



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electric Delivery

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

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

RE: ***Board Decision: Group Filing Requirements***
25-4224G Meridian Care Center FFY 2025 2% Reduction Appeal Group

Dear Messrs. Ricks and Redmond:

The above-captioned group 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 group appeal request was not filed in accordance with the Board Rules and regulations. The Board's decision is set forth below.

BACKGROUND:

On April 2, 2025, Meridian Care Center filed this optional group appeal with one Provider challenging the 2% reduction penalty for Fiscal Year 2025 Annual Update.

The sole Provider in this optional group, Meridian Care Center (67-5171), entered its final determination date into OH CDMS as October 4, 2024. However, the support document uploaded for the final determination is a *Notification of Non-Compliance for SNFs that have not submitted required Quality Reporting Program (QRP) Data for Federal Fiscal Year (FY) 2025* dated July 10, 2024. The record before the Board does not appear to include a copy of a final determination dated October 4, 2024.

BOARD DECISION:

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

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

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

(3) A copy of the final contractor or Secretary determination under appeal. . .

With respect to the filing of group appeals, Board Rule 12, Filing a Group Appeal, further explains:

12.2 General Requirements

In accordance with 42 C.F.R. § 405.1837, a group must meet the following requirements:

- Each participating provider (whether added by transfer or direct add) must individually satisfy the requirements for a Board hearing under 42 C.F.R. § 405.1835(a) or § 405.1835(c). . .

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

Board Rule 6.1 Initial Filing

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

7.1 Final Determination

7.1.1. General Requirements

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

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

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

7.1.2 Additional Requirements for Specific Determination Types

7.1.2.4 Quality Reporting Payment Reduction Decision

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

The Board finds that this appeal does not meet the regulatory requirements for filing as the Provider that was used to establish this optional group appeal failed to submit the final determination, dated October 4, 2024, on which the appeal is based, as required by 42 C.F.R. §§ 405.1835(b)(3), 405.1837, and the Board Rules. Without the final determination document, the Board is not able to determine whether the Provider has filed a jurisdictionally valid appeal.

Furthermore, the Board notes that this *optional* group appeal was filed with only one provider, in violation of the regulations and Board Rules. Specifically, 42 C.F.R. § 405.1837(b)(2) states:

(2) *Optional group appeals.* (i) **Two or more providers** not under common ownership or control may bring a group appeal before the Board. . .²

¹ Emphasis added.

² Bold emphasis added.

Therefore, the Board also finds that this group appeal fails to meet the regulatory requirements for filing an optional group appeal.

The Board has found that neither the Provider's Meridian Care Center (67-5171) appeal, nor the group appeal itself, have met the regulations or Board rules for filing an appeal. As a result, the Board hereby dismisses Case No. 25-4224G in its entirety and removes it from its docket.

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

Board Members:

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

FOR THE BOARD:

5/1/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Federal Specialized Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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***
Brandywine Hospital, Prov. No. 39-0076
FYE 06/30/2016
Case No. 20-0528

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 20-0528. Set forth below is the decision of the Board to dismiss the remaining issue.

Background

A. Procedural History for Case No. 20-0528

On **July 9, 2019**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end June 30, 2016.

On **December 9, 2019**, the Provider filed this individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage¹
3. DSH Payment – Medicaid Eligible Days²
4. Uncompensated Care (“UCC”) Distribution Pool³
5. 2 Midnight Census IPPS Payment Reduction⁴

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

¹ On July 20, 2020, this issue was transferred to Case No. 19-1409GC.

² This issue was withdrawn on January 4, 2024.

³ This issue was withdrawn via the Preliminary Position Paper on July 29, 2020.

⁴ On July 20, 2020, this issue was transferred to Case No. 19-1410GC.

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 **July 29, 2020**, the Provider timely filed its preliminary position paper.

On **October 22, 2020**, the Medicare Contractor filed a Jurisdictional Challenge⁶ with the Board over Issue 1, requesting that the Board dismiss this issue. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **November 24, 2020**, the Medicare Contractor timely filed its preliminary position paper.

On **November 13, 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. 19-1409GC – CHS CY 2016 DSH SSI Percentage CIRP Group

In their Individual Appeal Request, the Provider summarizes its DSH Payment/SSI Percentage (Provider Specific) issue as follows:

The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.

⁵ (Emphasis added.)

⁶ 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).

The Provider contends that the SSI percentage issued by CMS is flawed.

The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).⁷

The Group Issue Statement in Case No. 19-1409GC, to which the Provider transferred Issue No. 2, reads, in part:

Statement of the Issue:

Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

Statement of the Legal Basis:

The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

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

1. Availability of MEDPAR and SSA Records,
2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days and

⁷ Issue Statement at 1 (Dec. 9, 2019).

6. Failure to adhere to required notice and comment rulemaking⁸

On July 29, 2020, the Board received the Provider's preliminary position paper in 20-0528. 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).

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

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is \$39,000.

MAC's Contentions

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. The MAC contends that Issue 1 should be dismissed because it is duplicative of Issue 2, which was transferred to PRRB Case No. 19-1409GC. The portion of Issue 1 related to SSI realignment should be dismissed because there was no final determination over SSI

⁸ Group Issue Statement for PRRB Case No. 19-1409GC.

⁹ Provider's Preliminary Position Paper at 8-9 (Jul. 29, 2020).

realignment, and the appeal is premature as 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.

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."

Board Decision

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

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage; and (2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage issue that was appealed in Case No. 19-1409GC.

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.

¹⁰ Medicare Contractor's Jurisdictional Challenge at 6-7 (Oct. 22, 2020).

¹¹ Board Rule 44.4.3, v. 2.0 (Aug. 2018).

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 issue in Group Case No. 19-1409GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 20-0528 is duplicative of the DSH SSI Percentage issue in Case No. 19-1409GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6, the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS’ regulation interpretation for the SSI percentage is clearly not “specific” to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is *specific to this provider*. Further, any alleged “systemic” issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.¹⁵ Accordingly, the Provider’s reference to Issue 1 as “Provider Specific” and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged “provider specific” errors averred in Issue 1 are distinguished from the alleged “systemic” issues argued in Issue No. 2, and why those alleged “provider specific” errors should not be subsumed into the “systemic errors” issue appealed in Case No. 19-1409GC.

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. 19-1409GC, 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. Moreover, the Board finds that the Provider’s Preliminary Position Paper failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of position papers. As explained in the Commentary to Rule 23.3, 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.

¹³ *Id.*

¹⁴ *Id.*

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).

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.

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

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

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. 19-1409GC.

¹⁶ Last accessed Oct. 15, 2024.

¹⁷ (Emphasis added).

Accordingly, *based on the record before it*,¹⁸ the Board finds that the SSI Provider Specific issue in Case No. 20-0528 and the group issue from the CHS CIRP group under Case No. 19-1409GC 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, the Provider’s cost reporting period is already aligned with the Federal fiscal year end. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

* * * * *

Based on the foregoing, the Board has dismissed Issue 1. As there are no other issues remaining, the case will close and be removed from the Board’s docket.

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:

5/1/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

¹⁸ 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.



DEPARTMENT OF HEALTH & HUMAN SERVICES

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Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

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

RE: ***Notice of Dismissal***

Bayfront Health Brooksville, Prov. No. 10-0071, FYE 09/30/2017
Case No. 21-0348

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 21-0348. 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. 21-0348

On **June 19, 2020**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end September 30, 2017. The Provider is commonly owned by Community Health Systems, Inc. (“CHS”).

On **December 8, 2020**, CHS filed the Provider’s individual appeal request. The initial Individual Appeal Request contained seven (7) 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 Days³
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 Days⁵
6. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days⁶

¹ This issue was dismissed by the Board on September 18, 2024.

² On March 29, 2021, this issue was transferred to Case No. 20-1332GC.

³ On March 29, 2021, this issue was transferred to Case No. 20-1333GC.

⁴ On March 29, 2021, this issue was transferred to Case No. 20-1334GC.

⁵ On November 1, 2024, the Medicare Contractor filed a jurisdictional challenge over Issue 5.

⁶ On March 29, 2021, this issue was transferred to Case No. 20-1335GC.

7. DSH Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)⁷

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party (“CIRP”) group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **March 29, 2021**, the Provider transferred Issues 2, 3, 4, 6 and 7 to CHS CIRP groups.

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

On **December 11, 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 **September 1, 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 \$53,295 based on an *estimated* 150 days.

On **November 29, 2021**, the Medicare Contractor timely filed its preliminary position paper. With regard to Issue 5, the Medicare Contractor’s position paper noted that: (1) the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position; and (2) the Provider had failed to respond to any of the Medicare Contractor’s requests for that Medicaid eligible days listing.

⁷ On March 29, 2021, this issue was transferred to Case No. 20-1336GC.

⁸ (Emphasis added.)

