0690; FYE 08/31/2024)
    d. East Texas Medical Center (Provider No. 45-0083; FYE 10/31/2023)
4) Case 24-1640GC:
    a. Cortland Regional Medical Center, Inc. (Provider No. 33-0175, FYE 06/30/2024)
5) Case 24-1642G:
    a. Jupiter Medical Center (Provider No. 10-0253; FYE 09/30/2024)
6) Case 24-1618GC:
    a. Holmes Regional Medical Center (Provider No. 10-0019; FYE 09/30/2024)
    b. Cape Canaveral Hospital (Provider No. 10-0177; FYE 09/30/2024)
    c. Viera Hospital (Provider No. 10-0315; FYE 09/30/2024)
    d. Palm Bay Hospital (Provider No. 10-0316; FYE 09/30/2024)
7) Case 24-1577GC:
    a. ECU Health Medical Center f.k.a. Pitt County Memorial Hospital (Provider No. 34-0040, FYE 09/30/2024)
    b. Vidant Edgecombe Hospital (Provider No. 34-0107, FYE 09/30/2024)
8) Case 24-1579GC:
    a. Centra Health-Lynchburg General Hospital (Provider No. 49-0021; FYE 12/31/2023)
9) Case 24-1567GC:
    a. Geneva General Hospital (Provider No. 33-0058; FYE 12/31/2023)
    b. F.F. Thompson Hospital (Provider No. 33-0074; FYE 12/31/2023)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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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: **EJR Determination**
Baptist St. Anthony's Hospital (Provider Number 45-0231)
FYE: 12/31/2012
Case Number: 18-1788

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's Requests for Expedited Judicial Review ("EJR") filed June 26, 2025 in the above-referenced appeals. The Board's decision with respect to EJR is set forth below.

I. Background

On **February 28, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2012. The Provider is represented by Quality Reimbursement Services, Inc. ("QRS").

On **August 31, 2018**, Baptist St. Anthony's Hospital filed the individual appeal request. The initial Individual Appeal Request contained eight (8) issues:

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

[1] On March 5, 2025, the Board dismissed this issue.
[2] On January 22, 2019, this issue was transferred to Case No. 19-0702G.
[3] On January 22, 2019, this issue was transferred to Case No. 19-0703G.
[4] On January 22, 2019, this issue was transferred to Case No. 19-0704G.
[5] On July 2, 2025, this issue was withdrawn.
[6] On January 22, 2019, this issue was transferred to Case No. 19-0705G.

7. DSH Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[7]
8. Outlier Payments – Fixed Loss Threshold

The only issue remaining open in the case is Issue 8, and the issue statement in that issue is described as:

Issue 8: Outlier Payments - Fixed Loss Threshold

Statement of Issue

Whether the Provider 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 Provider contends the Secretary's final determination of outlier payments for the fiscal year 2004 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 for federal fiscal year 2004. 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.

[7] On January 22, 2019, this issue was transferred to Case No. 19-0706G.

> 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.[8]

The Board notes that the issue statement ***incorrectly*** asserts that the Providers are appealing their outlier threshold payments for ***fiscal year 2004***, though the case actually concerns the fiscal year ended in 2012. The parties have filed Preliminary and Final Position Papers. On **June 26, 2025**, the Provider filed a request for EJR and a response was filed by Federal Specialized Services on behalf of the Medicare Contractor on **July 3, 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.[9] Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[10] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[11] These predetermined, standardized amounts are calculated by the Secretary first determining a nationwide average allowable cost per discharge,[12] which is then further adjusted based on a wage index specific to the locality of the hospital.[13] Each discharge is also adjusted based on the severity of illness, which are classified as distinct diagnosis-related groups ("DRGs").[14] 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."[15]

While the PPS provides a fixed amount of reimbursement per patient regardless of actual costs incurred in rendering services,[16] Congress also authorized supplemental "outlier payments," or additional reimbursement for patients' care if the cost was atypically high.[17] Hospitals may request outlier payments "in any case where charges, adjusted to cost, exceed . . . the sum of the

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[8] Issue Statement at 7-8 (Aug. 31, 2018).
[9] *See* 42 U.S.C. § 1395f(b)(1).
[10] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[11] *Id.*
[12] 42 U.S.C. § 1395ww(d)(2)(A)-(C).
[13] 42 U.S.C. § 1395ww(d)(2)(H).
[14] 42 U.S.C. § 1395ww(d)(4).
[15] *See Cape Cod Hosp. v. Sebelius*, 630F.3d 203, 205-206 (D.C. Cir. 2011).
[16] *See Sebelius v. Auburn Reg'l Med. Ctr.*, 133 S.Ct. 817, 822 (2013).
[17] *See County of L.A. v. Shalala*, 192 F.3d 1005, 1009 (1999); 42 U.S.C. § 1395ww(d)(5)(A).

applicable DRG prospective payment rate . . . plus a fixed dollar amount determined by the Secretary."[18]

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.[19] 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."[20] This amount essentially makes a hospital responsible for a portion of the treatment's excessive costs.[21] 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.[22] The sum of the DRG rate plus the fixed loss threshold is known as the "outlier threshold."[23] Hospitals are typically paid 80% of the costs above the applicable outlier threshold.[24]

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.'"[25] 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.[26]

III. Positions of the Parties

As noted above, the Provider's issue statement outlines a challenge 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.[27] 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.

In their Final Position Paper, the Provider alleges that CMS set the cost outlier threshold too high and "the resulting amount of outlier payments each year fell short of the percentage required by the Medicare Act and the Providers did not receive the amount of outlier payments that Congress

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[18] 42 U.S.C. § 1395ww(d)(2)(A)(ii).
[19] *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).
[20] *See Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d at 50.
[21] *See Boca Raton Comm. Hosp., Inc. v. Tenet Health Care Corp.*, 582 F.3d 1227, 1229 (11th Cir. 2009).
[22] 42 U.S.C. § 1395ww(d)(5)(A)(iv).
[23] *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).
[24] 42 C.F.R. § 412.84(k).
[25] *Billings Clinic v. Azar*, 901 F.3d 301, 306 (D.C. Cir. 2018) (citing *Banner Health v. Price*, 87 F.3d at 1333).
[26] *Id.* (citing 68 Fed. Reg. 34494, 34499 (June 9, 2003)).
[27] 5 U.S.C. § 706(2).

intended."[28] They essentially argue that the Secretary's methodology in calculating the outlier cost threshold invited the abusive turbo-charging carried out by some hospitals, and that the use of this methodology persisted "[d]espite multiple warnings from providers, and red flags raised by the data on which the Secretary relied, and without valid justification[.]"[29]

The Provider notes that outlier payments were set at 5.1 percent of operating DRG payments, but outlier payments ultimately totaled less than this.[30] They argue the "Secretary's final determination of outlier payments for the fiscal years at issue herein is arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law. . ."[31] They argue that the Secretary adjusted cost-to-charge ratios in a manner that was contrary to evidence before the agency, despite warnings from commenters; failed to account for the impact of reconciliation; failed to respond to respond to valid comments and adjust the thresholds to achieve the 5.1% target; and failed to provide relevant data used in calculating the thresholds.[32]

The Medicare Contractor argues that substantially identical arguments were considered, and rejected, by the D.C. District Court in *District Hosp. Partners, L.P. v. Sebelius*.[33] It asks the Board to adopt the reasoning of the court and affirm the adjustments to outlier payments.[34] In fact, in this case, the Medicare Contractor's designated representative, Federal Specialized Services, has filed a Response to the Request for EJR noting that "a jurisdictional challenge will not be filed . . . The MAC will not challenge Provider's request for expedited judicial review."[35]

IV. Decision of the Board

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.

Jurisdiction

A Provider generally has a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if:

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[28] Provider's Final Position Paper at 21-22 (Dec. 22, 2023).
[29] *Id.* at 17.
[30] *Id.* at 20.
[31] *Id.* at 21.
[32] *Id.* at 21-22.
[33] Medicare Contractor's Final Position Paper at 18 (Jan. 17, 2024) (citing 973 F. Supp. 2d, 1 (D.D.C. 2014). The case was ultimately affirmed in part, reversed in part, and remanded, though the general rationale of the District Court was affirmed. *Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d 46 (D.C. Cir. 2015).
[34] *Id*. at 19.
[35] Medicare Contractor's Response to Provider's Request for Expedited Judicial Review (Jul. 3, 2025).

- They are dissatisfied with final determination 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; [36] and
- The amount in controversy is $10,000 or more.[37]

The Provider's documentation shows that the estimated amount in controversy exceeds $10,000.[38] The Provider has also timely appealed from its original NPR.

On August 21, 2008, new regulations governing the Board were effective.[39] 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*").[40] 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.[41]

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 this case is governed by CMS Ruling CMS-1727-R since the Provider is 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 issue is not otherwise precluded by statute or regulation.

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[36] 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).
[37] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[38] *See* 42 C.F.R. § 405.1835.
[39] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[40] 201 F. Supp. 3d 131 (D.D.C. 2016).
[41] *Id.* at 142.

V. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the Provider in the instant appeal is entitled to a hearing before the Board;

2) Based upon the Provider's 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

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 Provider's EJR Request for the remaining issue in the appeal. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only remaining issue under dispute in this case, the Board hereby closes the case 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
Nicola E. Musgrave, Esq.
Shakeba DuBose, Esq.

FOR THE BOARD:

7/21/2025

X Kevin D. Smith, CPA

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

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

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RE: ***Board Decision* – DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**
Trinity Hospital of Augusta (Provider No. 11-0039)
FYE 06/30/2017
Case No. 22-0780

Dear Mr. Ravindran and Ms. Huggins,

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. 22-0780*

On **August 24, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2017.

On **February 14, 2022**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained three (3) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage[1]
3. DSH Payment – Medicaid Eligible Days

The Provider is commonly owned/controlled by Quorum Health and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **September 7, 2022**, the Provider transferred Issue 2 to a Quorum Health group. 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 15, 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

[1] On September 7, 2022, this issue was transferred to PRRB Case No. 20-1339GC.

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.[2]

On **October 11, 2022**, the Provider timely filed its preliminary position paper.

On **January 4, 2023**, the Medicare Contractor 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 **January 20, 2023**, the Medicare Contractor timely filed its preliminary position paper.

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

In their Individual Appeal Request, Provider summarizes its DSH Payment/SSI Percentage (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 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 group issue statement in Case No. 20-1339GC, Quorum Health CY 2017 DSH SSI Percentage CIRP Group, to which the Provider transferred Issue 2 reads, in part:

---

[2] (Emphasis added).
[3] Issue Statement at 1 (Feb. 14, 2022).

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.[4]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $6,777.

On October 11, 2022, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Provider Specific

The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (June 30).

[4] Group Issue Statement, Case No. 20-1339GC.

> 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).[5]

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

[5] Provider's Preliminary Position Paper at 8-9 (Oct. 11, 2022).

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

Audit Adjustment Number(s): 1,16,17,19,30,S-D

Estimated Reimbursement Amount: $36,079[6]

The following is the Provider's ***complete*** position on Issue 3 set forth in their preliminary position paper:

Calculation of Medicaid Eligible Days

Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.

The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).

The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:

> [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.

Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2017 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling

[6] Appeal Request at Issue 3.

97-2 and the pertinent Federal Court decisions.[7]

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 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 with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. There has been no final determination over realignment. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[8]

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.[9]

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."[10] 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."[11] 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 their calculations based on the Provider's Fiscal Year End (June 30)" 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

[7] Provider's Preliminary Position Paper at 7-8.
[8] Medicare Contractor's Jurisdictional Challenge at 6-7 (Jan. 4, 2023).
[9] *Id*. at 4-6.
[10] *Id*. at 7.
[11] *Id*. at 9.

> 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.[12]

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 that 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 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 its appeal request.[13]

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. 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 January 4, 2023. 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 Medicare contractor, the amount in controversy is

[12] *Id*.
[13] *Id*. at 11.

$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 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 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 PRRB 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."[14] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[15] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[16]

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 Payment/SSI Percentage (Provider Specific) issue in this appeal 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 4.6[17], 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

[14] Issue Statement at 1.
[15] *Id.*
[16] *Id.*
[17] PRRB Rules v. 3.1 (Nov. 2021).

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.[18] Accordingly, Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 20-1339GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 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 Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) 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" in its Preliminary Position Paper 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.[19]

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods

[18] 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).
[19] (Emphasis added).

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.[20]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[21]

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 20-1339GC are the same issue.[22] 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.

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[20] Last accessed August 14, 2024.
[21] Emphasis added.
[22] 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).

B. DSH Payment – Medicaid Eligible Days

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 consistent with 42 C.F.R. § 405.1835(b) or (d) as applicable. *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(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*.[23]

Similarly, with regard to position papers,[24] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[25] 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.[26]

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 February 14, 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

[23] (Emphasis added).
[24] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[25] (Emphasis added).
[26] (Emphasis added).

under separate cover.[27] ***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.[28] 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. 20-1339GC 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. 22-0728 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:

7/21/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[27] Provider's Preliminary Position Paper at 8.
[28] *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

Janahan Ramanathan
Quality Reimbursement Services, Inc.
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RE: ***Board Determination on Representative's Responses to Show Cause Orders***

Dartmouth-Hitchcock Health FFY 2024 IPPS Understated Standardized Payment Amount CIRP Group, Case Number: 24-1484GC

Dartmouth-Hitchcock Health FFY 2024 ATRA IPPS Payment Reduction CIRP Group Case Number: 24-1549GC

Quorum Health FFY 2024 ATRA IPPS Payment Reduction CIRP Group Case Number: 24-1366GC

Nuvance Health FFY 2024 ATRA IPPS Payment Reduction CIRP Group Case Number: 24-1406GC

Houston Methodist FFY 2024 ATRA IPPS Payment Reduction CIRP Group Case Number: 24-1367GC

WVU Medicine FFY 2024 ATRA IPPS Payment Reduction CIRP Group Case Number: 24-1409GC

Dear Mr. Ramanathan:

The Provider Reimbursement Review Board ("Board") has reviewed responses to the Board's Show Cause Orders submitted by Quality Reimbursement Services, Inc. ("QRS") in the subject common issue related party ("CIRP") group appeals. A summary of the pertinent facts in these CIRP groups and the Board's determination are set forth below.

Pertinent Facts:

Case No.	Filed Date	Acknowl. Date	Full Formation Comments Due Date	Response to Full Formation Comments	Board Show Cause Order Date
24-1484GC	2/23/2024	2/26/2024	2/22/2025	No	3/20/2025
24-1549GC	2/23/2024	2/26/2024	2/22/2025	No	3/25/2025

24-1366GC	2/20/2024	2/22/2024	2/19/2025	3/21/2025	3/25/2025[1]
24-1406GC	2/21/2024	2/23/2024	2/20/2024	3/21/2025	3/25/2025[2]
24-1367GC	2/20/2024	2/22/2024	2/19/2025	3/21/2025	3/25/2025[3]
24-1409GC	2/21/2024	2/23/2024	2/20/2025	3/21/2025	3/25/2025[4]

On April 7, 2025, QRS filed identical responses to the Board's Show Cause Orders in Case Nos. 24-1549GC, 24-1366GC and 24-1406GC. On April 9, 2025, QRS filed the same responses to the Show Cause Orders issued in Case Nos. 24-1367GC and 24-1409GC. QRS' rationale for having previously missed the "Comments Regarding Full Formation" deadlines was due to disruptions caused by the January 2025 Eaton fire. QRS explained that the fire not only caused the evacuation of its headquarters but also "resulted in many of its employees having to flee their homes."[5] According to QRS, these conditions caused an "extensive impact" on its operations and many Board deadlines were missed, including the four noted in this correspondence.[6] QRS contends that these circumstances were outside of its control and that allowing the groups to proceed would not prejudice the Board or the Medicare Contractor. In addition, QRS argued that dismissal "would be an extreme remedy" considering the Board has already taken the remedial action of deeming the groups to be fully formed.[7]

Regarding Case No. 24-1484GC, QRS' Show Cause Order Response used the same rationale as the other groups but also included a reference to an earlier postponement determination issued by the Board which granted an extension to the Jurisdictional Challenge response deadline. QRS alleged that, in addition to the emergency conditions caused by the fire, " . . . a misunderstanding occurred surrounding which deadlines were part of the May 23, 2025 deadline extension (i.e., whether all deadlines were stayed or whether, as the Board's extension order did in fact state, only the deadline for responding to the jurisdictional challenge was extended.)"[8] According to QRS, these two

[1] Case Nos. 24-1406GC and 24-1366GC were marked fully formed prior to the issuance of the Board's Show Cause Orders which indicated that the groups **had not yet been** designated to be complete. The Representative's full formation responses were filed four days late so the Board's Show Cause Orders still required the Representative's response showing cause as to why the groups should not be dismissed for failure to **timely** reply.
[2] *Id*.
[3] The Board's Show Cause Order recognized that the Full Formation Comments were filed 30 days after the deadline.
[4] The Board's Show Cause Order recognized that the Full Formation Comments were filed 29 days after the deadline.
[5] *See, e.g.*, Case No. 24-1409GC, Response to Board at 1 (Apr. 9, 2025).
[6] Importantly, the Board notes that in at least two other groups filed during the same time frame: Skagit Regional Health FFY 2024 ATRA IPPS Payment Reduction CIRP Group, Case No. 24-1407GC, and St. Luke's Health FFY 2024 ATRA IPPS Payment Reduction CIRP Group, Case No. 24-1408GC, Case Acknowledgement and Critical Due Dates letters were issued on the same date as that in Case No. 24-1406GC, and all had the same February 20, 2025 deadline to submit Comments Regarding Full Formation. In both Case Nos. 24-1407GC & 24-1408GC, the Comments Regarding Full Formation were timely filed on the February 20, 2025 deadline by Celestina Cantos of QRS, also located at the Arcadia office location.
[7] *See, e.g.*, Case No. 24-1409GC, Response to Board at 1 (Apr. 9, 2025).

[8] *See, e.g.*, Case No. 24-1484GC, Response to Board at 1 (Apr. 4, 2025).

circumstances are what contributed to QRS missing the Comments Regarding Full Formation deadline.

Board Determination:

QRS maintains that dismissal in these group cases is not warranted due to the challenges it experienced because of the January 2025 wildfires that occurred in the vicinity of the QRS headquarters. Although QRS did not specifically ask that the Board make a finding of good cause for having missed the deadlines in these groups, QRS' use of the terms "emergency conditions" and "extraordinary circumstances outside of its control," suggest that is QRS' intent.

Regarding a good cause extension for the filing of an appeal, the regulation at 42 C.F.R. § 405.1836(b) states in pertinent part:

> The Board may find good cause to extend the time limit **only if the provider demonstrates in writing it [could] not reasonably be expected to file timely due to extraordinary circumstances beyond its control** (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180-day limit specified in § 405.1835(a)(3).[9]

The language in this regulation is reiterated in Board Rule 2.1.4: **Extension(s) to Filing an Appeal under 42 CFR 405.1836**.[10] Although not the exact situation in these cases, the Rule refers to "extraordinary circumstances" as was alleged in these groups. Board Rule 2.1.4 actually quotes the section of the regulation, stating, "the Board may find good cause to extend the time limit ***only if*** the provider demonstrates in writing it could not be expected to file timely ***due to extraordinary circumstances beyond its control*** (such as a natural or other catastrophe, fire or strike) . . . ". The Board Rule further makes clear that the request must ". . . provide any relevant information and documents 'demonstrat[ing] . . . [the provider] could not be expected to file timely due to extraordinary circumstances beyond its control."

In these groups, although QRS' responses to the Show Cause Orders refer to the wildfires as having caused it to miss the deadlines (*or file late responses*), QRS failed to provide any specific documentation in support of its argument that there were extraordinary circumstances which prevented it from timely filing.[11] The Board notes that according to it's website, QRS' Arcadia, California location is only one of the company's seven offices, with six other offices located in states that would not be affected by the California wildfires.[12] QRS' responses are devoid of any information regarding the specific number or percentage of QRS employees that were impacted or how the company's work was distributed among the company's offices. Indeed, as noted earlier, a QRS employee in the Arcadia office did file timely responses in two other cases on the February 20, 2025 deadline. Therefore, although QRS' filed timely responses to the Board's Show Cause Orders in the subject group cases, the Board finds the explanation for late filing of the Comments Regarding

[9] (Bold emphasis added.)
[10] Board Rules v.3.2 (Dec. 15, 2023)
[11] 42 C.F.R. § 405.1836(b).
[12] *See* https://qualityreimbursement.com/contact (last visited July 22, 2025).

Full Formation is deficient. QRS has failed to clearly substantiate its purported good cause justification through support evidence such as evacuation orders, news clippings, or even the specific reference to the person responsible for the filings.

In Case No. 24-1484GC, QRS included an additional argument, that it was confused as to the Board's earlier notice postponing deadlines. The Board's November 18, 2024 determination (*to which QRS referred*) granted an extension to the Jurisdictional Challenge response deadline in 230 cases and ordered QRS to file no later than May 23, 2025. However, in the same response, QRS acknowledged, ". . . the Board's extension order **DID IN FACT STATE**, only the deadline for responding to the jurisdictional challenge was extended."[13] Accordingly, the Board finds there was no misunderstanding about the deadline for the Comments Regarding Full Formation in Case No. 24-1484GC.

After a review of the facts in these cases, the Board finds dismissal of the groups to be appropriate based on QRS' failure to respond to the Comments Regarding Full Formation in Case Nos. 24-1484GC and 24-1549GC, and for having filed late responses in Case Nos. 24-1366GC, 24-1406GC, 24-1367GC and 24-1409GC. QRS has failed to meet its responsibilities per Board Rule 5.2, which require the representative to meet Board deadlines and respond timely to correspondence or requests from the Board. The Rule specifically notes that, "[f]ailure 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." In addition, QRS failed to comply with Board 19.2, which requires that "at the one-year mark . . . , they must notify the Board if the group is complete and, if not, which providers have not yet received a final determination for the specified fiscal year and intend to join the group." In addition, QRS failed to show good cause for the forgoing failures.

Finally, the Board notes that QRS pursued a "good cause" determination in *Merit Health River Region v. Becerra*, No. 1:2023cv00906 – D.D.C. 2025. On March 11, 2025, the Court found that the Board's decision to dismiss the appeal for the Provider's failure to file a timely preliminary position paper was reasonably explained and was supported by substantial evidence. The court held that, not only was the Board not given full information, even if it had, the Board rationally concluded that QRS' failure to meet the deadline was an "administrative oversight" and did not meet the criteria to find good cause.

In conclusion, given its discretionary authority in 42 C.F.R. § 405.1868 and Board Rule 41.2, which states the Board may dismiss a case upon failure of the group to comply with Board procedures or filing deadlines, the Board dismisses Case Nos. 24-1484GC, 24-1549GC, 24-1366GC, 24-1406GC, 24-1367GC and 24-1409GC and removes them from the 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:

7/22/2025

X Kevin D. Smith, CPA

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

[13] (Emphasis added.)

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Danelle Decker, National Government Services, Inc. (J-K)
Michael Redmond, Novitas Solutions Inc. c/o GuideWell Source (J-H)
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision*** **– DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**
Merit Health Central (Provider No. 25-0072)
FYE 09/30/2018
Case No. 22-1074

Dear Mr. Ravindran and Mr. Lamprecht:

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

Background

A. *Procedural History for Case No. 22-1074*

On **January 6, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2018.

On **June 1, 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 – 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]

The Provider is commonly owned/controlled by Community Health Systems, Inc. (hereinafter "CHS") and, thereby, 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 **December 13, 2022**, the Provider transferred Issues 2, 4 and 5 to CHS CIRP groups. As a result, 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).

[1] On December 13, 2022, this issue was transferred to Case No. 21-1206GC.
[2] On December 13, 2022, this issue was transferred to Case No. 20-2149GC.
[3] On December 13, 2022, this issue was transferred to Case No. 21-0066GC.

On **June 2, 2022**[4], 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 **June 15, 2023**, the Provider timely filed its preliminary position paper.

On **August 28, 2023**, the Medicare Contractor 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 **September 1, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **September 21, 2023**, the Medicare Contractor filed its preliminary position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 21-1206GC

In their Individual Appeal Request, the Provider summarizes its DSH Payment/SSI Percentage (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 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).[6]

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[4] On Feb. 27, 2023, an updated Critical Due Dates Notice was sent.
[5] (Emphasis added.)
[6] Issue Statement at 1 (Jun. 1, 2022).

The Group issue Statement in Case No. 21-1206GC, CHS CY 2018 DSH SSI Percentage CIRP Group, to which the Provider transferred Issue No. 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]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $35,189.

On June 15, 2023, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Issue #1: Provider Specific**
>
> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.

[7] Group Issue Statement, Case No. 21-1206GC.

> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[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 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): 4, 21, 22, S-D.

[8] Provider's Preliminary Position Paper at 7-8 (June 15, 2023).

Estimated Reimbursement Amount: $44,171[9]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the Jewish Hospital case[10] 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] 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:

> [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 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).[12]

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.[13]

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

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[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 8.
[12] *Id.* at 8-9.
[13] Jurisdictional Challenge at 6-7 (Aug. 28, 2023).

> 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). The Provider has not exhausted all available remedies for this issue. The MAC requests that the PRRB dismiss this issue consistent with recent jurisdictional decisions.[14]

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.[15]

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."[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:
>
> > . . . 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
>
> Yet, the Provider 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.[18]

Issue 3 – DSH Payment – Medicaid Eligible Days

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

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[14] *Id*. at 7.
[15] *Id*. at 4-6.
[16] *Id*. at 8.
[17] *Id*. at 9.
[18] *Id*. at 9-10.