On **November 1, 2024**, the Medicare Contractor timely filed a Jurisdictional Challenge⁹ with the Board over Issue 5 requesting that the Board dismiss this issue. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider *failed* to file any response.

On **November 1, 2024**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. (“QRS”).

On **April 28, 2025**, QRS timely filed its final position paper.

On **April 28, 2025**, almost 5 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.”¹⁰ The Listing was 17 pages with roughly 2,873 Medicaid eligible days. QRS’ filing did not explain why the listing of so many days (again around 2,873 days) was being submitted at this late date or why it was not final (*i.e.*, why it was “pending finalization”) at this late date, *more than 7 years after the fiscal year at issue had closed*. NOTE—the roughly 2,873 included in this belated listing is *exponentially* larger than the original *estimated* impact of 150 days included with the appeal request.

B. Description of Issue 5 in the Appeal Request

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the 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

⁹ Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled “Board Jurisdiction” but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement *per se*, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) (“*Auburn*”). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 (“The Board will dismiss appeals that fail to *meet the timely filing requirements and/or jurisdictional requirements.*”); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

¹⁰ (Emphasis added.)

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): 5,15,16,S-D

Estimated Reimbursement Amount: \$53,000¹¹

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the *Jewish Hospital* case¹² 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

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

¹¹ Appeal Request at Issue 5.

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 (Sept. 1, 2021).

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.¹⁴

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.¹⁵ The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a 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 either the initial appeal or the position papers.

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

No Access to Data

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

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

¹⁴ Jurisdictional Challenge at 5 (Nov. 1, 2021).

¹⁵ Board Rule 44.4.3, v. 3.2 (Dec. 2023).

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

(3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.¹⁶

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

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

Rule 25 Preliminary Position Papers¹⁷

COMMENTARY:

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

25.1 Content of Position Paper Narrative

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

¹⁶ (Bold emphasis added.)

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

25.1.1 The Provider's Position Paper

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

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R.

§ 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

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

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on December 11, 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.¹⁸

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carry[s the] burden of production of evidence and burden of proof by 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

¹⁸ (Emphasis added.)

- 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 1, 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.¹⁹ Significantly, the position paper did *not* include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the “estimated impact” included with its appeal request (i.e., the estimated impact of \$53,295 based on an estimated 150 days). The Provider’s complete briefing of this issue in its position paper is as follows:

Calculation of Medicaid Eligible Days

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

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

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

[T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a

¹⁹ Provider’s Preliminary Position Paper at 8.

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.

On November 1, 2024, the Medicare Contractor filed a Jurisdictional Challenge, requesting dismissal of DSH Payment – 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 25.2.2. 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.²⁰

Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Jurisdictional Challenge. However, the Provider **failed** to timely respond to that Motion by the December 1, 2024 filing deadline (*i.e.*, 30 days after November 1, 2024).

However, on April 28, 2025 (nearly 5 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 17 pages with roughly 2,873 Medicaid eligible days. QRS’ filing did not explain why the listing of so many days (again around 2,873 days) was being submitted at this late date or why it was not final (*i.e.*, why it was “pending finalization”) at this late date, **more than 7 years after the fiscal year at issue had closed**. NOTE—the roughly 2,873 included in this belated listing is *exponentially* larger than the original estimate of 150 days included with the appeal request. Regardless, this filing was nearly 5 months past the deadline for responding to the Jurisdictional Challenge *and, more importantly, was roughly 3½ year past the deadline for including it with its preliminary position paper* since the position paper deadline was August 5, 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

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

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).

Moreover, the Board rejects the Provider's attempt to label the April 28, 2025 filing as a "Supplement to Position Paper" and does not accept that filing because:

1. The alleged "Supplement" was filed *more than 3½ 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 *more than 5 months after the deadline* for filing a response to the Jurisdictional Challenge.
2. The alleged "Supplement" fails to explain the following critical information: (a) *why* it was being filed so late (*i.e.*, upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the roughly 2,873 days was not previously available, *in whole or in part* (*i.e.*, it is not clear why the Provider failed to identify a single day at issue until more than 4 years after this appeal was filed and more than 7 years after the fiscal year at issue had closed); and (c) why the listing still was *not* a "*final*" listing at this late date.
3. Neither the Board Rules nor the December 11, 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* 2,873 days listed in the alleged "Supplement" is, without explanation, *exponentially* larger than the original estimated 150 days included with the appeal request).²¹

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

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

Based on the above, the Board finds that the Provider has failed to comply with the Board’s procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(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.²³

B. 1115 Waiver Days

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

The appeal was filed with the Board in December 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...

²² (Emphasis added.)

²³ See also *Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022): The Board acts reasonably, and not arbitrarily and capriciously, when it applies its “claims-processing rules faithfully to [a provider’s] appeal.” *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide “[a]n explanation [] for each specific item under appeal.” 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that “[s]ome issues may have multiple components,” and that “[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible.” Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a “common example” of an appeal involving issues with “multiple components” that must be appealed as “separate issue[s] and described as narrowly as possible.” Board Rules §§ 8.1, 8.2.

(2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final...determination under appeal, including an account of...

(i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]

(ii) How and why the provider believes Medicare payment must be determined differently for each disputed item...²⁴

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

The following information and supporting documentation must be submitted for each issue raised in the appeal request.

- An issue title and a concise issue statement describing:
 - the adjustment, including the adjustment number,
 - the controlling authority,
 - why the adjustment is incorrect,
 - how the payment should be determined differently,
 - the reimbursement effect, and
 - the basis for jurisdiction before the [Board].

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

Several examples are identified below, but these are not exhaustive lists of categories or issues.

A. Disproportionate Share Hospital Payments

Common examples include: . . . ***Section 1115 waiver days (program/waiver specific)***. . .²⁵

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.²⁶

²⁴ 42 C.F.R. § 405.1835(b).

²⁵ (Bold and italic emphasis added).

²⁶ See 73 Fed. Reg. 30190 (May 23, 2008).

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

(e) Adding issues to the hearing request. After filing a hearing request... a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –

...

(3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider 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, 2000.²⁷ Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program and not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

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

(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i)

²⁷ 65 FR 47054, 47087 (Aug. 1, 2000).

of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

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

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

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

Finally, even in the Provider’s final position paper, the Provider fails to identify what § 1115 waiver program(s) are involved and whether or not the § 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as “days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act” and the patients underlying those days are “deemed eligible for Medicaid” based on “the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered.” Rather, the final position paper is perfunctory in that it only makes perfunctory conclusions.²⁸

²⁸ For example, QRS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that “the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool.” However, QRS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is QRS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? QRS fails to brief the merits of its claims and fails to establish the Board’s jurisdiction

Again, the Provider failed to so develop its position paper notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Nov. 2021) as applied via Board Rule 27.2.

The Board’s finding that neither the appeal request nor final position paper met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.²⁹ In that case, the provider’s issue was tied to improper calculation to DSH payment and read in part, “[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the ‘Medicare Fraction’ for purposes of the calculation of the provider’s [disproportionate share] payment . . .”³⁰ The Court found that “[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently.”³¹ The Court found that this 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.³² Here, the Board makes the same finding based on similarly *overly generalized language*.

* * * * *

Based on the foregoing, the Board has dismissed the remaining issue in this case – (Issue 5). As no issues remain, the Board hereby closes Case No. 21-0348 and removes it from the Board’s docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

For the Board:

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

5/1/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the final position paper references “uncompensated care pool.”

²⁹ No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

³⁰ *Id.* at *11.

³¹ *Id.*

³² *Id.*



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Raphoel Muller
Complete Care at Wayne Hills
130 Terhune Drive
Wayne, NJ 07470

RE: ***Notice of Dismissal***

Complete Care at Wayne Hills (Provider Number 31-5110)
FFY 2025
Case Number: 25-0769

Dear Mr. Muller,

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:

Procedural History for Case No. 25-0769

On **November 15, 2024**, the Provider filed an individual appeal request. The appeal request contained one issue:

1. Quality Reporting Program ("QRP") APU Penalty

The Final Determination Document submitted is the text of an email from the QRP Help Desk's Valerie Denning, presumably to the Provider. It reads:

Thank you for providing information regarding the reconsideration request for CCN 315110.

The request was submitted to an incorrect email address. Per your documentation, the email address used was snfqrpreconsideration@cms.hhs.gov. The correct email address is SNFQRPreconsiderations@cms.hhs.gov – Reconsiderations (plural).

I'm sorry, we never received this request so it was not reviewed by CMS, and as a result, there is no outcome.

On **November 18, 2024**, 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 its Letter of Representation:

Due Dates and Required Documents

December 3, 2024

Representation Letter – The Letter of Representation is insufficient as filed. A representation letter must be dated; must include the Provider Name/Provider Number and Fiscal or Calendar Year in dispute and PRRB Case Number. You must also identify the Representative's Name; Organization; Mailing Address; Telephone Number and Email Address. Please re-submit the representation letter in accordance with the instructions set forth in Board Rule 5.4.