> 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 Provider's preliminary position paper, the Provider makes the broad allegation, ". . . 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. . ." 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]

The MAC contends that the Provider is attempting to untimely and improperly add the issue of Section 1115 waiver days as a sub-issue via its preliminary position paper, filed on June 15, 2023.[20] The MAC asserts that prior to the preliminary position paper, the Provider had not formally added the dispute to the appeal, nor had it otherwise raised the issue of section 1115 waiver days.[21] The MAC contends that the Provider's attempt to add the issue within its preliminary position paper is improper and untimely, citing 42 C.F.R. § 405.1835(e), which governs when specific Medicare payment issues may be added to the original hearing request, including a timeframe of no later than 60 days after the expiration of the applicable 180-day deadline to file an appeal.[22]

The MAC contends that the section 1115 waiver days issue is one component of the DSH issue. The MAC references Board Rule 8 (version 3.1), which lists Section 1115 waiver days (program/waiver specific) as a common example of issues with multiple components for which each contested component must be appealed as a separate issue and described as narrowly as possible.[23] The MAC contends that the Board Rules support the argument that section 1115 waiver days issue is a component of DSH different from the generic Medicaid eligible days issue and must be identified and appealed separately.[24]

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. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

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[19] *Id*. at 14.
[20] *Id*. at 13.
[21] *Id*.
[22] *Id*. at 12-13.
[23] *Id*. at 13-14.
[24] *Id*.

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 & 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 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 PRRB Case No. 21-1206GC.

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."[25] 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)."[26] 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."[27]

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 this appeal 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

[25] Issue Statement at 1.
[26] *Id.*
[27] *Id.*

PRRB Rule 4.6[28], 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.[29] Accordingly, Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 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 did not 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. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) 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" in its Preliminary Position Paper 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.[30]

[28] PRRB Rules v. 3.1 (Nov. 2021).
[29] 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).
[30] (Emphasis added).

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[31]

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."[32]

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 21-1206GC are the same issue.[33] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

Additionally, in its Preliminary Position Paper, the Provider states, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra [sic] (Appellants' reply brief included as Exhibit P-3)." The Board finds that this incorporation by reference does not comply with the regulatory and Board rule requirements to *fully* develop the Provider's position in the Preliminary Position Paper. Particularly, 42 C.F.R. § 405.1853 provides in pertinent part:

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

[31] Last accessed August 14, 2024.
[32] Emphasis added.
[33] 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).

> 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[34]

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

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), 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:

---

[34] (Emphasis added).

> 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(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*.[35]

Similarly, with regard to position papers,[36] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[37] 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.[38]

---

[35] (Emphasis added).
[36] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[37] (Emphasis added).
[38] (Emphasis added).

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 June 1, 2022 (nearly 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.[39] ***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.[40] 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. The Board takes administrative notice that it has made similar dismissal in other cases involving CHS providers.[41]

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 June of 2022 and the regulations required the following:

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[39] Provider's Preliminary Position Paper at 9.

[40] *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.

[41] An example of a CHS individual provider case in which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

> (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…[42]

Board Rule 7.2.1 (2021) elaborated on this regulatory requirement, instructing providers:

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
> - the relevant adjustment(s), including the adjustment number(s),
> - the controlling authority (*e.g.*, specific regulation, Federal Register issuance, manual provision, or Ruling),
> - why the adjustment(s) is incorrect,
> - how the payment should be determined differently,
> - the reimbursement effect, and
> - the basis for jurisdiction before the Board.

Board Rule 8 (2021) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include, but are not limited to:
>
> - ***Section 1115 waiver days (program/waiver specific) . . .***[43]

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

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.[44]

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.[45] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program and not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2022) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

[44] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[45] 65 FR 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 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.

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

The Board's finding that neither the appeal request nor final position paper met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[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*.

[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 appeal did not include the *alleged* § 1115 waiver days sub-issue consistent with 42 C.F.R. §§ 405.1835(b)(2)-(3), 412.106(b)(4)(iii), and 405.1871(a)(3) and Board Rules 7.1, 8, 25, and 27.2.[50] In the alternative, the Board finds that, even if it had been included as part of the appeal, the Board would find that the issue was not properly developed in the position paper process.

****

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. 21-1206GC 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. 22-1074 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:

7/23/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson Leong, FSS

[50] If § 1115 waiver days were found to be part of the appeal request and had been properly briefed, the Board would still need to address an additional jurisdictional issue – review whether it had jurisdiction over the 1115 waiver days. For example, the Board has found that when a class of days (*e.g.*, 1115 waiver days) is excluded due to choice, error, and/or advertence from the as-filed cost report, then that class of days is an unclaimed cost for which the Board would lack jurisdiction under 42 U.S.C. § 1395oo(a). *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 061852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days from the appeal because no days were claimed with the as-filed cost report due to choice, error and/or inadvertence and, as such, the practical impediment standard or futility concept in the *Norwalk* and *Danbury* Board decisions is not applicable) (available at: https://www.cms.gov/regulations-and-guidance/review-boards/prrbreview/list-of-prrb-jurisdiction-decisions-items/2017-11 (last accessed Mar. 26, 2025)).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Cape Fear Valley Hoke Hospital (Prov. No. 34-0188), FYE 09/30/2017, Case No. 22-0307

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the pending appeal in Case No. 22-0307. Set forth below is the decision of the Board to dismissing the two (2) issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") SSI Percentage (Provider Specific) and Medicaid Eligible Days issues.

Background:

A. ***Procedural History for Case No. 22-0307***

On **July 6, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2017. The Provider is commonly owned by Cape Fear Valley Health.

On **December 22, 2021**, Quality Reimbursement Services, Inc. ("QRS") filed the Provider's individual appeal request. The Individual Appeal Request included two (2) issues:

1. DSH SSI Percentage (Provider Specific)
2. DSH Medicaid Eligible Days

As the Provider is commonly owned/controlled by Cape Fear Valley Health, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on the same date the individual appeal was filed, QRS directly added Cape Fear Valley Hoke Hospital to the Cape Fear Valley Health CY 2017 DSH SSI Percentage CIRP Group under Case No. 22-0308GC, which is a group appeal purportedly related to DSH / SSI Systemic Errors.[1]

On **December 23, 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,

[1] *See* Group Issue Statement, Case No. 22-0308GC.

> 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.[2]

On **August 17, 2022**, the Provider timely filed its preliminary position paper.

On **November 23, 2022**, the Medicare Administrative Contractor ("MAC") timely filed its preliminary position paper.[3] On the same date, it filed a substantive claim challenge.

On **November 28, 2022**, the MAC filed a jurisdictional challenge over the two 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. 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. 22-0308GC

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 CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[4]

The Group Issue Statement in Case No. 22-0308GC to which Provider was directly added, reads in part:

---

[2] (Emphasis added).
[3] In its Preliminary Position Paper, 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 the listing on Sept. 1, 2022, but there is no evidence of a response.
[4] Issue Statement at 1 (June 25, 2021).

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.[5]

Here, it is important to note that the amount in controversy listed for both Issue 1 in the Provider's individual appeal request and the Direct Add request to the group for Cape Fear Valley Hoke Hospital is $4,441.

On August 17, 2022, the Board received the Provider's Preliminary Position Paper ("PPP"_ in Case No. 22-0307. 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 the Provider's DSH calculation. This

[5] Group Issue Statement, Case No. 22-0308GC.

> is based on certain data from the State of North Carolina and the Provider does not support the SSI percentage issued by CMS.
>
> 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.
>
> The Provider has worked with the State of North Carolina 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.[6]

C. Description of Issue 2 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 2 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.

[6] Provider's Preliminary Position Paper at 8-9 (Aug. 17, 2022).

> 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, 5, 16, s-d
>
> Estimated Reimbursement Amount: $17,624[7]

Regarding the Medicaid eligible days issue, in its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[8] 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.[9]

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 two components: 1) SSI data accuracy and 2) SSI realignment.[10] The MAC contends that the first sub-issue should be dismissed because it is duplicative of the issue directly added to Case No. 22-0308GC. Additionally, the MAC avers that the portion related to SSI realignment should be dismissed as it was not briefed in Provider's PPP and thus, abandoned.[11] Alternatively, the MAC argues that the issue is moot as Provider's fiscal year end is identical to the federal fiscal year end (September 30) and the Medicare computation would be the same. Finally, the MAC contends that Provider failed to comply with the requirements of 42 CFR 405.1853(b)(2) and Board Rule 25, which require fully developed PPPs.[12]

Issue 2 – DSH Payment – Medicaid Eligible Days

The MAC contends that the Provider failed to properly develop its arguments within its PPP in accordance with Board Rule 25 and that Provider has not submitted a Medicaid eligible days listing or explained why such is unavailable.[13]

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[7] Appeal Request at Issue 2.
[8] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[9] Provider's Preliminary Position Paper at 7.
[10] Normally, Providers argue there are three components related to the SSI Provider Specific issue. However, in this case, the Provider only briefed two aspects and the MAC's jurisdiction challenge only addresses those two components.
[11] Medicare Contractor's Jurisdictional Challenge at 6 (Nov. 28, 2022).
[12] *Id*. at 2.
[13] *Id.*

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. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." 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 Nos. 1 and 2.

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 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 directly added to Case No. 22-0308GC.

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."[14] 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)."[15] 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."[16]

[14] Issue Statement at 1.
[15] *Id.*
[16] *Id.*

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 22-0308GC 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.[17] 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."[18] 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 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, Board Rule 25.2.2 specifies in pertinent part:

> **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.[19]

In its PPP (filed on August 17, 2022), the Provider only cites to the 2000 Federal Register as the source for the MEDPAR data it claims it has yet to receive.[20] 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:

---

[17] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[18] Provider's PPP at 8.
[19] (Emphasis added).
[20] *See* Provider's PPP at 8-9.

> 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.[21]

This CMS webpage describes access to DSH data ***from 1998 to 2023*** and instructs providers to submit a request via email to access their DSH data.[22] 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 and should not be subsumed into the "systemic errors" issue appealed in Case No. 22-0308GC.

[21] Last accessed June 17, 2025.
[22] Emphasis added.

Accordingly, *based on the record before it*, the Board finds that DSH SSI Percentage (Provider Specific) issue in the instant appeal and the group issue from Group Case 22-0308GC are the same issue.[23] 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 Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

The second aspect of the DSH - 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. In fact, the Provider's cost reporting period is September 30, 2017, therefore it is *already* on the Federal FYE. 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 states Issue 2 as:

> **Statement of the 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

[23] 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 Cape Fear Valley Health CIRP group per 42 C.F.R. § 405.1837(b)(1).

> the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[24]

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*

[24] Individual Appeal Request, Issue 2.

> *timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[25]

Similarly, with regard to position papers,[26] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[27] 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.[28]

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 December 22, 2021 (more than 3.5 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

[25] (Emphasis added).
[26] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[27] (Emphasis added).
[28] (Emphasis added).

separate cover.[29] ***To-date, there is no evidence that the listing has been provided—even after the MAC requested the listing on a separate occasion***.[30] 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.[31] 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 hereby dismisses the two (2) issues in this case –DSH – SSI Percentage (Provider Specific) (Issue 1) and Medicaid Eligible Days (Issue 2). As no issues remain, the Board hereby closes Case No. 22-0307 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:

7/25/2025

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

[29] Provider's Preliminary Position Paper at 8.
[30] MAC Preliminary Position Paper at 17.
[31] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Nathan Summar
Community Health Systems, Inc.
4000 Meridian Boulevard
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Byron Lamprecht
WPS Government Health Administrators
1000 N 90th Street, Suite 302
Omaha, NE 68114

RE: ***Board Decision* – DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**
East Georgia Regional Medical Center (Provider No. 11-0075)
FYE 09/30/2017
Case No. 21-1786

Dear Mr. Summar 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. 21-1786*

On **April 7, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2017.

On **September 24, 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) – (Medicaid Fraction)[3]
6. DSH Payment – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days) – (SSI Fraction)[4]

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.

[1] On April 13, 2022, this issue was transferred to PRRB Case No. 20-0997GC.
[2] On April 13, 2022, this issue was transferred to PRRB Case No. 19-2620GC.
[3] On April 13, 2022, this issue was transferred to PRRB Case No. 20-1336GC.
[4] On May 4, 2022, this issue was transferred to PRRB Case No. 20-1334GC.

§ 405.1837(b)(1). For that reason, on **April 13 and May 4, 2022**, the Provider transferred Issues 2, 4, 5 and 6 to Community Health 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 **September 27, 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 5, 2022**, the Provider timely filed its preliminary position paper.

On **June 27, 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 **September 15, 2022**, the MAC timely filed its preliminary position paper.

On **January 12, 2023**, the MAC requested from the Provider all documentation necessary to resolve Issue 3 (DSH Payment – Medicaid Eligible Days).

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

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.
>
> . . .

[5] (Emphasis added).

> 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]

Here, it is important to note that the amount in controversy listed for both Issues 1 (Provider Specific) and Issue 2 (Systemic Errors) in the Provider's individual appeal request is $19,529.