MAC's Contentions

On **November 21, 2024**, the Board received a letter from the Medicare Contractor ("MAC") stating that the Provider violated Board Rule 7.1.1 by failing to submit a proper final determination. The MAC also argued that the Provider violated Board Rule 7.1.2.4 by failing to attach the original decision on the payment reduction by CMS and the final reconsideration decision. The MAC requested that "the Board instruct the Provider to submit the missing documentation along with their complete letter of representation or dismiss the Provider's appeal for incomplete filing."¹

Provider's Response

On **November 27, 2024**, the Board received a letter from the Provider that "serves as the representation letter" for the appeal. It provided all the information requested in the Board's Notice of Case Acknowledgement and Critical Due Dates for the representation letter. It also provided what could be interpreted as response to MAC's letter, stating in pertinent part:

Complete Care at Wayne Hills submitted an appeal of reduction of payment on July 11, 2024. No response was received and upon follow-up were made aware that the email address that the reconsideration was sent to had a missing letter. There was no email kicked back, to alert the center of the email not being received. The original email for reconsideration was sent on July 11th, this email contained the information required and was sent prior to the deadline. Please note that reconsideration was sent as

¹ Novitas Letter Regarding Incomplete Appeal Request at 2 (Nov. 21, 2024).

the facility was in compliance with reporting as seen in the uploaded documents.

We ask that the determination be reconsidered as the sender had no way of knowing that the email did not go through and the facility was compliant in reporting.²

Finally, on January 6, 2025, the Provider filed their preliminary position paper. Included as Exhibit P-3 was CMS's July 1, 2024 letter of "Non-Compliance that May Result in a 2% Reduction to Your FY 2025 Annual Payment Update for CCN 315110".

Decision of the Board:

Board Rule 7 (Dec. 2023) reads, in pertinent part:

Rule 7 Support for Appealed Final Determination, Availability of Issue-Related Information and Basis for Dissatisfaction

The provider must support the determination being appealed . . . consistent with 42 C.F.R. § 405.1835(b) or (d) as applicable.

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.

7.1 Final Determination

7.1.1 General Requirements

. . .

Include a copy of the **final** determination, such as the NPR, revised NPR, exception determination letter, Federal Register notice, or quality reporting period reduction decision. Note that preliminary determinations are not appealable.

In their initial appeal request, the Provider failed to provide a copy of the final determination or an explanation of why the final determination was missing. The explanation of why the final determination was missing did not come until the November 27, 2024 corrected Representative Letter, and the Board finds that a "typo" on the email address to request reconsideration is not "through no fault of its own" for the Provider. Therefore, the Board finds the Provider violated Board Rule 7.1.1 by not including a copy of the final determination.

² Provider's Representation Letter and Response at 1 (Nov. 27, 2024).

Board Rule 7.1.2.4 provides additional requirements for providers appealing from Quality Reporting Payment Reduction Decisions, such as in the instant appeal. It reads:

7.1.2.4 Quality Reporting Payment Reduction Decision

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

Here, as previously noted, there is no final decision from which to appeal, as the Provider's request for reconsideration was sent to an invalid email address. The preliminary decision was not included with the appeal request and was not received by the Board until it was included as Exhibit P-3 to the Provider's Preliminary Position Paper filed on January 6, 2025, nearly 2 months after the receipt of the individual appeal request. Therefore, the Board finds that the Provider failed to produce the documents necessary for an appeal of Quality Reporting Payment Reduction in violation of Board Rule 7.1.2.4.

Board Rule 41.2 permits the Board to dismiss cases on its own motion:

The Board may dismiss a case or an issue on its own motion:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
- ***upon failure of the provider or group to comply with Board procedures or filing deadlines*** (see 42 C.F.R. § 405.1868);
- 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.³

In summary, the Board hereby dismisses the appeal as the Provider failed to comply with Board Rule 7.1.1 and 7.1.2.4. The Board hereby closes Case No. 25-0769 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.

³ (Emphasis added.)

Board Members Participating:

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

For the Board:

5/1/2025

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-L)
Wilson C. Leong, Esq., Federal Specialized 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***
Baylor Scott & White All Saints Medical Center Forth Worth
Prov. No. 45-0137
FYE 00/30/2015
Case No. 20-0090

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 20-0090. Set forth below is the decision of the Board to dismiss the sole remaining issue in this appeal challenging the Provider’s reimbursement related to its Medicaid Eligible Days.

Background

A. Procedural History for Case No. 20-0090

On **April 3, 2019**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end September 30, 2015.

On **October 2, 2019**, the Provider filed this individual appeal request. The initial Individual Appeal Request contained two (2) issues:

1. SSI Percentage (Provider Specific) – ***withdrawn on March 1, 2025***
2. SSI Percentage – ***transferred on April 23, 2020***
3. SSI Fraction Medicare Managed Care Part C Days – ***transferred on April 23, 2020***
4. SSI Fraction Dual Eligible Days – ***transferred on April 23, 2020***
5. Medicaid Eligible Days
6. Medicaid Fraction Medicare Managed Care Part C Days – ***transferred on April 23, 2020***
7. Medicaid Fraction Dual Eligible Days – ***transferred on April 23, 2020***
8. Uncompensated Care Distribution Pool– ***transferred on April 23, 2020***
9. 2 Midnight Census IPPS Payment Reduction – ***transferred on April 23, 2020***
10. Standardized Payment Amount – ***transferred on April 23, 2020***

On **October 10, 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 25.¹*

On **May 27, 2020**, the Provider filed its Preliminary Position Paper.

On **September 15, 2020**, the Medicare Contractor timely filed its Preliminary Position Paper.

On **August 12, 2021**, the Medicare Contractor filed a Jurisdictional Challenge over Issue 1.

On **August 14, 2024**, the Board issued the Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

Provider's Final Position Paper – *For each remaining issue, the position paper **must** state the material facts that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), **and provide arguments applying the material facts** to the controlling authorities. This filing **must** also include **any exhibits** the Provider will use to support its position. See Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.²*

On **February 20, 2025**, the Provider filed its Final Position Paper.

On **March 7, 2025**, the Provider filed a Redacted Medicaid Eligible Days Listing.

On **March 12, 2025**, the Medicare Contractor filed its Final Position Paper.

On **March 18, 2025**, the Medicare Contractor filed a Jurisdictional Challenge³ with the Board over Issues 1 and 5 requesting that the Board dismiss both issues.

¹ (Emphasis added.)

² (Emphasis added.)

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

On **March 31, 2025**, the Provider withdrew Issue 1.

On **April 1, 2025**, the Provider filed a response to the Jurisdictional Challenge.

B. Description of Issue 5 in the Appeal Request – Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations. The Provider describes Issue 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, 5, 7, 31, s-d

Estimated Reimbursement Amount: \$46,000⁴

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the *Jewish Hospital* case⁵ 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.⁶

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).

⁴ Appeal Request at Issue 5.

⁵ *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994).

⁶ Provider’s Preliminary Position Paper at 7-8.

Medicare Contractor's Contentions

The Medicare Contractor requests that the Board dismiss the DSH – Medicaid Eligible Days issue arguing:

The MAC argues 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 27.⁷

The Medicare Contractor notes that position papers must include a fully developed narrative and all exhibits, but the neither the preliminary nor final position paper in this case contained a finalized eligibility day listing.⁸ At the time of the Jurisdictional Challenge, the Provider had not yet submitted complete, unredacted listing to the Medicare Contractor.⁹

Additionally, the Medicare Contractor contends the Provider is attempting to add the Section 1115 Waiver days issue improperly and untimely. The Section 1115 Waiver days were not part of the initial appeal request and untimely added via its Final Position Paper.¹⁰

Provider's Jurisdictional Response

The Provider filed a Jurisdictional Response on April 1, 2025. The response argues that the Section 1115 Waiver Days currently claimed were not untimely added. It claims the issue statement in the appeal argued that the Medicare Contractor “failed to include all Medicaid eligible days, *including but not limited to* Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.”¹¹ It claims the “including but not limited to” language “makes clear that the Provider appealed all Medicaid eligible days, including section 1115 waiver days.”¹²

The Provider then discusses the Board's Rules, and **incorrectly** claim the July 1, 2015 version of these rules “were the instructions in effect at the time the Provider filed its appeal.”¹³ It argues that the applicable Board Rules do not specify that Section 1115 Waiver Days are to be appealed as separate issues.

The Board notes that the instant appeal was filed on October 2, 2019. Thus, Board Rule 8 (v. 2.0), which was effective August 29, 2018, is applicable. Board Rule 8.1 **specifically** notes that Section 1115 waiver days is a separate issue:

⁷ Jurisdictional Challenge at 6.

⁸ *Id.* at 10.