The DSH/SSI Systemic Errors Group Issue Statement in Case No. 20-0997GC, CHS CY 2017 DSH SSI Percentage CIRP Group, to which the Provider transferred Issue 2 (Systemic Errors) reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and

[6] Issue Statement at 1 (Sept. 24, 2021).

6. Failure to adhere to required notice and comment rulemaking procedures.[7]

On May 5, 2022, the Provider filed its Preliminary Position Paper ("PPP"). 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 Georgia and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Georgia 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**

[7] Group Issue Statement, Case No. 20-0997GC.
[8] Provider's Preliminary Position Paper at 8-9 (May 5, 2022).

> 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): 6,7,S-D
>
> Estimated Reimbursement Amount: $11,000[9]

Regarding the Medicaid eligible days issue, in its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[10] 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 because it failed to brief the issue in its PPP. [12] Second, the MAC questions the Provider's preservation realignment rights when the Provider's cost reporting year end is identical to the federal fiscal year end.[13] Third, notwithstanding the foregoing, the MAC argues the realignment sub-issue is premature because the hospital has yet to formally request realignment of its SSI percentage, and such an election is not a final intermediary determination ripe for appeal. [14]

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.[15] Finally, the

[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 6-7 (Jun. 27, 2022).
[13] Id.
[14] *Id*. at 7.
[15] *Id*. at 4-6.

MAC argues "the Provider did not file a **complete** preliminary and final [sic][16] position papers in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3."[17] 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."[18] Specifically the MAC avers:

> Within its Provider's preliminary paper, the Provider makes the broad allegation that "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" 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.[19]

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 Provider's 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.[20]

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[16] Note: Final position papers have not been filed, nor have their due dates been set at this time.
[17] *Id*. at 8.
[18] *Id*. at 9.
[19] *Id*. at 9-10.
[20] *Id*. at 11-12.

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 June 27, 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 Nos. 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 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. 20-0997GC.

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."[21] 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)."[22] 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."[23]

[21] Issue Statement at 1.
[22] *Id.*
[23] *Id.*

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).

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to a single provider.[24] 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."[25] 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, 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.[26]

In its PPP (filed on May 5, 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:

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[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] See Provider's PPP at 9.
[26] (Emphasis added).

> 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.[27]

This CMS webpage describes access to DSH data ***from 1998 to 2023*** and instructs providers to submit a request via email to access their DSH data.[28] 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. 20-0997GC.

[27] Last accessed July 25, 2025.
[28] 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 20-0997GC are the same issue.[29] 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. In fact, the Provider's cost reporting period is September 30, 2017, therefore it is *already* on the Federal FYE. 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.

[29] 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).

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*.[30]

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

[30] (Emphasis added).
[31] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[32] (Emphasis added).

> 4. Explain when the documents will be available.
>
> Once the documents become available, ***promptly*** forward them to the Board and the opposing party.[33]

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 September 24, 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 separate cover.[34] ***To-date, no listing has been provided—even after the MAC requested the listing on at least two (2) occasions***.[35] 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.[36] 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. The Board takes administrative notice that it has made similar dismissal in other cases involving CHS providers.[37]

****

[33] (Emphasis added).
[34] Provider's Preliminary Position Paper at 8.
[35] *See* MAC's *Requests for Documentation* letter dated January 12, 2023.
[36] *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.
[37] An example of a CHS individual provider case in which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

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. 20-0997GC 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. 21-1786 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:

7/25/2025

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

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

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: ***Request for Reconsideration of Board's Dismissal of Appeal***
Tomball Regional Medical Center (Provider Number 45-0670)
FYE: 06/30/2015
Case Number: 19-1377

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the Request for Reconsideration of the Board's Dismissal of Appeal submitted by Tomball Regional Medical Center ("Provider") on May 27, 2025. The decision of the Board is set forth below.

Pertinent Facts:

On **March 27, 2025**, the Board dismissed the remaining two issues in the appeal – Issue No. 1: DSH Payment/SSI Percentage (Provider Specific) and Issue No. 5: DSH Payment – Medicaid Eligible Days and closed the instant appeal. In the dismissal, the Board found the Provider noncompliant with 42 C.F.R. §§ 405.1835(a)-(b), 405.1853(b)(2)-(3), 405.1871(a)(3), and 412.106(b)(4)(iii) and Board Rules 7, 8, 25, and 27.[1]

On **May 27, 2025**, the Provider requested reinstatement of the Section 1115 Waiver Days component of the DSH Payment – Medicaid Eligible Days issue.[2]

Provider's Reinstatement Request

The Provider argues that "there is no section 1115 waiver days issue, and as such it was not added timely, or untimely to the Provider's appeal."[3]

[1] The Board also noted a failure to comply with the instructions included in the Board's Notices setting the Board's deadlines.
[2] The Provider's request was titled "Request for Reconsideration and Reinstatement of Dismissal of Medicaid Eligible Days & Section 1115 Waiver Days Issue." In fact, the request only addresses Section 1115 Waiver Days. As stated in the Pertinent Facts section, the traditional Medicaid eligible days issue was dismissed by the Board on March 27, 2025.
[3] Provider's Request for Reconsideration and Reinstatement of Dismissal of Medicaid Eligible Days & Section 1115 Waiver Days Issue at 1 (May 27, 2025).

The Provider's argument is that 1115 waiver days are a component or sub issue of the Medicaid Eligible Days issue, and regulations and Board rules do not place a time limit on adding those.[4]

They go on to argue:

> 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 Share Payment Percentage. The text of sections 405.1811 and 405.1835, and the discussion of these sections in the proposed and final rules are clear that in order to add an "issue" or claim or self-disallow an issue, it is necessary to identify the specific adjustment that would result in additional reimbursement. Likewise, the August 29, 2018 PRRB instructions – which were the instructions in effect at the time the Provider filed its appeal – provides, at Rule 7.2.1, that for purposes of identifying the "issue" under appeal the provider need only
>
> > Give an issue title and a concise issue statement describing:
> >
> > - *the adjustment*, *including the adjustment number*,
> > - *the controlling authority,*
> > - *why the adjustment* is incorrect,
> > - how the payment should be determined differently,
> > - the reimbursement effect, and
> > - the basis for jurisdiction before the PRRB.
>
> There is no dispute that the same cost report adjustment that affects other types of Medicaid eligible days also affects section 1115 waiver days.
>
> Rule 8 is internally inconsistent with Rule 7. Whereas Rule 8 refers to "components" of an issue, and gives section 1115 waiver days as an example, Rule 7.2.1 provides that, for purposes of identifying the "issue" under appeal, the provider needs to give "an issue title and a concise issue statement" that describes the cost report adjustment, including the cost report adjustment number, the controlling authority, why the cost report adjustment is incorrect, how the payment should be determined differently, the reimbursement effect, and the basis for jurisdiction before the

[4] *Id*. at 2.

> PRRB. Thus, Rule 8 is both inconsistent with the regulations and Rule 7. Further, whereas Rule 7 directs providers to Rule 8, Rule 8 directs the providers to Rule 7. This direction is flatly inconsistent with Rule 7, as explained above, or the at the very least is confusing and misleading.
>
> Moreover, Rule 8 is predicated on the supposed need "[t]o comply with the regulatory requirement to specifically identify the items in dispute." Thus, Rule 8 proceeds from the misunderstanding that the regulations require that sub-issues or "components" of an issue must be identified, when in fact, and as explained above, this is not true. For this reason, Rule 8's requirement to identify "components" of an issue is invalid.[5]

Board's Analysis and Decision:

Consistent with *Baylor All Saints Medical Center v. Becerra*,[6] issued March 21, 2025, as well as *Atrium Health Carolinas Med. Ctr. v. Kennedy*, No. 1:23-cv-01742-CRC (D.D.C. July 21, 2025), the Board ***denies*** the reinstatement request. The Board's prior decision to dismiss 1115 waiver days was proper. The Provider did not brief the issue ***or*** include an eligible days listing in the appeal request or preliminary paper.

As the Board indicated in its initial decision, although the Provider did appeal Medicaid eligible days, that issue ***is separate and distinct*** from the § 1115 waiver days as recognized by numerous Board, Administrator and Court decisions[7] as well as the Board's Rules that were in effect when the appeal for this case was filed. In contrast to the Provider's argument that Section 1115 waiver days and Medicaid Eligible Days were not considered separate issues by the Board, the plain wording of Rule 8 proves otherwise:

---

[5] *Id.* at 2-3.
[6] *Baylor All Saints Medical Center v. Becerra*, 2025 WL 888500 (N.D. Texas, 2025).
[7] *See, e.g.*, *QRS 1993-2007 DSH/Iowa Indigent Patient /Charity Care (GA) Group v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Jan. 15, 2013), *affirming* PRRB Dec. No. 2013-D02 (Nov. 21, 2012)*; St. Dominic-Jackson Mem'l Hosp. v. Sebelius*, No. 3:12-cv-832, 2014 WL 8515280 (S.D. Miss. 2014); *Singing River Health Sys. v. Novitas Solutions, Inc.*, PRRB Dec. 2016-D19 (Sept. 20, 2016), *rev'd* CMS Adm'r Dec. (Nov. 18, 2016); *CCT&B 2005-2006 Hurricane Katrina § 1115 Waiver UCP Days Grp. v. Novitas Solutions, Inc*., PRRB Dec. 2016-D18 (Sep. 16, 2016), *rev'd* CMS Adm'r Dec. (Nov. 18, 2016), *aff'd sub nom. Forrest Gen. Hosp. v. Hargan*, No. 2:17-CV-8, 2018 WL 11434575 (S.D. Miss. Feb. 22, 2018), *rev'd & remanded Forrest Gen. Hosp. v. Azar*, 926 F.3d 221 (5th Cir. 2019); *Southwest Consulting UMass Mem'l Health Care & Steward Health 2009 DSH CCHIP Section 1115 Waiver Days Grps. v. Nat'l Gov't Servs., Inc*., PRRB Dec. 2017-D04 (Jan. 27, 2017), *rev'd* CMS Adm'r Dec. (Mar. 21, 2017), *vacated & remanded sub nom*. *HealthAlliance Hosps., Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. Oct. 26, 2018); *Florida Section 1115 LIP Rehab DSH Waiver Days Grps. v. First Coast Serv. Options*, PRRB Decs. 2018-D21, 2018-D22 (Feb. 8, 2018), *vacated by* Adm'r Dec. (Mar. 30, 2018), *rev'd by Bethesda Health Inc. v. Azar*, 389 F. Supp. 3d 32 (DDC 2019), *aff'd by* 980 F.3d 121 (D.C. Cir. 2020).

> **Rule 8 Framing Issues for Adjustments 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.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: dual eligible Medicare Part A/Medicaid, dual eligible Medicare Part C/Medicaid, SSI data matching, state/program specific general assistance days, ***Section 1115 waiver days (program/waiver specific)***, and observation bed days.[8]

Regardless, of whether the Provider *properly* included the § 1115 waiver days issue in its appeal request (which it did not), QRS also failed to properly develop the merits of the § 1115 waiver day issue in the Provider's preliminary position paper filing. As stated in the original dismissal, this is an independent basis for dismissal of the § 1115 waiver day issue. Specifically, the material facts and legal arguments needed to establish the merits of the Provider's claims regarding the § 1115 waiver days issue along with the relevant supporting documentation were not properly briefed and included in the preliminary position paper filing.

Not only did the Provider fail to provide a necessary listing with the Preliminary Position Paper but it has provided no explanation for why there was no listing. The exhibits to the Preliminary Position Paper were not filed in a timely manner, and did not meet the requirements of 42 C.F.R. § 405.1853(b)(2)-(3) or Board Rules 7, 8, 25 and 27.

Further, the Board finds the Provider's request for reinstatement fails to establish good cause. Board Rule 47 (v. 3.2 (Dec. 15, 2023)) reads, in relevant part:

> **Rule 47 Reinstatement**
>
> **47.1 Motion for Reinstatement**
>
> * * *

[8] Board Rules v. 2.0 (Aug. 29, 2018) (Emphasis added).

> [T]he Board will not reinstate an issue(s)/case if the provider was at fault.
>
> * * *
>
> **47.3 Dismissals for Failure to Comply with Board Procedures**
>
> Upon written motion demonstrating good cause, the Board may reinstate a cause dismissed for failure to comply with Board procedures. Generally, administrative oversight, settlement negotiations or a change in representative will not be considered good cause to reinstate. . .

As such, the Board declines to exercise its discretion and denies the request for reconsideration. Accordingly, Case No. 19-1377 remains closed.

Board Members Participating:

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

FOR THE BOARD:

7/28/2025

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
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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Byron Lamprecht
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RE: ***Board Decision* – DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**
Lake Norman Regional Medical Center (Provider No. 34-0129)
FYE 09/30/2016
Case No. 19-1715

Dear Mr. Summar 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. 19-1715*

On **September 10, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2016.

On **March 6, 2019**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – SSI Fraction/Medicare Managed Care Part C Days[2]
4. DSH Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[3]
5. DSH Payment – Medicaid Eligible Days
6. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days[4]
7. DSH Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[5]
8. Uncompensated Care ("UCC") Distribution Pool[6]
9. 2 Midnight Census IPPS Payment Reduction[7]

[1] On October 22, 2019, this issue was transferred to PRRB Case No. 19-0173GC.
[2] On October 22, 2019, this issue was transferred to PRRB Case No. 19-0175GC.
[3] On October 22, 2019, this issue was transferred to PRRB Case No. 19-0198GC.
[4] On October 22, 2019, this issue was transferred to PRRB Case No. 19-0159GC.
[5] On October 22, 2019, this issue was transferred to PRRB Case No. 19-0197GC.
[6] On October 22, 2019, this issue was transferred to PRRB Case No. 19-0177GC.
[7] On October 22, 2019, this issue was transferred to PRRB Case No. 19-0185GC.

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). For that reason, on **October 22, 2019**, the Provider transferred Issues 2, 3, 4, 6, 7, 8 and 9 to Community Health groups. As a result, there are two (2) remaining issues in this appeal: Issue 1 (DSH Payment/SSI Percentage (Provider Specific)) and Issue 5 (DSH Payment – Medicaid Eligible Days).

On **April 17, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

On **October 29, 2019**, the Provider timely filed its preliminary position paper.

On **February 21, 2020**, the Medicare Administrative Contractor ("MAC") timely filed its preliminary position paper.

On **April 17, 2020**, the MAC filed a jurisdictional challenge, requesting the dismissal of Issue 1. The Provider filed a Jurisdictional Response on **April 28, 2020**.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-0173GC

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

[8] (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.[9]

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 $30,000.

The DSH/SSI Systemic Errors Group Issue Statement in Case No. 19-0173GC, CHS CY 2016 HMA DSH SSI Percentage (Systemic Errors) CIRP Group, to which the Provider transferred Issue 2 (Systemic Errors), reads, in part:

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

[9] Issue Statement at 1 (Mar. 6, 2019).
[10] Group Issue Statement, Case No. 19-0173GC.

On October 29, 2019, the Provider filed its Preliminary Position Paper ("PPP"). 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 North Carolina and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of North Carolina 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.[11]

C. Description of Issue 5 in the Appeal Request

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

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory

[11] Provider's Preliminary Position Paper at 8-9 (Oct. 29, 2019).

> 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): 5,6,11,S-D
>
> Estimated Reimbursement Amount: $105,000[12]

Regarding the Medicaid eligible days issue, in its Preliminary Position Paper, the Provider argues that pursuant to the *Jewish Hospital* case[13] 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.[14]

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). 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 (Systemic Errors), which was transferred to CIRP Group Case No. 19-0173GC.[15] The MAC further avers that 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.[16] Finally, the MAC points out Provider's fiscal year end and the federal fiscal year end, both September 30, are identical and the result of the Medicare computation would be the same.[17]

Provider's Jurisdictional Response

[12] Appeal Request at Issue 5.
[13] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[14] Provider's Preliminary Position Paper at 7-8.
[15] Jurisdictional Challenge at 2-4 (Apr. 17, 2020).
[16] *Id.* at 4-5
[17] *Id.* at 5.

The Provider argues that the issues are not duplicative because "issues #1 and 2 represent different components of the SSI issue, which was specifically adjusted during the audit."[18] In arguing that the Provider Specific and Systemic Errors issues are distinguished, the Provider lists several of the systemic errors identified in *Baystate* that resulted from CMS' improper policies and data matching.[19] The Provider also states that such systemic errors implicate CMS Ruling 1498-R.[20]

Relative to its SSI Provider Specific issue, the Provider argues that the issue "is not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the 'systemic errors' category."[21] The Provider avers that in *Baystate*, the Board considered whether an understatement of the SSI fraction resulted due to the number of days included in the fraction, independent of the identified systemic errors.[22] The Provider further contends that it has identified patients believed to be entitled to both Medicare Part A and SSI benefits but were excluded from their SSI percentage due to errors that are or may be specific to the Provider and not systemic as was the case in *Baystate*.[23]

Finally, the Provider contends that because the MAC adjusted the Provider's SSI percentage on its cost report, which negatively impacted its FY 2016 DSH payments, the excluded patients that the Provider has identified entitles it to a correction of its SSI percentage.[24]

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 & 5.

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 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

[18] Jurisdictional Response at 1 (Apr. 28, 2020).
[19] *Id.* at 1-2.
[20] *Id.* at 2.
[21] *Id*.
[22] *Id*.
[23] *Id.*
[24] *Id*.

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. 19-0173GC.

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."[25] 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)."[26] 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."[27]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 19-0173GC also alleges that the MAC and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to several 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.[28] Rather, it applies to all SSI calculations. To this end, the Board reviewed the Provider's *Preliminary Position Paper* to see if it further clarified Issue 1. However, the Provider's PPP does not explain how this argument is ***specific to this provider.*** Instead, the PPP refers to systemic *Baystate* data matching issues and how state records can be used to determine SSI entitlement. Not until the Provider filed its *Jurisdictional Response* does it purportedly distinguish what it categorizes as "various errors of omission and commission that do not fit into the 'systemic errors' category" from the data matching errors addressed in *Baystate*. Moreover, while Provider's *Jurisdictional Response* (not its PPP) lists certain errors that result in the MEDPAR data excluding all individuals eligible for SSI, the Provider still does not provide any examples of the errors it claims are specific to it and that are not included in systemic errors category. The Provider simply argues there are various errors that are not included in the systemic errors category and that these *unidentified* errors of omission and commission apply to it specifically.

Additionally, in its PPP, the Provider cites *Loma Linda Community Hospital* and alleges that "SSI entitlement of individuals can be ascertained from State records"[29] but that MEDPAR data is unavailable to complete a reconciliation of its records.[30] But the Provider does not to explain its

---

[25] Issue Statement at 1.
[26] *Id.*
[27] *Id.*
[28] 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, 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).
[29] Provider's Preliminary Position Paper at 8-9 (Oct. 29, 2019).
[30] *Id.* at 8.

alleged similarities to *Loma Linda Community Hospital* or how it can ascertain SSI entitlement from the state records. By comparison, in its *Jurisdictional Response*, the Provider states that it "has analyzed Medicare Part A records and has been able to identify patients believed to be entitled to both Medicare Part A and SSI."[31]

In accordance with 42 C.F.R. § 405.1853(b), the commentary to Rule 23.3 (Aug. 29, 2018) explains that the Board requires preliminary position papers "to 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." Additionally, Board Rule 25.2.2 specifies:

> **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.[32]

In its PPP (filed on October 29, 2019), the Provider only cites to the 2000 Federal Register as the source for the MEDPAR data it claims it has yet to receive.[33] But additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred long before the filing of Provider's PPP. 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.

[31] Jurisdictional Response at 2 (April 28, 2020).
[32] PRRB Rules v 2.0 (August 29, 2018) (Emphasis added).
[33] PPP at 8-9.

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.[34]

This CMS webpage describes access to DSH data ***from 1998 to 2023*** and instructs providers to submit a request via email to access their DSH data. The Provider's appeal is relative to FYE 2016.

Based on the foregoing, the Board finds that the Provider's *Preliminary Position Paper* failed to comply with Board Rules 23 and 25 (Aug. 29, 2018) 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 2016 was allegedly unavailable in October 2019.

Assuming arguendo that the Provider's *Jurisdictional Response* could supplement a PPP (which it cannot), as mentioned above, the Provider has still 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. 19-0173GC. Thus, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced.

Accordingly, the Board finds that the SSI Provider Specific issue in Case No. 19-1715 (as set forth in the Provider's Issue Statement and its Preliminary Position Paper) and the group issue from Group Case 19-0173GC are the same issue.[35] 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 to indicate that a proper written realignment request was made by the Provider and that the MAC has made a final determination regarding DSH SSI Percentage realignment from

[34] Last accessed July 28, 2025.
[35] 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).

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. Finally, Provider's fiscal year end and the federal fiscal year end—September 30—are identical. 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*.[36]

Similarly, with regard to position papers,[37] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[38] 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*, 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.[39]

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 March 6, 2019 (over 6 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

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[36] (Emphasis added).
[37] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[38] (Emphasis added).
[39] (Emphasis added).

preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[40] ***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.[41] 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. The Board takes administrative notice that it has made similar dismissal in other cases involving CHS providers.[42]

****

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. 19-0173GC 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. 19-1715 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:

7/28/2025

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

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

[40] Provider's Preliminary Position Paper at 8.
[41] *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.
[42] An example of a CHS individual provider case in which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Nathan Summar
Community Health Systems, Inc.
4000 Meridian Boulevard
Franklin, TN 37067

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GuideWell Source
2020 Technology Parkway, Suite 100
Mechanicsburg, PA 17050

RE: ***Board Decision*** **– DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**
Tomball Regional Medical Center (Provider No. 45-0670)
FYE 06/30/2017
Case No. 20-0583

Dear Mr. Summar and Mr. Redmond,

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. 20-0583***

On **July 16, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2017.

On **January 6, 2020**, 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)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – Medicaid Eligible Days
4. Uncompensated Care ("UCC") Distribution Pool[2]
5. 2 Midnight Census IPPS Payment Reduction[3]

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). For that reason, on **August 19, 2020**, the Provider transferred Issues 2 and 5 to Community Health groups. As a result, there are two (2) remaining issues in this appeal: Issue 1

[1] On August 19, 2020, this issue was transferred to PRRB Case No. 20-0997GC.
[2] This issue was withdrawn on August 12, 2020.
[3] On August 19, 2020, this issue was transferred to PRRB Case No. 20-0999GC.

(DSH Payment/SSI Percentage (Provider Specific)) and Issue 3 (DSH Payment – Medicaid Eligible Days).

On **January 9, 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.[4]

On **August 27, 2020**, the Provider timely filed its preliminary position paper.

On **December 2, 2020**, the Medicare Administrative Contractor ("MAC") timely filed its preliminary position paper.

On **October 1, 2021**, the 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. 20-0997GC

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

[4] (Emphasis added).

> CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[5]

Here, it is important to note that the amount in controversy listed for both Issues 1 (Provider Specific) and Issue 2 (Systemic Errors) in the Provider's individual appeal request is $46,000.

The DSH/SSI Systemic Errors Group Issue Statement in Case No. 20-0997GC, CHS CY 2017 DSH SSI Percentage CIRP Group, to which the Provider transferred Issue 2 (Systemic Errors) reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 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.[6]

[5] Issue Statement at 1 (Jan. 6, 2020).
[6] Group Issue Statement, Case No. 20-0997GC.

On August 27, 2020, the Provider filed its Preliminary Position Paper ("PPP"). 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 their calculation based on the Provider's Fiscal Year End (June 30).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), 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).[7]

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**

[7] Provider's Preliminary Position Paper at 8-9 (Aug. 27, 2020).

> 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): 5,16,17,36,S-D
>
> Estimated Reimbursement Amount: $67,000[8]

Regarding the Medicaid eligible days issue, in its Preliminary Position Paper, the Provider argues that pursuant to the *Jewish Hospital* case[9] 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.[10]

MAC's Contentions

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

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

[8] Appeal Request at Issue 3.
[9] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[10] Provider's Preliminary Position Paper at 7-8.

> available remedies for this issue. The MAC requests that the PRRB 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 (Systemic Errors) issue are considered the same issue by the Board.[12]

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 October 1, 2021. 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 Nos. 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 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. 20-0997GC.

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."[13] 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

[11] Jurisdictional Challenge at 6-7 (Oct. 1, 2021).
[12] *Id*. at 4-6.
[13] Issue Statement at 1.

instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[14] 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."[15]

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).

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to a single provider. 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.[16] Furthermore, the Provider cites *Loma Linda Community Hospital* and alleges that "SSI entitlement of individuals can be ascertained from State records."[17] 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, Board Rule 25.2.2 specifies:

> **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.[18]

In its PPP (filed on August 27, 2020), 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:

---

[14] *Id.*
[15] *Id.*
[16] *See* Provider's PPP at 9.
[17] *Id.*
[18] PRRB Rules v 2.0 (August 29, 2018) (Emphasis added).

> 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.[19]

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. 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 (August 29, 2018) 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. 20-0997GC.

[19] Last accessed August 14, 2024.

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 20-0997GC are the same issue.[20] 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

Although the MAC's Jurisdictional Challenge does not address Issue 5, pursuant to Board Rule 41.2, the Board takes the issue under consideration sua sponte.

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

[20] 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).

> 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*.[21]

Similarly, with regard to position papers,[22] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[23] 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,* 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

[21] (Emphasis added).
[22] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[23] (Emphasis added).

> the documents become available, ***promptly*** forward them to the Board and the opposing party.[24]

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 January 6, 2020 (over 5 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.[25] ***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.[26] 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. The Board takes administrative notice that it has made similar dismissals in other cases involving CHS providers.[27]

****

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. 20-0997GC 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. 20-0583 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.