⁹ *Id.* at 12.

¹⁰ *Id.* at 12-14.

¹¹ Jurisdictional Response at 1 (emphasis in original).

¹² *Id.*

¹³ *Id.* at 2.

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.

The Jurisdictional Response does not address the failure to include an eligibility listing with its position papers, and merely notes “the Provider submitted a redacted listing on March 7, 2025, and an unredacted listing to the MAC.”¹⁴

Decision of the Board

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

As set forth below, the Board hereby *dismisses* the Provider’s sole 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 either the initial appeal or the position papers.

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

No Access to Data

If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to

¹⁴ *Id.* at 4.

payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

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

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

(3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.¹⁵

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:

¹⁵ (Bold emphasis added.)

Rule 25 Preliminary Position Papers¹⁶

COMMENTARY:

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

25.1 Content of Position Paper Narrative

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

25.1.1 The Provider's Position Paper

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

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

¹⁶ (Underline emphasis added to these excerpts and all other emphasis in original.)

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 2, 2019 included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

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

The hospital has the burden of furnishing data adequate to prove eligibility for *each* Medicaid patient *day claimed* under this paragraph, *and* of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.¹⁷

¹⁷ (Emphasis added.)

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

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

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

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

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

On May 27, 2020, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.¹⁸ 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 \$45,937 based on an estimated 150 days). The Provider’s complete briefing of this issue in its position paper is as follows:

Calculation of Medicaid Eligible Days

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

The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits:

¹⁸ Provider’s Preliminary Position Paper at 11 (May 27, 2020).

Cabell Huntington Hospital, Inc. v. Shalala, 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F. 3d 1261 (9th Cir. 1996).

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

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

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

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

On **March 18, 2025**, the Medicare Contractor filed a Jurisdictional Challenge, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); 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.¹⁹

¹⁹ See also Board’s jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency’s calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

The Provider's Jurisdictional Response does not address the failure to include an eligibility listing with its position papers, and merely notes "the Provider submitted a redacted listing on March 7, 2025, and an unredacted listing to the MAC."²⁰

The Redacted Listing was 20 pages with hundreds of Medicaid eligible days. QRS' filing did not explain why the listing of so many days (compared to the estimated 150 days alleged in its position papers) was being submitted at this late date. The Board notes that the days included in this belated listing is *exponentially* larger than the original estimate of 150 days included with the position papers. Regardless, this filing was submitted ***nearly five years past the deadline for including it with its preliminary position paper*** since the position paper deadline was May 29, 2020.

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

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for *each* Medicaid patient day claimed"²¹ and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provide the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board 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.²²

²⁰ *Id.* at 4.

²¹ (Emphasis added.)

²² See also *Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):
The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation []for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o

B. 1115 Waiver Days

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

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

(b) Contents of request for a Board hearing on final contractor determination. The provider's request for a Board hearing...must be submitted in writing to the Board, and the request must include...

(2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final...determination under appeal, including an account of...

(i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]

(ii) How and why the provider believes Medicare payment must be determined differently for each disputed item...²³

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

The following information and supporting documentation must be submitted for each issue raised in the appeal request.

- An issue title and a concise issue statement describing:
 - the adjustment, including the adjustment number,
 - the controlling authority,
 - why the adjustment is incorrect,
 - how the payment should be determined differently,
 - the reimbursement effect, and

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.

²³ 42 C.F.R. § 405.1835(b).

- the basis for jurisdiction before the [Board].

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

Several examples are identified below, but these are not exhaustive lists of categories or issues.

A. Disproportionate Share Hospital Payments

Common examples include: . . . ***Section 1115 waiver days (program/waiver specific).*** . . .²⁴

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.²⁵

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, 2000.²⁶ Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program and not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

²⁴ (Bold and italic emphasis added).

²⁵ See 73 Fed. Reg. 30190 (May 23, 2008).

²⁶ 65 FR 47054, 47087 (Aug. 1, 2000).

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

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

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

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

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

Regardless, even if the Provider had included in its appeal request (which it did not), the Provider failed to properly develop the issue in its position paper filings. First, the Provider's preliminary position paper does not even mention § 1115 waiver days (much less even identify the specific 1115 waiver day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (2018). As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* § 1115 waiver days sub-issue.

Finally, even in the Provider's final position paper, the Provider fails to identify what § 1115 waiver program(s) are involved and whether or not the § 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered."²⁷ Rather, the final position paper is perfunctory in that it only makes perfunctory conclusions.²⁷ 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*.²⁸ 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 . . ."²⁹ 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."³⁰ 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.³¹ Here, the Board makes the same finding based on similarly *overly generalized language*.

* * * * *

Based on the foregoing, the Board has dismissed the sole remaining issue in this case – (Issue 5). As no issues remain, the Board hereby closes Case No. 20-0090 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

For the Board:

²⁷ 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."

²⁸ No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

²⁹ *Id.* at *11.

³⁰ *Id.*

³¹ *Id.*

Kevin D. Smith, CPA

Ratina Kelly, CPA

Nicole E. Musgrave, Esq.

Shakeba DuBose, Esq.

5/5/2025

X Ratina Kelly

Ratina Kelly, CPA

Board Member

Signed by: PIV

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Stephanie Webster, Esq.
Ropes & Gray, LLP
2099 Pennsylvania Ave NW
Washington, DC 20006

RE: ***Expedited Judicial Review Determination***

25-0495GC Univ of Rochester CY 2011 Post-Allina II DSH Part C Days CIRP Group

Dear Ms. Webster:

The Provider Reimbursement Review Board (“Board”) has reviewed the Providers’ Petition for Expedited Judicial Review (“EJR”) filed on April 16, 2025 in the above-referenced group appeal. The Board’s decision on jurisdiction and EJR is set forth below.

Background and Issue:

On October 29, 2024, the Board received a request to establish a Common Issue Related Party (“CIRP”) group for University of Rochester’s CY 2011. The CIRP group is appealing from original Notices of Program Reimbursement (“NPRs”) which implement the final rule published in the June 9, 2023 Federal Register (“June 2023 Final Rule”)¹ as it pertains to the Providers’ FYE 12/31/2011 cost reports.

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 the *Allina* litigation. The Providers contend that “part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction for patients eligible for Medicaid.”² The Providers are seeking to challenge the CMS policy adopted in the June 2023 Final Rule to be applied *retroactively* for periods prior to October 1, 2013.

¹ 88 Fed. Reg. 37772 (June 9, 2023).

² Issue Statement at 1 (Oct. 29, 2024).

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 prospective payment system (“PPS”).³ Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.⁴

The PPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.⁵ This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.⁶

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage (“DPP”).⁷ As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to be paid to a qualifying hospital.⁸ The DPP is defined as the sum of two fractions expressed as percentages.⁹ Those two fractions are referred to as the “Medicare/SSI fraction” and the “Medicaid fraction.” 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 ¹⁰

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.¹¹

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

⁴ *Id.*

⁵ See 42 U.S.C. § 1395ww(d)(5).

⁶ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

⁷ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(l).

⁸ See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

⁹ See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

¹⁰ (Emphasis added.)

¹¹ 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.¹²

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.¹³

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 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 Secretary¹⁴ 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

¹² (Emphasis added.)

¹³ 42 C.F.R. § 412.106(b)(4).

¹⁴ of Health and Human Services.

patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].¹⁵

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.¹⁶

With the creation of Medicare Part C in 1997,¹⁷ 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.¹⁸ 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. These 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*¹⁹

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.²⁰

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.²¹ In the FFY 2005 IPPS final rule, the Secretary purportedly changed her 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."²² In response to a comment regarding this change, the Secretary explained that:

¹⁵ 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).

¹⁶ *Id.*

¹⁷ 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. § 1395w-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.

¹⁸ 68 Fed. Reg. 27154, 27208 (May 19, 2003).

¹⁹ *Id.* (italics emphasis added).

²⁰ 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).

²¹ 69 Fed. Reg. 28196, 28286 (May 18, 2004).

²² 69 Fed. Reg. at 48916, 49099 (Aug. 11, 2004).

. . . 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.²³

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.²⁴ 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).²⁵ 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” in reference to Medicare Advantage (Part C).²⁶

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.

²³ *Id.* (emphasis added).

²⁴ 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

²⁵ *Id.* at 47411.

²⁶ 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).

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.²⁷

In 2014, the U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),²⁸ 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 the FFY 2005 IPPS rule.²⁹ 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 2004.³⁰ 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 fiscal years 2014 and beyond.³¹ 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 fiscal year 2012 which included Part C days.³² A number of hospitals appealed this action.³³ In *Azar v. Allina Health Services* ("*Allina II*"),³⁴ 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.³⁵ 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."³⁶ 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.³⁷

²⁷ *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).

²⁸ 746 F. 3d 1102 (D.C. Cir. 2014).

²⁹ *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.").

³⁰ *Id.* at 2011.