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[24] (Emphasis added).
[25] Provider's Preliminary Position Paper at 8.
[26] *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.
[27] An example of a CHS individual provider case in which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

Board Members Participating:

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

For the Board:

7/29/2025

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision* – DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**
Baylor Scott & White Medical Center Lake Pointe (Provider No. 45-0742)
FYE 05/31/2008
Case No. 20-0593

Dear Mr. Ravindran and Mr. Redmond,

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. 20-0593*

On **July 23, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2008.

On **January 8, 2020**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained eight (8) issues:

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

[1] On August 21, 2020, this issue was transferred to PRRB Case No. 20-1969GC.
[2] On August 21, 2020, this issue was transferred to PRRB Case No. 20-1970GC.
[3] This issue was dismissed on March 20, 2025.
[4] On August 21, 2020, this issue was transferred to PRRB Case No. 20-1972GC.
[5] This issue was dismissed on March 20, 2025.

8. Standardized Payment Amount[6]

The Provider is commonly owned/controlled by Baylor Scott & White Health (hereinafter "BS&W Health") and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **August 21, 2020**, the Provider transferred Issues 2, 3, 6 and 8 to BS&W Health groups. As a result, there are two (2) remaining issues in this appeal: Issue 1 (DSH Payment/SSI Percentage (Provider Specific)) and Issue 5 (DSH Payment – Medicaid Eligible Days).

On **January 9, 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.[7]

On **August 31, 2020**, the Provider timely filed its preliminary position paper.

On **December 7, 2020**, the Medicare Administrative Contractor ("MAC") timely filed its preliminary position paper.

On **April 5, 2022**, the 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.

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

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 14-1211GC

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.

[6] On August 21, 2020, this issue was transferred to PRRB Case No. 20-1974GC.
[7] (Emphasis added).

> . . .
>
> 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.[8]

Here, it is important to note that the amount in controversy listed for both Issues 1 (Provider Specific) and Issue 2 (Systemic Errors) in the Provider's individual appeal request is $11,000.

On August 31, 2020, the Provider filed its Preliminary Position Paper ("PPP"). The following is the entirety of Provider's position on Issue 1 (Provider Specific) 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 their 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 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).[9]

[8] Issue Statement at 1 (Jan. 8, 2020).
[9] Provider's Preliminary Position Paper at 8-9 (Aug. 31, 2020).

C. Description of Issue 5 in the Appeal Request

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

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 4,6,13,14,15,22,23,S-D
>
> Estimated Reimbursement Amount: $42,000[10]

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

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

[10] Appeal Request at Issue 5.
[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 7-8.

are duplicative of Issue 2. Further, the MAC argues that the portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[13]

Issue 5 – DSH Payment – Medicaid Eligible Days

In its April 5, 2022 Jurisdictional Challenge, the MAC did not address Issue 5.

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 April 5, 2022. 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.

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 Nos. 1 & 5.

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 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. 14-1211GC.

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."[14] Per the appeal request, the

[13] Medicare Contractor's Jurisdictional Challenge at 6-7 (Apr. 5, 2022).
[14] Issue Statement at 1.

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)."[15] 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."[16]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 14-1211GC 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 only this provider. 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, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 14-1211GC but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal.

In accordance with 42 C.F.R. § 405.1853(b), the Commentary to Rule 23.3 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, Board Rule 25.2.2 specifies:

> **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.[17]

In its PPP (filed on August 31, 2020), the Provider only cites to 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

[15] *Id.*
[16] *Id.*
[17] (Emphasis added).

> 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.[18]

This CMS webpage describes access to DSH data ***from 1998 to 2023*** and instructs providers to submit a request via email to access their DSH data. The Provider's appeal is relative to FYE 2008.

Based on the foregoing, the Board finds that the Provider's *Preliminary Position Paper* failed to comply with Board Rules 23 and 25 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 2008 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. 14-1211GC.

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 14-1211GC are the same issue.[19] 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.

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[18] Last accessed July 29, 2025.

[19] 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 BS&W CIRP group per 42 C.F.R. § 405.1837(b)(1).

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

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

> **Statement of the 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.[20]

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:

[20] Individual Appeal Request, Issue 3.

> 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(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*.[21]

[21] (Emphasis added).

Similarly, with regard to position papers,[22] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[23] 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,* 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.[24]

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 January 8, 2020 (over 5.5 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.[25] ***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.[26] 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)

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[22] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[23] (Emphasis added).
[24] (Emphasis added).
[25] Provider's Preliminary Position Paper at 8.
[26] *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.

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. 14-1211GC 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. 20-0593 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:

7/29/2025

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244-1850
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 Reconsideration of Board's Dismissal of Appeal***
Baylor University Medical Center (Provider Number 45-0021)
FYE: 06/30/2012
Case Number: 19-0352

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the Request for Reconsideration of the Board's Dismissal of Appeal submitted by Baylor University Medical Center ("Provider") on November 13, 2024. The decision of the Board is set forth below.

Pertinent Facts:

On **July 22, 2024**, the Board dismissed the remaining issue in the appeal, Issue No. 5: DSH Payment – Medicaid Eligible Days and closed the instant appeal. In the dismissal, the Board found the Provider noncompliant with 42 C.F.R. §§ 405.1835(a)-(b), 405.1853(b)(2)-(3), and 412.106(b)(4)(iv) and Board Rules 7, 8, 25, and 27.[1]

On **November 13, 2024**, the Provider requested reinstatement of the DSH Payment – Medicaid Eligible Days issue.

Provider's Reinstatement Request:

The Provider "asserts that there is no section 1115 waiver days issue, and as such it was not added timely, or untimely to the Provider's appeal."[2]

The Provider's argument is that 1115 waiver days are a component or sub issue of the Medicaid Eligible Days issue, and regulations and Board rules do not place a time limit on adding those.[3] The Provider further argues:

[1] The Board also noted a failure to comply with the instructions included in the Board's Notices which set the Board's deadlines.
[2] Request for Reconsideration and Reinstatement of Dismissal of Medicaid Eligible Days & *1115 Medicaid Waiver Days for Baylor University Medical Center* at 1 (Nov. 13, 2024).
[3] *Id*. at 2.

> Rule 8 is internally inconsistent with Rule 7. Whereas Rule 8 refers to "components" of an issue, and gives section 1115 waiver days as an example, Rule 7.2.1 provides that, for purposes of identifying the "issue" under appeal, the provider needs to give "an issue title and a concise issue statement" that describes the cost report adjustment, including the cost report adjustment number, the controlling authority, why the cost report adjustment is incorrect, how the payment should be determined differently, the reimbursement effect, and the basis for jurisdiction before the PRRB. Thus, Rule 8 is both inconsistent with the regulations and Rule 7. Further, whereas Rule 7 directs providers to Rule 8, Rule 8 directs the providers to Rule 7. This direction is flatly inconsistent with Rule 7, as explained above, or at the very least is confusing and misleading.[4]

The Provider also contends

> [w]hen auditing other types of Medicaid eligible days, the MAC does not need to know on what basis was a patient eligible for Medicaid . . . Change 12669 specifically requires the MAC, upon receipt of the provider's section 1115 waiver days listing, to identify the State waiver programs potentially at issue and audit the provider's listing:
>
> > For providers with patients whose inpatient stay is covered by a Section 1115 waiver program funding pool, which pays health care providers that provide uncompensated care to patients who are uninsured and is matched by Title XIX federal funds, *the MAC shall review the State's Section 1115 program documents to determine the method by which the provider identifies eligible inpatient stay days*.
> >
> > 2. The MAC shall select a sample of accounts from the provider's submitted Section 1115 log for further review.
> >
> > 3. The MAC shall request documentation from the provider for the selected sample and review the documentation to ensure that: a) the provider has accurately included the inpatient stay in the Section 1115 waiver program for reimbursement through the funding pool based on the provider's Section 1115 approved program documents; and b) has accurately included the inpatient stay on the Section 1115 log.

[4] *Id.*

> 4. The MAC shall review the provider's applicable documentation that details the patient's length of stay and the acute-care unit that the patient's stay occurred to verify the patient's length of stay in an inpatient acute section of the hospital.[5]

The Provider continues its argument, stating:

> to the extent the Board believes more information is needed, the Board could simply ask the Provider to supply it, or for the parties to identify any material issues of fact. To dismiss a case without asking for such information, in advance of a hearing, would be an abuse of discretion and would point to the Board simply wishing to take cases off its docket rather than extend the opportunity for a hearing to a provider that has a statutory right to it and a statutory right to have its section 1115 waiver days counted. *See Forrest General*,[6] 926 F. 3d at 227-28.[7]

Board's Analysis and Decision:

Consistent with Baylor All Saints Medical Center v. Becerra,[8] issued March 21, 2025 as well as *Atrium Health Carolinas Med. Ctr. v. Kennedy*, No. 1:23-cv-01742-CRC (D.D.C. July 21, 2025), the Board denies the reinstatement request. The Board's prior decision to dismiss 1115 waiver days was proper. The Provider failed on two counts, as it failed to include the issue in the appeal request or provide a listing at that time, but then also did not brief the issue ***or*** include a days listing in the required preliminary position paper.

In addition, as noted by the Provider in its Reinstatement Request, the Board received the instant appeal on October 31, 2018.[9] At the time the filing of this appeal, PRRB Rules v. 2.0, effective August 29, 2018, were in effect. In contrast to the Provider's argument that Section 1115 waiver days or Medicaid Eligible Days were not considered separate issues by the Board, the plain wording of Rule 8 proves otherwise:

> **Rule 8 Framing Issues for Adjustments 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,*

[5] *Id*. at 4.
[6] Citing *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019).
[7] Request for Reconsideration and Reinstatement of Dismissal of Medicaid Eligible Days & *1115 Medicaid Waiver Days for Baylor University Medical Center* at 4-5.
[8] *Baylor All Saints Medical Center v. Becerra*, 2025 WL 888500 (N.D. Texas, 2025).
[9] Request for Reconsideration and Reinstatement of Dismissal of Medicaid Eligible Days & *1115 Medicaid Waiver Days for Baylor University Medical Center* at 1.

> *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.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: dual eligible Medicare Part A/Medicaid, dual eligible Medicare Part C/Medicaid, SSI data matching, state/program specific general assistance days, ***Section 1115 waiver days (program/waiver specific)***, and observation bed days.[10]

Regardless of whether the Provider *properly* included the § 1115 waiver days issue in its appeal request (which it did not), QRS also failed to properly develop the merits of § 1115 waiver day issue in the Provider's preliminary position paper filing. As stated in the original dismissal, this is an independent basis for dismissal of the § 1115 waiver day issue. Specifically, the material facts and legal arguments needed to establish the merits of the Provider's claims regarding the § 1115 waiver days issue along with the relevant supporting documentation were not properly briefed and included in the preliminary position paper filing.

Not only did the Provider fail to provide a necessary listing with the Preliminary Position Paper but it has provided no explanation for why there was no listing. The exhibits to the Preliminary Position Paper were not filed in a timely manner, and did not meet the requirements of 42 C.F.R. § 405.1853(b)(2)-(3) or Board Rules 7, 8, 25 and 27.

The Board finds the Provider's request for reinstatement fails to establish good cause. Board Rule 47 reads, in relevant part:

> **Rule 47 Reinstatement**
>
> * * *
>
> **47.1 Motion for Reinstatement**
>
> [T]he Board will not reinstate an issue(s)/case if the provider was at fault.
>
> * * *
>
> **47.3 Dismissal for Failure to Comply with Board Procedures**

[10] Board Rules (v. 2.0 (Aug. 29, 2018)) (Emphasis added).

> Upon written motion demonstrating good cause, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, administrative oversight, settlement negotiations or a change in representative will not be considered good cause to reinstate. . .

As such, the Board declines to exercise its discretion and denies the request for reconsideration. Accordingly, Case No. 19-0352 remains closed.

BOARD MEMBERS:

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

FOR THE BOARD:

7/29/2025

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
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H)

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 Reconsideration of Board's Dismissal of Appeal***
Baylor Scott & White Medical Center Hillcrest (Provider Number 45-0101)
FYE: 08/31/2015
Case Number: 19-0140

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the Request for Reconsideration of the Board's Dismissal of Appeal submitted by Baylor Scott & White Medical Center Hillcrest ("Provider", also identified in the Request letter as "Hillcrest Baptist Medical Center") on July 23, 2024. The decision of the Board is set forth below.

Pertinent Facts:

On **May 24, 2024**, the Board dismissed the remaining issue in the appeal, Issue No. 5: DSH Payment – Medicaid Eligible Days and closed the instant appeal. In the dismissal, the Board found the Provider noncompliant with 42 C.F.R. §§ 405.1835(a)-(b), 405.1853(b)(2)-(3), and 412.106(b)(4)(iv) and Board Rules 7, 8, 25, and 27.[1]

On **July 23, 2024**, the Provider requested reinstatement of the DSH Payment – Medicaid Eligible Days issue.