³¹ 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).

³² *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).

³³ 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)).

³⁴ 139 S.Ct. 1804 (2019).

³⁵ *Id.* at 1817.

³⁶ *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.

³⁷ 139 S.Ct at 1814.

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 2013.³⁸ 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.³⁹

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.⁴⁰ Relevant to the instant EJR Request, the June 2023 Final Rule provides the following guidance on the extent to which it is to be applied *retroactively*:

[T]he 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.⁴¹

Further, 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

³⁸ 85 Fed. Reg. 47723 (Aug. 6, 2020).

³⁹ CMS Ruling 1739-R at 1-2.

⁴⁰ 88 Fed. Reg. 37772 (June 9, 2023).

⁴¹ *Id.* at 37775 (emphasis added).

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
2. “We do not agree that it is arbitrary or capricious to treat hospitals’ Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II*. It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital’s appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary’s interpretation set forth in this final action.**”⁴⁴
3. “Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant

⁴² 88 Fed. Reg. at 37788 (emphasis in original).

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

⁴⁴ *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).

to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions **contained in the NPRs or revised NPRs.*** Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights.* Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised **NPRs** will provide hospitals with a **vehicle to appeal** the new final action* even if the Medicare fraction or DSH payment does not change numerically.”⁴⁵

4. “*When the Secretary’s treatment of Part C days in this final action is reflected **in NPRs and revised NPRs**, providers, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], will be able to challenge the agency’s interpretation **by appealing those NPRs and revised NPRs**.* While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings.”⁴⁶

The above discussion in the preamble to the June 9, 2023 Final Rule makes clear that hospitals covered by that Final Rule would have appeal rights maturing with the yet-to-be-issued NPRs (original or revised) that would apply the finalized policy.

Providers’ Position:

A. Providers’ Appeal Request

The Providers’ appeal request includes a “Statement of Jurisdiction” asserting that the Providers have met the applicable statutory conditions for appeal because they are dissatisfied with their original NPRs which apply the June 9, 2023 retroactive final rule related to Part C days. They cite language from that final rule which outlined Providers’ ability to challenge this final rule once they were issued NPRs implementing the rule.⁴⁷

The “Statement of Issue” included with the appeal requests state that the issue concerns the “proper treatment in the Medicare [DSH] calculation of days for [Medicare Part C patients] in the aftermath of the *Allina II* litigation.”⁴⁸ The Providers contend that the part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.⁴⁹

The Providers characterized the relevant background facts as follows:

1. In the FY 2005 IPPS Final Rule, CMS first announced a policy change to count Part C days “in the SSI fraction and to exclude those days from the numerator of the Medicaid

⁴⁵ *Id.* at 37788 (emphasis added).

⁴⁶ *Id.* (emphasis added).

⁴⁷ Appeal Request, Statement of Jurisdiction (citations omitted).

⁴⁸ Appeal Request, Statement of Issue at 1.

⁴⁹ *Id.*

fraction.”⁵⁰

2. In *Allina I*, the D.C. Circuit vacated that policy change.⁵¹
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 2004 rule in 2012 SSI fractions published in 2014 was procedurally invalid” because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking. The Supreme Court’s decision “did not address the D.C. Circuit’s alternate ruling that the readopted policy was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the policy could not ‘take effect’ under the terms of the statute until after proper notice-and-comment rulemaking.”⁵²
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, 2013.⁵³

Based on the above, the Providers maintain that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule “is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, exceeds the agency’s statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence.”⁵⁴

B. Providers’ Petition for EJR

The Providers have requested EJR over the “post-*Allina* retroactive Part C policy issue” because they believe they have met the requirements for a hearing before the Board, but the Board lacks “the authority to decide the substantive and procedural validity of CMS’ final rule published in the Federal Register on June 9, 2023.”⁵⁵ It seeks a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.⁵⁶ “The Providers contend that the new, post-*Allina* retroactive part C days rule, applied in the original [NPRs] appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence.”⁵⁷ Since the Board is bound by this regulation,⁵⁸ it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² *Id.* (citing to 139 S. Ct. at 1816).

⁵³ *Id.*

⁵⁴ *Id.* (citing to 5 U.S.C. § 706(2)).

⁵⁵ Providers’ Petition for Expedited Judicial Review at 13 (Apr. 16, 2025).

⁵⁶ *Id.* at 16.

⁵⁷ *Id.* at 1-2.

⁵⁸ 42 C.F.R. § 405.1867.

On April 23, 2025, the Medicare Contractor's representative, Federal Specialized Services, filed a timely response to the Request for EJR in this case. It simply advised that "a jurisdictional challenge will not be filed. A substantive claim challenge will not be filed. The MAC will not challenge Provider's request for expedited judicial review."⁵⁹

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 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;⁶⁰
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, \$50,000 or more.⁶¹

For this CIRP Group, the providers all appealed from original NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. All of the providers were directly added to the group within 180 days of the issuance of their NPRs and the amount in controversy exceeds \$50,000.

The Board finds that the Providers in Case No. 25-0495GC have all filed timely appeals from their original NPRs concerning the same common issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these NPRs. The Board also finds that the amount in controversy in the case exceeds \$50,000 as required by 42 C.F.R. § 405.1837(a)(3). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

⁵⁹ Response to Provider's Request for Expedited Judicial Review (Apr. 23, 2025).

⁶⁰ 42 U.S.C. § 1395oo(b) (referring to the provisions of subsection (a)); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).

⁶¹ 42 U.S.C. § 1395oo(b); 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 years in this case and that the Providers in this group appeal are entitled to a hearing before the Board;
- 2) Based upon the Providers' assertions regarding the Post-*Allina II* DSH 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 Post-*Allina II* DSH Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, is valid.

Accordingly, the Board finds that the question of the validity of the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes this case.

Board Members Participating:

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

FOR THE BOARD:

5/5/2025

X

Kevin D. Smith, CPA

Kevin D. Smith, CPA

Board Chair

Signed by: Kevin D. Smith -A

Enclosures: Schedule of Providers

cc: Danelle Decker, National Government Services, Inc. (J-K)
Wilson Leong, 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

Jaspreet Walia
Sonoma Specialty Hospital
501 Petaluma Avenue
Sebastopol, CA 95472

RE: ***Notice of Dismissal***
Sonoma Specialty Hospital (Provider Number 05-2057)
Case Number: 24-0129

Dear Ms. Walia:

The Provider Reimbursement Review Board (“Board” or “PRRB”) received Sonoma Specialty Hospital’s Individual Appeal Request in Case No. 24-0129 on November 3, 2023. On August 13, 2024, a Notice of Hearing was issued to the parties which required the Provider to file its Witness List by April 22, 2025 and set a hearing for May 22, 2025. A Witness List has not been received.

The Board staff attempted to contact the Provider’s Representative via email on April 14, 2025, and April 23, 2025 to inquire as to whether the Provider was still pursuing the appeal. A Notice of Potential Dismissal was issued by the Board Chair on April 28, 2025, which required a response by May 2, 2025, and advised that a failure to respond by the filing deadline would result in the dismissal of the case. To date, the Provider has not responded to any of the inquiries. The Provider’s last filing in this cause occurred on June 27, 2024 with the filing of its preliminary position paper.

Board Rule 41.2 (Dec. 2023) permits dismissal or closure of a case on the Board’s own motion:

- *if it has a reasonable basis to believe that the issues have been fully settled or **abandoned**;*
- upon failure of the provider or group to comply with Board procedures 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.***¹

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

¹ (Emphasis added.)

(a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.

(b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—

- (1) Dismiss the appeal with prejudice;
- (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
- (3) Take any other remedial action it considers appropriate.

The Provider failed to respond to the Board's Notice of Potential Dismissal. Accordingly, the Board hereby dismisses Case No. 24-0129 with prejudice and removes it from the Board's docket.

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

Board Members:

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

For the Board:

5/6/2025

X Kevin D. Smith, CPA

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

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

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***

Baylor University Medical Center, Prov. No. 45-0021, FYE 06/30/2014
Case No. 19-2263

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-1377. 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. 19-2263

On **January 29, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2014.

On **July 16, 2019**, the Board received the Provider's individual appeal request. The Individual Appeal Request contained five (10) issues:

1. DSH Medicaid Fraction Dual Eligible Days¹
2. Uncompensated Care ("UCC") Distribution Pool²
3. DSH Payment – Medicaid Eligible Days
4. 2 Midnight Census IPPS Payment Reduction³
5. DSH Payment/SSI Percentage (Provider Specific)⁴
6. DSH/SSI Fraction Medicare Managed Care Part C Days⁵
7. DSH/SSI Percentage⁶

¹ On February 24, 2020, this issue was transferred to PRRB Case No. 17-0808GC.

² On February 4, 2025, this issue was withdrawn.

³ On February 24, 2020, this issue was transferred to PRRB Case No. 18-1420GC.