Provider's Reinstatement Request:

The Provider argues a deprivation of due process because "no notice was given in the 2015 [version of PRRB rules] that providers are required to specifically mention section 1115 days in their appeal requests."[2] They went on to "assert[] that there is no section 1115 waiver days issue, and as such it was not added timely, or untimely to the Provider's appeal."[3]

[1] The Board also noted a failure to comply with the instructions included in the Board's Notices which set the Board's deadlines).
[2] Request for Reconsideration and Reinstatement of Dismissal of Medicaid Eligible Days at 1 (Jul. 23, 2024).
[3] *Id*.

The Provider's argument is that 1115 waiver days are a component or sub issue of the Medicaid Eligible Days issue, and regulations and Board rules do not place a time limit on adding those.[4] The Provider goes on to argue:

> First, the rule purports to exist so as to comply with what is in the regulations; however, the regulations deal with appealing issues, not "components" of issues, and as explained above, the regulations consider an "issue" to be a specific cost report adjustment. Thus Rule 8's extension to "components" is not consistent with the regulations and is invalid because it is based on a false premise.
>
> Second, not only are section 1115 waiver days not mentioned in Rule 8.2, neither are Medicaid eligible days. Thus, even if Rule 8's extension to "components of issues" were valid (and the Provider contends it is not) Providers had no notice that were required to specify section 1115 waiver days in their appeal requests, and it would be a denial of due process to dismiss a provider's request for appeal because the provider did not reference section 1115 waiver days within its appeal of Medicaid eligible days.
>
> . . .
>
> Third, Rule 8 is internally inconsistent with Rule 7. Whereas Rule 8 refers to "components" of an issue, Rule 7.1 provides that, for purposes of identifying the "issue" under appeal, the provider need only "[g]ive a concise issue statement" that describes the cost report adjustment, including the cost report adjustment number and why the cost report adjustment is incorrect. Thus, Rule 8 is both inconsistent with the regulations and Rule 7.[5]

Board's Analysis and Decision:

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

The Board disagrees with the Provider's argument that "there is no section 1115 waiver issue." As the Board indicated in its initial decision, although the Provider appealed Medicaid eligible days, that issue ***is separate and distinct*** from the § 1115 waiver days as recognized by numerous Board, Administrator and Court decisions[6] as well as the Board's Rules in in effect when the appeal for this case was filed.

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[4] *Id*. at 2.
[5] *Id*. at 3.
[6] *See, e.g.*, *QRS 1993-2007 DSH/Iowa Indigent Patient /Charity Care (GA) Group v. Blue Cross Blue Shield Ass'n*,

The Board notes that the Provider cites the incorrect iteration of Board Rules when it continually cites the July 1, 2015 version of the Board Rules.[7] At the time the filing of this appeal, October 12, 2018, PRRB Rules v. 2.0, effective August 29, 2018, were in effect. In contrast to the Provider's argument that Section 1115 waiver days or Medicaid Eligible Days were not considered separate issues by the Board, the plain wording of Rule 8 proves otherwise:

> **Rule 8 Framing Issues for Adjustments 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.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: dual eligible Medicare Part A/Medicaid, dual eligible Medicare Part C/Medicaid, SSI data matching, state/program specific general assistance days, ***Section 1115 waiver days (program/waiver specific)***, and observation bed days.[8]

Regardless of whether the Provider *properly* included the § 1115 waiver days issue in its appeal request (which it did not), QRS also failed to properly develop the merits of § 1115 waiver day issue in any of the Provider's preliminary position paper filings (and then failed to even file an *optional* final position paper by the November 23, 2023 filing deadline). As stated in the original dismissal, this is an independent basis for dismissal of the § 1115 waiver day issue. Specifically, the material facts and legal arguments needed to establish the merits of the Provider's claims

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Adm'r Dec. (Jan. 15, 2013), *affirming* PRRB Dec. No. 2013-D02 (Nov. 21, 2012)*; St. Dominic-Jackson Mem'l Hosp. v. Sebelius*, No. 3:12-cv-832, 2014 WL 8515280 (S.D. Miss. 2014); *Singing River Health Sys. v. Novitas Solutions, Inc.*, PRRB Dec. 2016-D19 (Sept. 20, 2016), *rev'd* CMS Adm'r Dec. (Nov. 18, 2016); *CCT&B 2005-2006 Hurricane Katrina § 1115 Waiver UCP Days Grp. v. Novitas Solutions, Inc*., PRRB Dec. 2016-D18 (Sep. 16, 2016), *rev'd* CMS Adm'r Dec. (Nov. 18, 2016), *aff'd sub nom. Forrest Gen. Hosp. v. Hargan*, No. 2:17-CV-8, 2018 WL 11434575 (S.D. Miss. Feb. 22, 2018), *rev'd & remanded Forrest Gen. Hosp. v. Azar*, 926 F.3d 221 (5th Cir. 2019); *Southwest Consulting UMass Mem'l Health Care & Steward Health 2009 DSH CCHIP Section 1115 Waiver Days Grps. v. Nat'l Gov't Servs., Inc*., PRRB Dec. 2017-D04 (Jan. 27, 2017), *rev'd* CMS Adm'r Dec. (Mar. 21, 2017), *vacated & remanded sub nom. HealthAlliance Hosps., Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. Oct. 26, 2018); *Florida Section 1115 LIP Rehab DSH Waiver Days Grps. v. First Coast Serv. Options*, PRRB Decs. 2018-D21, 2018-D22 (Feb. 8, 2018), *vacated by* Adm'r Dec. (Mar. 30, 2018), *rev'd by Bethesda Health Inc. v. Azar*, 389 F. Supp. 3d 32 (DDC 2019), *aff'd by* 980 F.3d 121 (D.C. Cir. 2020).

[7] v. 1.3

[8] Board Rules (v. 2.0 (Aug. 29, 2018) (Emphasis added).

regarding the § 1115 waiver days issue along with the relevant supporting documentation were not properly briefed and included in the preliminary position paper filing.

The Board's analysis is consistent with a related Baylor case, *Baylor All Saints Medical Center v. Becerra*,[9] issued March 21, 2025, as well as *Atrium Health Carolinas Med. Ctr. v. Kennedy*, No. 1:23-cv-01742-CRC (D.D.C. July 21, 2025). As such, the Board denies the reinstatement request. The Board's prior decision to dismiss 1115 waiver days was proper. Not only did the Provider fail to identify the issue in its Request for Hearing or include a list of days, it also failed to brief the issue ***or*** include a days listing in the preliminary position paper.

Along with the arguments covered in the Board's dismissal regarding noncompliance with Board Rules 25 and 27 addressing the development of the Provider's issue, the Provider's request for reinstatement fails to establish good cause. Board Rule 47 reads, in relevant part:

> **Rule 47 Reinstatement**
>
> **47.1 Motion for Reinstatement**
>
> * * *
>
> [T]he Board will not reinstate an issue(s)/case if the provider was at fault.
>
> * * *
>
> **47.3 Dismissal for Failure to Comply with Board Procedures**
>
> Upon written motion demonstrating good cause, the Board may reinstate a cause dismissed for failure to comply with Board procedures. Generally, administrative oversight, settlement negotiations or a change in representative will not be considered good cause to reinstate. . .

As such, the Board declines to exercise its discretion and denies the request for reconsideration. Accordingly, Case No. 19-0140 remains closed.

BOARD MEMBERS:

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

[9] *Baylor All Saints Medical Center v. Becerra*, 2025 WL 888500 (N.D. Texas, 2025).

FOR THE BOARD:

7/29/2025

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
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H)

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 Reconsideration and Reinstatement of Board's Dismissal of Appeal***
San Angelo Community Medical Center (Provider Number 45-0340)
FYE: 08/31/2016
Case Number: 19-1699

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the Request for Reconsideration and Reinstatement of Board's Dismissal of Appeal submitted by San Angelo Community Medical Center ("Provider") on May 19, 2025. The decision of the Board is set forth below.

Pertinent Facts:

On **March 10, 2025**, the Board dismissed the remaining issues in the appeal, including Issue No. 3: DSH Payment – Medicaid Eligible Days and closed the instant appeal. In the dismissal, the Board found the Provider noncompliant with 42 C.F.R. §§ 405.1835(a)-(b), 405.1853(b)(2)-(3), and 412.106(b)(4)(iv) and Board Rules 7, 8, 25, and 27.[1]

On **May 19, 2025**, the Provider requested reconsideration and reinstatement of the DSH Payment – Medicaid Eligible Days issue.

Provider's Position:

The Provider "asserts that there is no section 1115 waiver days issue, and as such it was not added timely, or untimely to the Provider's appeal."[2]

The Provider's argument is that 1115 waiver days are a component or sub issue of the Medicaid Eligible Days issue, and regulations and Board rules do not place a time limit on adding those.[3] They go on to argue:

> [T]he Provider timely appealed the non-inclusion of Medicaid eligible days, saying "[t]he MAC, contrary to the regulation, *failed to include all Medicaid eligible days, including but not limited to*

[1] The Board also noted a failure to comply with the instructions included in the Board's Notices setting the Board's deadlines).
[2] Request for Reconsideration and Reinstatement of Dismissal of Medicaid Eligible Days & 1115 Medicaid Waiver Days at 1 (May 19, 2025).
[3] *Id*. at 2.

> Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation." Emphasis added. The italicized language above 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.
>
> . . .
>
> Rule 8 is internally inconsistent with Rule 7. Whereas Rule 8 refers to "components" of an issue, and gives section 1115 waiver days as an example, Rule 7.2.1 provides that, for purposes of identifying the "issue" under appeal, the provider needs to give "an issue title and concise issue statement" that describes the cost report adjustment, including the cost report adjustment number, the controlling authority, why the cost report adjustment is incorrect, how the payment should be determined differently, the reimbursement effect, and the basis for jurisdiction before the PPRB. Thus, Rule 8 is both inconsistent with the regulations and Rule 7.[4]

Board's Analysis and Decision:

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

The Board disagrees with the Provider's argument that "there is no section 1115 waiver days issue." As the Board indicated in its initial decision, although the Provider appealed Medicaid eligible days, that issue ***is separate and distinct*** from the § 1115 waiver days as recognized by numerous Board, Administrator and Court decisions[5] as well as the Board's Rules in in effect when the appeal for this case was filed.

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[4] *Id*. at 1-2.

[5] *See, e.g.*, *QRS 1993-2007 DSH/Iowa Indigent Patient /Charity Care (GA) Group v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Jan. 15, 2013), *affirming* PRRB Dec. No. 2013-D02 (Nov. 21, 2012)*; St. Dominic-Jackson Mem'l Hosp. v. Sebelius*, No. 3:12-cv-832, 2014 WL 8515280 (S.D. Miss. 2014); *Singing River Health Sys. v. Novitas Solutions, Inc.*, PRRB Dec. 2016-D19 (Sept. 20, 2016), *rev'd* CMS Adm'r Dec. (Nov. 18, 2016); *CCT&B 2005-2006 Hurricane Katrina § 1115 Waiver UCP Days Grp. v. Novitas Solutions, Inc*., PRRB Dec. 2016-D18 (Sep. 16, 2016), *rev'd* CMS Adm'r Dec. (Nov. 18, 2016), *aff'd sub nom. Forrest Gen. Hosp. v. Hargan*, No. 2:17-CV-8, 2018 WL 11434575 (S.D. Miss. Feb. 22, 2018), *rev'd & remanded Forrest Gen. Hosp. v. Azar*, 926 F.3d 221 (5th Cir. 2019); *Southwest Consulting UMass Mem'l Health Care & Steward Health 2009 DSH CCHIP Section 1115 Waiver Days Grps. v. Nat'l Gov't Servs., Inc*., PRRB Dec. 2017-D04 (Jan. 27, 2017), *rev'd* CMS Adm'r Dec. (Mar. 21, 2017), *vacated & remanded sub nom*. *HealthAlliance Hosps., Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. Oct. 26, 2018); *Florida Section 1115 LIP Rehab DSH Waiver Days Grps. v. First Coast Serv. Options*, PRRB Decs. 2018-D21, 2018-D22 (Feb. 8, 2018), *vacated by* Adm'r Dec. (Mar. 30, 2018), *rev'd by Bethesda Health Inc. v. Azar*, 389 F. Supp. 3d 32 (DDC 2019), *aff'd by* 980 F.3d 121 (D.C. Cir. 2020).

The Board's analysis is consistent with a recent case, *Baylor All Saints Medical Center v. Becerra*,[6] issued March 21, 2025, as well as *Atrium Health Carolinas Med. Ctr. v. Kennedy*, No. 1:23-cv-01742-CRC (D.D.C. July 21, 2025).