⁴ On March 31, 2025, this issue was withdrawn.

⁵ On February 24, 2020, this issue was transferred to PRRB Case No. 19-2420GC.

⁶ On February 24, 2020, this issue was transferred to PRRB Case No. 17-0806GC.

8. Standardized Payment Amount⁷
9. DSH/SSI Fraction Medicare Managed Care Part C Days⁸
10. DSH/SSI Fraction Dual Eligible Days⁹

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

Provider's Preliminary Position Paper – *For each issue*, the position paper **must** state the material facts that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and provide arguments applying the material facts*** to the controlling authorities. This filing **must** include ***any exhibits*** the Provider will use to support its position and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.¹⁰

On **March 11, 2020**, the Provider filed its preliminary 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

⁷ On February 24, 2020, this issue was transferred to PRRB Case No. 19-1970GC.

⁸ On February 24, 2020, this issue was transferred to PRRB Case No. 19-2420GC.

⁹ On February 24, 2020, this issue was transferred to PRRB Case No. 17-0806GC.

¹⁰ (Emphasis added).

calculated to include all hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.

Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its 2014 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.¹¹

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

On **March 9, 2021**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 8. The Provider did not file a response to the jurisdictional challenge.

On **May 9, 2023**, the Provider requested a Change of Representative to Quality Reimbursement Services, Inc

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

Provider's Final Position Paper – *For each remaining issue*, the position paper **must** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and provide arguments applying the material facts*** to the controlling authorities. This filing **must** *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 27 for more specific content requirements.*¹²

On **February 4, 2025**, the Provider withdrew Issue 2.

On **February 7, 2025**, the Provider timely filed its final position paper. The following is the Provider's ***complete*** position on Issue 3 set forth therein:

¹¹ Provider's Preliminary Position Paper at 7-8. Note the Provider's Preliminary Position Paper was submitted as a hardcopy and received by the Board on March 11, 2020.

¹² (Emphasis added).

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 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, the Provider contends that the total number of days reflected in its 2015 cost report does not reflect an accurate number of Medicaid eligible days, as 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. *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")*.¹³

On **February 20, 2025**, the Provider submitted a redacted listing of 1115 waiver days.

On **February 27, 2025**, the Medicare Contractor timely filed its final position paper.

On **March 21, 2025**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 3.

On **March 31, 2025**, the Provider withdrew Issue 5.

The Provider filed a timely response to the jurisdictional challenge on **April 1, 2025**.

B. Description of Issue 3 in the Appeal Request

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

The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.

The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.¹⁴

¹³ Provider's Final Position Paper at 9-10 (emphasis added).

¹⁴ Issue Statement at 5 (July 16, 2019).

The Provider estimated the reimbursement impact of the issue at \$70,423 based on an increase of 150 additional Medicaid days but failed to include a list of the additional days.¹⁵

MAC's Jurisdictional Challenges

Issue 3 – DSH Payment – Medicaid Eligible Days

The Medicare Contractor contends that this issue should be dismissed because the Provider failed to 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.

The Medicare Contractor notes that a Medicaid eligible days listing was never received with the Provider's preliminary position paper. The Medicare Contractor further notes that the Provider failed to submit either a redacted or unredacted listing of additional Medicaid eligible days with its final position paper.¹⁶

The Medicare Contractor contends 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 and final position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. The Provider has not submitted accurate and sufficient data to demonstrate that patients were eligible for Medicaid on the claimed patient hospital days or identified as to why the data is not yet available or when it will become available.¹⁷

Additionally, the Medicare Contractor argues this issue should be dismissed because the Provider is attempting to untimely and improperly add the issue of Section 1115 waiver days as a sub-issue via its final position paper filed on February 7, 2025. The Medicare Contractor issued the Provider's NPR on January 29, 2019. In accordance with 42 C.F.R. § 415.1835(e), the deadline for adding issues to the appeal was September 26, 2019. The issue was informally added through the Provider's final position paper, more than five years after the filing deadline to add an issue.¹⁸

The Medicare Contractor contends that the Section 1115 Waiver Days issue is one component of the DSH issue that must be appealed as a separate issue. The Medicare Contractor 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 appeal

¹⁵ Issue Statement at 5 and Calculation Support at 6 (July 16, 2019).

¹⁶ Medicare Contractor's Jurisdictional Challenge at 7-8 (Feb. 7, 2025).

¹⁷ *Id.* at 9-10.

¹⁸ *Id.* at 10-12.

separately.¹⁹

Provider's Jurisdictional Responses

Issue 3 – DSH Payment – Medicaid Eligible Days

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:

Section 1115 waiver days are part and parcel of Medicaid eligible days. And whereas the [Medicare Contractor] states that the Section 1115 Waiver Days issue is one component of the DSH issue, the regulations at 42 C.F.R. § 405.1835 contain requirements for appealing an “issue” and a time limit on adding an “issue” – not on clarifying “sub-issues” or “components” of an issue. 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.²⁰

The Provider goes on to contend that the version of Board Rule 8 (July 1, 2015) that it alleges was effective when the Provider filed its appeal, makes no mention of “section 115 waiver days” nor even “Medicaid eligible days.” Thus, even if Rule 8’s extension to “components of issues” were valid (and the Provider contends it is not), the Provider had no notice that it was required to specify section 1115 waiver days in its appeal request, and it would be a denial of due process for the PRRB to dismiss the section 1115 waiver days component of its appeal of Medicaid eligible days.²¹

Finally, the Provider contends that prior to submission of the Provider’s Final Position Paper, the Fifth Circuit ruled that the statute and CMS’s own regulations require that CMS regard inpatient days attributable to an uncompensated care pool population as Medicaid eligible days, *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019). The Medicare Contractor is required by specific command of CMS to accept and audit the Provider’s section 1115 waiver days in providers’ Medicaid Fractions. Following a string of litigation defeats, including those in *Forrest General Hospital* and *Bethesda Health, Inc. v. Azar*, 980 F.3d 121 (D.C. Cir.2020), CMS issued Change Request 12669, Transmittal No. 11912 (March 16, 2023). The Provider asserts that under this Transmittal, the Medicare Contractor has the duty to accept the Provider’s listing

¹⁹ *Id.* at 12-13.

²⁰ Provider’s Jurisdictional Response at 1-2 (Apr. 1, 2025).

²¹ *Id.* at 2-3.

of section 1115 days and audit them. The Provider states that it submitted an redacted listing to the Medicare Contractor on February 24, 2025.²²

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

1. Section 1115 Waiver Days

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

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

(b) Contents of request for a Board hearing on final contractor determination. The provider's request for a Board hearing...must 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...*²³

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

²² *Id.* at 3-4.

²³ 42 C.F.R. § 405.1835(b).

The following information and supporting document must be submitted for each issue raised in the appeal request.

- An issue title and a concise issue statement describing:
 - the adjustment, including the adjustment number,
 - the controlling authority,
 - why the adjustment is incorrect,
 - how the payment should be determined differently,
 - the reimbursement effect, and
 - the basis for jurisdiction before the Board.²⁴

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

Several examples are identified below, but these examples are not exhaustive lists of categories or issues.

A. Disproportionate Share Hospital Payments

Common examples include, but are not limited to:

...

- ***Section 1115 waiver days (program/waiver specific)***²⁵

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.²⁶ 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

²⁴ v. 2.0 (Aug. 2018).

²⁵ (Bold and italic emphasis added).

²⁶ See 73 Fed. Reg. 30190 (May 23, 2008).

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, 2000.²⁷ Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program *and* not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction.²⁰ In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

²⁷ 65 FR 47054, 47087 (Aug. 1, 2000).

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.

Regardless, even if the Provider had included in its appeal request (which it did not), the Provider failed to properly develop the issue in its position paper filings. First, the Provider's preliminary position paper does not even mention § 1115 waiver days (much less even identify the specific 1115 waiver day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (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* § 1115 waiver days sub-issue.

Finally, even in the Provider's final position paper, the Provider fails to identify what § 1115 waiver program(s) are involved and whether or not the § 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the final position paper is perfunctory. 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 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*.²⁸ 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 . . ."²⁹ 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."³⁰ The Court found that this was a description of

²⁸ No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

²⁹ *Id.* at *11.

³⁰ *Id.*

the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.³¹ Here, the Board makes the same finding based on similarly *overly generalized language*.

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 27.2.³² 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.

2. *Medicaid Eligible Days*

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

³¹ *Id.*

³² 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).

(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.³³

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 Papers³⁴

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.)

³³ (Bold emphasis added.)

³⁴ (Underline emphasis added to these excerpts and all other emphasis in original.)

- and require no further documentation to be submitted.
- B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
- C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
- D. Provide a conclusion applying the material facts to the controlling authorities

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on July 19, 2019 included instructions on the content of the Provider's preliminary position paper consistent with the above 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.³⁵

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),

³⁵ (Emphasis added.)

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

On March 11, 2020, the Provider filed its preliminary position paper in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.³⁶ 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 \$70,423 based on an estimated 150 days).

On February 7, 2025, the Provider filed its final position paper. The position paper stated that a redacted version of the Provider’s Medicaid Eligible Days listing was to be sent under separate cover. Subsequently, on March 21, 2025, the Medicare Contractor filed a Jurisdictional Challenge. In its final position paper submitted to the Board on February 27, 2025, the Medicare Contractor states:

On 02/20/2025, the Provider sent a redacted listing to the MAC, which they claim on the cover page is “additional Medicaid Eligible Days” but the heading for the listing is “1115 Waiver days”

...

The Provider has never submitted to the MAC a list of the original Medicaid eligible days for this issue.³⁷

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”³⁸ and, pursuant to Board Rule 25, the Provider

³⁶ Provider’s Preliminary Position Paper at 8.

³⁷ Medicare Contractor’s Final position Paper at 17.

³⁸ (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 submit a finalized listing of Medicaid eligible days, notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is \$0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position 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.³⁹

Based on the foregoing, the Board dismisses the remaining issue, Issue 3, in this case. As no issues remain, the Board hereby closes Case No. 19-2263 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:

5/6/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

³⁹ See also *Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022): The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [] for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security 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***
Merit Health River Oaks, Prov. No. 25-0138, FYE 09/30/2018
Case No. 22-1201

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 22-1201. Set forth below is the decision of the Board to dismiss the 2 remaining issues in this appeal challenging the Provider’s Disproportionate Share Hospital (“DSH”) for SSI Percentage (Provider Specific) and Medicaid Eligible Days.

Background

A. Procedural History for Case No. 22-1201

On **February 3, 2022**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end September 30, 2018. The Provider is commonly owned/controlled by Community Health Systems, Inc. (“CHS”).

On **July 25, 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 Percentage¹
3. DSH Payment – Medicaid Eligible Days
4. DSH Payment – Medicare Managed Care Part C Days (SSI Fraction & Medicaid Fraction)²
5. DSH Payment –Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days, Eligible SSI Days for Which No Payment Was Made) – (SSI Fraction)³

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party (“CIRP”) group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **February 1, 2023**, the Provider transferred Issues 2, 4 and 5 to CHS CIRP groups.

¹ On February 1, 2023, this issue was transferred to PRRB Case No. 21-1206GC.

² On February 1, 2023, this issue was transferred to PRRB Case No. 20-2149GC.

³ On February 1, 2023, this issue was transferred to PRRB 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 **July 27, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

Provider's Preliminary Position Paper – *For each issue, the position paper **must** state the material facts that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), **and provide arguments applying the material facts** to the controlling authorities. This filing **must include any exhibits the Provider will use to support its position** and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.⁴*

On **March 20, 2023**, the Provider timely filed its preliminary position paper.

On **April 3, 2023**, the Board issued a new Critical Due Dates Notice, after Alert 23 was issued and normal operations resumed following the COVID-19 pandemic.

On **May 16, 2023**, the Medicare Contractor timely filed its preliminary position paper.

On **May 24, 2023**, the Medicare Contractor filed a Jurisdictional Challenge⁵ with the Board over Issues 1 and 3 requesting that the Board dismiss these issues. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. The Provider filed an untimely response on **June 27, 2023**.

On **June 26, 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. 21-1206GC – CHS CY 2018 DSH SSI Percentage CIRP Group

In their Individual Appeal Request, Provider summarizes its DSH Payment/SSI Percentage (Provider Specific) issue as follows:

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).

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.⁶

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,

⁶ Issue Statement at 1 (Jul. 25, 2022).

5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.⁷

On March 20, 2023, the Board received the Provider's preliminary position paper in Case No. 22-1201. The following is the Provider's **complete** position on Issue 1 set forth therein:

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.

The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of *Advocate Christ Medical Center, et al, v Xavier Becerra* (Appellants' reply brief included as Exhibit P-3).⁸

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is \$20,503.

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.

⁷ Group Issue Statement, Case No. 21-1206GC.

⁸ Provider's Preliminary Position Paper at 10 (Mar. 20, 2023).

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): 13,14,27,S-D

Estimated Reimbursement Amount: \$39,714⁹

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the *Jewish Hospital* case¹⁰ and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.¹¹ 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 [or Providers'] Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's [or Providers'] Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).¹²

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue. First, the MAC argues that the Provider has abandoned the SSI

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 8-9.

¹² *Id.* at 9.

realignment sub-issue: “[T]he Provider has abandoned the issue of SSI realignment and, therefore, it should be considered withdrawn. The Provider did not brief this issue within its preliminary position paper. . .”¹³ The MAC also argues the appeal is premature:

The decision to realign a hospital’s SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination.

. . .

The Provider’s appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board 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 issue in PRRB Case No. 21-1206GC 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 arguments regarding the merits of its claim in its Preliminary Position Paper.”¹⁷

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 2018 cost report does not

¹³ Jurisdictional Challenge at 6 (May 24, 2023).

¹⁴ *Id.* at 6-7.

¹⁵ *Id.* at 4-6.

¹⁶ *Id.* at 7.

¹⁷ *Id.* at 9.

reflect an accurate number of Medicaid eligible days. . .” The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats their appeal request.¹⁸

Provider’s Jurisdictional Response

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.¹⁹ 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 May 24, 2023. The Provider did not file a response until June 27, 2023, which was untimely and therefore, will not be considered by the Board.

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 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.”²⁰ The Provider’s legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare

¹⁸ *Id.* at 11.

¹⁹ Board Rule 44.4.3, v. 3.1 (Nov. 2021).

²⁰ Issue Statement at 1.

Contractor “did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i).”²¹ The Provider argues that “its’ SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . .” and it “. . . disagrees with the [Medicare Contractor]’s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary’s Regulations.”²²

The Provider’s DSH/SSI Percentage issue in group Case No. 21-1206GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 22-1201 is duplicative of the DSH/SSI Percentage issue in group 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, the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS’ regulation interpretation for the SSI percentage is clearly not “specific” to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is *specific to this provider*. Further, any alleged “systemic” issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.²³ Accordingly, the Provider’s reference to Issue 1 as “Provider Specific” and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged “provider specific” errors averred in Issue 1 are distinguished from the issues argued in Issue 2, and why those alleged “provider specific” errors should not be subsumed into the 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 25.2.²⁴ Moreover, the Board finds that the Provider’s Preliminary Position Paper failed to comply with Board Rule 25 (Nov. 1, 2021) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers “to be *fully* developed and include *all available* documentation necessary to provide a *thorough understanding* of the parties’ positions.” Here, it

²¹ *Id.*

²² *Id.*

²³ The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. See *Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). See also *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

²⁴ 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.

is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged “errors” and include *all* exhibits.

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

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, then provide the following information in the position papers:

1. *Identify* the missing documents;
2. *Explain why* the documents remain unavailable;
3. *State the efforts* made to obtain the documents; and
4. *Explain when* the documents will be available.

Once the documents become available, promptly forward them to the Board and the opposing party.²⁵

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

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

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

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that “What [MMA] section 951 cannot mean is that HHS must give hospitals data that

²⁵ (Emphasis added).

²⁶ Last accessed Oct. 15, 2024.

²⁷ (Emphasis added).

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*,²⁸ the Board finds that the SSI Provider Specific issue in Case No. 22-1201 and the group issue from the CHS CIRP group under Case No. 21-1206GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

Additionally, in its Preliminary Position Paper, the Provider states, “The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra [sic] (Appellants’ reply brief included as Exhibit P-3).” The Board finds that this incorporation by reference does not comply with the regulatory and Board rule requirements to *fully* develop the Provider’s position in the Preliminary Position Paper. Particularly, 42 C.F.R. § 405.1853 provides in pertinent part:

(2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper *must set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.²⁹

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.

²⁸ Again, the Board notes that the Provider failed to timely respond to the Jurisdictional Challenge.

²⁹ (Emphasis added).

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.³⁰

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:

³⁰ Individual Appeal Request, Issue 3.

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.*³¹

Similarly, with regard to position papers,³² Board Rule 25.2.1 requires that “the parties must exchange ***all available*** documentation as exhibits to fully support your position.”³³ 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.³⁴

³¹ (Emphasis added).

³² The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.

³³ (Emphasis added).

³⁴ (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 July 25, 2022 (over 2.5 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.³⁵ ***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.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.

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 July 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 in the manner prescribed by the Board, and the request must include...

³⁵ Provider's Preliminary Position Paper at 10.

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.

(2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final...determination under appeal, including an account of...

(i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]

(ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.³⁷

Board Rule 7.2.1 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 explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "...each contested component must be appealed as a separate issue and described as narrowly as possible...". The Rule goes on:

Several examples are identified below, but these examples are not exhaustive lists of categories or issues.