The Board notes that the Provider cites the incorrect iteration of Board Rules when it continually cites the July 1, 2015 version of the Board Rules.[7] At the time the filing of this appeal, March 6, 2019, PRRB Rules v. 2.0, effective August 29, 2018, were in effect. In contrast to the Provider's argument that Section 1115 waiver days or Medicaid Eligible Days were not considered separate issues by the Board, the plain wording of Rule 8 proves otherwise:

> **Rule 8 Framing Issues for Adjustments 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.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: dual eligible Medicare Part A/Medicaid, dual eligible Medicare Part C/Medicaid, SSI data matching, state/program specific general assistance days, ***Section 1115 waiver days (program/waiver specific)***, and observation bed days.[8]

Regardless of whether the Provider *properly* included the § 1115 waiver days issue in its appeal request (which it did not), QRS also failed to properly develop the merits of § 1115 waiver day issue in the Provider's preliminary position paper filing. As stated in the original dismissal, this is an independent basis for dismissal of the § 1115 waiver day issue. Specifically, the material facts and legal arguments need to establish the merits of the Provider's claims regarding the § 1115 waiver days issue along with the relevant supporting documentation were not properly briefed and included in the preliminary position paper filing.

Not only did the Provider fail to provide a necessary listing with the Preliminary Position Paper but has provided no explanation for why there was no listing. The exhibits to the Preliminary Position Paper were not filed in a timely manner, and did not meet the requirements of 42 C.F.R. § 405.1853(b)(2)-(3) or Board Rules 7, 8, 25 and 27.

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[6] *Baylor All Saints Medical Center v. Becerra*, 2025 WL 888500 (N.D. Texas, 2025).
[7] v. 1.3
[8] Board Rules v. 2.0 (Aug. 29, 2018) (Emphasis added).

Further, the Board finds the Provider's request for reinstatement fails to establish good cause. Board Rule 47 (v. 3.2 (Dec. 15, 2023)) reads, in relevant part:

> **Rule 47 Reinstatement**
>
> **47.1 Motion for Reinstatement**
>
> * * *
>
> [T]he Board will not reinstate an issue(s)/case if the provider was at fault.
>
> * * *
>
> **47.3 Dismissal for Failure to Comply with Board Procedures**
>
> Upon written motion demonstrating good cause, the Board may reinstate a cause dismissed for failure to comply with Board procedures. Generally, administrative oversight, settlement negotiations or a change in representative will not be considered good cause to reinstate. . .

As such, the Board declines to exercise its discretion and denies the request for reconsideration. Accordingly, Case No. 19-1699 remains closed.

BOARD MEMBERS:

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

FOR THE BOARD:

7/29/2025

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
Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)

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

RE: **Determination re: Filing Requirements/Denial of Transfer Request**
Mary Lanning Healthcare (28-0032)
Appealed Period: 12/31/2015
PRRB Case No.: 25-2658

Dear Mr. Ravindran:

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 February 15, 2025, Quality Reimbursement Services ("QRS") filed an appeal request, on behalf of the above referenced Provider, based on a *CMS One-Time Notification Transmittal 12785* dated August 13, 2024. The appeal identified a sole issue in dispute: Medicare Fraction (SSI) – Statutory & Systemic Errors.

Upon review of the appeal request and the supporting jurisdictional documentation, the Board notes that the Provider has stated the amount in controversy as $6,242.

On July 19, 2025, the Provider requested that the sole issue in the subject individual appeal be transferred to an Optional group, case number 25-5045G, QRS CY 2015 Medicare Fraction (SSI) - Statutory & Systemic Errors Group. By letter dated July 28, 2025, the transfer was effectuated in OH CDMS resulting in the closure of case number 25-2658.

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 $6,242 and submitted no further documentation or calculation to indicate that the appeal request had met the $10,000 amount in controversy threshold, the Board notes that the individual appeal request failed 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.

Since the Provider failed to initially meet the minimum filing requirements, the Board hereby denies the transfer of the sole issue, Medicaid Statutory & Systemic Errors issue, from case number 25-2658 to group case number 25-5045G and rescinds the previous July 28, 2025 notification which granted the transfer. The status of case number 25-2658 will reflect that the case was dismissed, in its entirety, by the Board as a result of failing to meet the minimum filing requirements.

Lastly, the Board admonishes QRS for filing appeal requests which do not meet the minimum filing requirements as outlined in the rules and regulations referenced above. These jurisdictionally deficient appeal requests create an undue administrative burden on the Board and its staff. In the future, please confirm that an individual appeal request meets the $10,000 controversy amount threshold before filing an appeal with the Board.

Board Members:

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

FOR THE BOARD:

7/31/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
East Georgia Regional Medical Center, Prov. No. 11-0075, FYE 09/30/2018
Case No. 23-0334

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0334. 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. 23-0334*

On **June 24, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2018. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **December 1, 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 Unduly Narrow Definition of SSI Entitlement[1]
3. DSH Payment – Medicaid Eligible Days
4. DSH Payment – Medicare/SSI and Medicaid Fractions – Medicare Managed Care Part C Days[2]
5. DSH Payment – SSI/Medicare and Medicaid Fractions – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[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 **June 9, 2023**, the Provider transferred Issues 2, 4 and 5 to CHS CIRP groups.

[1] On June 9, 2023, this issue was transferred to Case No. 21-1206GC.
[2] On June 9, 2023, this issue was transferred to Case No. 20-2149GC.
[3] On June 9, 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 **December 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.[4]

An updated Critical Due Date Notification was sent by the Board on **March 28, 2023**, establishing new deadlines in light of Alert 23, the resumption of normal Board operations following the COVID-19 pandemic.

On **July 5, 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 $43,053 based on an *estimated* 100 days.

On **September 6, 2023**, the Medicare Contractor timely filed a Jurisdictional Challenge[5] with the Board over Issues 1 and 3 requesting that the Board dismiss these issues. Pursuant to Board Rule

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[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).

44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **September 11, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **October 26, 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 any of the Medicare Contractor's requests for that Medicaid eligible days listing.

On **November 20, 2023**, almost 2 months after the deadline for responding 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."[6] The Listing was 16 pages with roughly 2,247 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 2,247 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 2,247 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]

[6] (Emphasis added.)
[7] Issue Statement at 1 (Dec. 1, 2022).

The Group issue Statement in Case No. 21-1206GC, to which the Provider transferred Issue No. 2, reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[8]

On July 5, 2023, the Board received the Provider's preliminary position paper in 23-0334. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Issue #1: Provider Specific**
>
> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.

[8] Group Appeal Issue Statement in Case No. 21-1206GC.

> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[9]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $38,724.

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 it is premature because the Provider has not exhausted all available remedies.[10]

Finally, the MAC asserts that the Provider did not file a complete preliminary position paper, and therefore violated Board Rule 25 and 42 C.F.R. § 405.1853.

Issue 3 – DSH Payment – Medicaid Eligible Days

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

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[9] Provider's Preliminary Position Paper at 7-8 (Jul. 5, 2023).
[10] Medicare Contractor's Jurisdictional Challenge at 6-7 (Sep. 6, 2023).

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.[11] 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. 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."[12] 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.

[11] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[12] Issue Statement at 1.

§ 1395ww(d)(5)(F)(i)."[13] 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."[14]

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. 23-0334 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 21-1206GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[15], 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. 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.[17] 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 (Nov. 1, 2021), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties'

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[13] *Id.*
[14] *Id.*
[15] PRRB Rules v. 3.1 (Nov. 2021).
[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.

positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents (Nov. 1, 2021)**
>
> If documents necessary to support your position are still unavailable, then provider the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.[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 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]

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

[18] (Italics and underline emphasis added.)
[19] Last accessed Oct. 15, 2024.
[20] (Emphasis added).

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*,[21] the Board finds that the SSI Provider Specific issue in Case No. 19-2704 and the group issue from the CHS CIRP group under Case No. 20-1332GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

Additionally, in its Preliminary Position Paper, the Provider states, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra [sic] (Appellants' reply brief included as Exhibit P-3)." The Board finds that this incorporation by reference does not comply with the regulatory and Board rule requirements to *fully* develop the Provider's position in the Preliminary Position Paper. Particularly, 42 C.F.R. § 405.1853(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*.[22]

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.

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[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.
[22] (Emphasis added).

B. DSH Payment – Medicaid Eligible Days

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal in either the initial appeal or the position 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.[23]

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:

[23] (Bold emphasis added.)

Rule 25 Preliminary Position Papers[24]

> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will issue a notice setting deadlines for the first position paper generally at eight months after filing the appeal request for the provider, and twelve months for the Medicare contractor. Even though it will not be addressed in the Board's notice, the provider may file an *optional* response no later than ninety days following the due date for the Medicare contractor's preliminary position paper. Therefore, the Board requires preliminary position papers to present the ***fully*** developed positions of the parties and expects that parties will be diligent in planning and conducting any required investigation, discovery, and analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the applicable sub-section.

25.1.1 Provider's Position Paper

The provider's preliminary position paper must:

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
B. For ***each*** issue that has not been fully resolved, provide a ***fully*** developed narrative that:
    - States the material facts that support the provider's claim.
    - Identifies the controlling authority (*e.g.*, statutes, regulations, policy, or case law) supporting the provider's position.
    - Provides a conclusion applying the material facts to the controlling authorities.
C. Comply with Rule 25.2 addressing Exhibits.

. . .

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

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, then provider the following information in the position papers:

1. Identify the missing documents;
2. Explain why the documents remain unavailable;
3. State the efforts made to obtain the documents; and
4. Explain when the documents will be available.

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

The Board requires the parties file a ***complete*** preliminary position paper that includes a fully developed narrative (Rule 25.1), all exhibits (Rule 25.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn.

> **COMMENTARY**: Note that the change to require filing of the ***complete*** preliminary position paper was effective on August 29, 2018. Accordingly, failure to file a ***complete*** preliminary position paper with the Board will result in the Board dismissing your appeal or taking other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on December 2, 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.[25]

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 July 5, 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.[26] 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 $43,053 based

[25] (Emphasis added.)
[26] Provider's Preliminary Position Paper at 9.

on an estimated 100 days). The Provider's complete briefing of this issue in its position paper is as follows:

> **Issue #3: Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicaid 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, 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.

Notably, the Medicare Contractor sent a request for the Provider's list of Medicaid Eligible days (and also discussed the lack of the listing in the Medicare Contractor's own position paper filing). The notice was sent to the Provider on February 8, 2023, over *four years after the end of the Provider's cost reporting period*. The Provider failed to file any response.

However, on November 20, 2023 (over a month 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 16 pages with roughly 2,247 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 2,247 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 2,247 days 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 a month past the deadline for responding to the Jurisdictional Challenge *and, more importantly,* ***was nearly 4 months past the deadline for including it with its preliminary position paper*** since the position paper deadline was July 31, 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 merely 2 months after the Provider changed its designated representative to QRS does not excuse the Provider for its failure to include the information with its preliminary position paper or its failure to timely respond to the Jurisdictional Challenge. Board Rule 5.2 makes clear that "the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings." Moreover, the Board rejects the

Provider's attempt to label the November 20, 2023 filing as a "Supplement to Position Paper" and does not accept that filing because:

1. The alleged "Supplement" was filed ***nearly 4 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 ***1.5 months*** *after the deadline* for filing a response to the Jurisdictional Challenge requesting the dismissal of Issue 3.

2. The alleged "Supplement" fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the roughly 2,247 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 nearly 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 December 2, 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* 2,247 days listed in the alleged "Supplement" is, without explanation, *exponentially* larger than the original estimated 100 days included with the appeal request).[27]

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"[28] 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.

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[27] *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 on written agreement between the parties."

[28] (Emphasis added.)

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(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.[29]

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 December of 2022 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[30]

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[29] *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.

[30] 42 C.F.R. § 405.1835(b).

Board Rule 7.2.1 (2021) elaborated on this regulatory requirement, instructing providers:

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>   - the relevant adjustment(s), including the adjustment number(s),
>   - the controlling authority (*e.g.*, specific regulation, Federal Register issuance, manual provision, or Ruling),
>   - why the adjustment(s) is incorrect,
>   - how the payment should be determined differently,
>   - the reimbursement effect, and
>   - the basis for jurisdiction before the Board.

Board Rule 8 (2021) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

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

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

42 C.F.R. § 405.1835(e) 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.

[31] (Bold and italic emphasis added).
[32] *See* 73 Fed. Reg. 30190 (May 23, 2008).

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

In this regard, the Board notes that section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[33] 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:

> (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

[33] 65 FR 47054, 47087 (Aug. 1, 2000).

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.

Finally, even in the Provider's final position paper, the Provider fails to identify what § 1115 waiver program(s) are involved and whether or not the § 1115 waive days at issue would qualify under 42 C.F.R. § 412.106(b)(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 perfunctory in that it only makes perfunctory conclusions.[34] Again, the Provider failed to so develop its position paper notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Nov. 2021) as applied via Board Rule 27.2.

The Board's finding that neither the appeal request nor final position paper met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[35] 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 . . ."[36] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[37] The Court found that this 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.[38] 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. 23-0334 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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

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

[36] *Id*. at *11.

[37] *Id.*

[38] *Id.*

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For the Board:

7/31/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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