A. Disproportionate Share Hospital Payments

Common examples include, but are not limited to:

- ***Section 1115 waiver days (program/waiver specific).*** . . .³⁸

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.³⁹

³⁷ 42 C.F.R. § 405.1835(b).

³⁸ (Bold and italic emphasis added).

³⁹ See 73 Fed. Reg. 30190 (May 23, 2008).

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

(e) Adding issues to the hearing request. After filing a hearing request... a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –

...

(3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

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

In this regard, the Board notes that section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.⁴⁰ Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program and not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

(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

⁴⁰ 65 FR 47054, 47087 (Aug. 1, 2000).

a waiver approved under section 1115 of the Social Security Act.

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

Because the Provider did not raise the Section 1115 Waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The 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 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*.⁴¹ 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 . . ."⁴² 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."⁴³ 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.⁴⁴ Here, the Board makes the same finding based on similarly *overly generalized language*.

* * * * *

Based on the foregoing, the Board has dismissed the two (2) remaining issues in this case – (Issues 1 and 3). As no issues remain, the Board hereby closes Case No. 22-1201 and removes it

⁴¹ No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

⁴² *Id.* at *11.

⁴³ *Id.*

⁴⁴ *Id.*

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

Board Members Participating:

For the Board:

Kevin D. Smith, CPA

5/6/2025

Ratina Kelly, CPA

Nicole E. Musgrave, Esq.

Shakeba DuBose, Esq.

X Ratina Kelly

Ratina Kelly, CPA

Board Member

Signed by: PIV

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



Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244 1850
410-786-2671

Via Electronic Delivery

Kerneisha Murphy, Nurse Practitioner
Southeast Regional Medical Center
719 Avenue G
Kentwood, LA 70444-0021

Re: ***Dismissal for Failure to Meet Minimum Filing Requirements***

Southeast Regional Medical Center, Provider No. 19-2058, FFY 2025, Case No. 25-4124

Dear Ms. Murphy:

The Provider Reimbursement Review Board (“Board”) has reviewed the above-referenced appeal request. After review of the facts outlined below, the Board has determined that the appeal request is fatally flawed as it was not filed in accordance with the regulations and Board Rules. The Board’s review and determination are set forth below.

Pertinent Facts:

On **March 25, 2025**, Southeast Regional Medical Center (the “Provider”) filed an appeal with the Board to establish Case No. 25-4124. The appeal was filed from a determination entitled “Notice of Quality Reporting Program NonCompliance Decision Upheld” (“QRS Determination”) dated September 26, 2024.

The Provider’s appeal request did not, however, include:

- a Letter of Representation (Board Rule 5.4) and
- a calculation of the reimbursement impact on the facility (Board Rule 6.4).¹

On **March 28, 2025**, the Board issued an Acknowledgement and Critical Due Dates Notice in which it set a briefing schedule for the Parties to file preliminary position papers and requested a Representation Letter and Calculation Support. The deadline for the required support documents was set for **April 14, 2025**.

On **April 16, 2025**, the Board issued a final request for the Information and gave the Provider a new deadline of **April 30, 2025**.

To date, the Provider has not complied with either of the Board’s Requests for Information.

¹ Board Rules Version 3.2 (Dec 15, 2023)

Board Decision:

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

42 C.F.R. § 405.1835 establishes the right to a Board hearing and the required contents for an appeal request. Specifically, 42 C.F.R. § 405.1835(a)(2) requires that “[t]he amount in controversy (as determined in accordance with § 405.1839) must be \$10,000 or more.” Board Rules 5.4 and 6.4 further address individual appeal requirements related to Representative letters and Calculation Support. Finally, Board Rule 6.1.1 indicates that the Board will dismiss appeal requests that do not meet the *minimum* filing requirements as identified in 42 C.F.R. § 405.1835(b).

The Board has determined that the Provider’s appeal request was not filed in accordance with the regulations at 42 C.F.R. § 405.1835 and with the Board Rules.

First, the Provider’s appeal request failed to include a proper Representation Letter as required in Board Rule 5.4. A letter of representation is required to be uploaded even if the Provider is representing itself or a parent organization is representing an affiliated provider. In this case, the document submitted as the Representative letter was a copy of the Provider's Inpatient Quality Reconsideration Request. Although this documentation was on the Provider’s letterhead, it was not addressed to the Board and it did not provide contact information for the Board appeal. In fact, the letter, which was addressed to Centers for Medicare and Medicaid Services (“CMS”), was signed by Mark Murphy, Administrator of Southeast Regional Medical Center. Mr. Murphy is not listed as the contact person in the Office of Hearings Case and Document Management System (“OH CDMS.”) The designated representative listed in OH CDMS is Kerneisha Murphy, Nurse Practitioner.

Second, although the Provider listed an estimated reimbursement impact of \$24,027 for the “2% Percentage Reduction” issue in OH CDMS, the calculation support uploaded to demonstrate the reimbursement impact says “N/A.” As noted, the regulation at 42 C.F.R. § 405.1835(a)(2) and Board Rule 6.4 require an estimate of the reimbursement impact.²

Finally, the Board finds that the Provider was afforded two separate opportunities to cure the noted deficiencies. The Provider has failed to respond to both the Board’s March 28, 2025 and April 16, 2025 Requests. Accordingly, the Board hereby dismisses Case No. 25-4124 since the appeal request is fatally flawed and does not meet the *minimum* filing requirements as outlined above and for failure to timely respond to the Board’s Requests for Information. Based on the above, the Board closes this case and removes it from its docket.

² See also FAQ for Quality Reimbursement Appeals at <https://www.cms.gov/files/document/faqs-quality-reporting-appeals.pdf>, stating that the provider “. . . must estimate the financial impact of the payment reduction and include a dollar amount in the Amount in Controversy data field. You must upload a copy of the calculation used to determine the amount in controversy, including an explanation of any factors used to calculate this estimate.”

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

Board Members:

Kevin D. Smith, CPA

Ratina Kelly, CPA

Nicole E. Musgrave, Esq.

Shakeba DuBose, Esq.

For the Board:

5/8/2025

X Ratina Kelly

Ratina Kelly, CPA

Board Member

Signed by: PIV

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



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

Janahan Ramanathan
Quality Reimbursement Services, Inc.
150 North Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Notice of Dismissal***

24-1314GC BS&W Health FFY 2024 ATRA IPPS Payment Reduction CIRP Group

Dear Mr. Ramanathan:

The Provider Reimbursement Review Board (“Board”) has reviewed the subject common issue related party (“CIRP”) group appeal for which a Show Cause Order was issued. A summary of the pertinent facts and the Board’s determination are set forth below.

Pertinent Facts:

On **February 15, 2024**, Quality Reimbursement Services, Inc. (“QRS”) formed the “BS&W Health FFY 2024 ATRA IPPS Payment Reduction CIRP Group” under Case No. 24-1314GC in the Office of Hearings Case and Document Management System (“OH CDMS”) with 23 providers. The providers filed from the August 28, 2023 notice in the Federal Register.¹

On **February 20, 2024** the Board issued an Acknowledgement and Critical Due Dates Notice (ACDD) which required the Representative to file Comments Regarding Full Formation by a **February 14, 2025** deadline.

On **March 21, 2025**, thirty-five days after the deadline, QRS marked Case No. 24-1314GC as fully formed in OH CDMS.²

On **March 24, 2025**, as is standard practice, the Board issued a “Group Completion Notice” which set the Parties’ preliminary position paper deadlines.

¹ The 180-day filing deadline from the August 28, 2023 Federal Register expired on February 24, 2024. Pursuant to the Civil Rules of Procedure and 42 C.F.R. § 405.1801(d)(3), “[i]f the last day of the designated time period is 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 reviewing entity is unable to conduct business in the usual manner, the deadline becomes the next day that is not one of the aforementioned days.). Therefore, the filing deadline was extended to February 26, 2024.

² Although the group had finally been marked “fully formed,” a Show Cause Order had already been prepared based on QRS’ failure to respond to the February 20, 2024 ACDD notification. The Show Cause Order indicated that the group was deemed to be fully formed AND ordered the Provider to show cause as to why the case should not be dismissed for failure to **timely**, and appropriately, respond to the Board ACDD Notice which set **February 14, 2025** as the deadline for the Group Representative to inform the Board regarding the group’s full formation.

On **March 25, 2024**, the Board's Show Cause Order was issued (although, technically, it was four days after QRS had designated the group to be fully formed). The Representative's Comments Regarding Full Formation were still filed more than a month late. The Board's Order required the Representative to submit its comments by **April 7, 2025**, showing cause as to why the case should not be dismissed. Accordingly, QRS was obligated to respond by the deadline. The Board's Order explicitly stated that "[f]ailure of the Group Representative to file its response by this deadline, will result in the Board taking remedial action and the case will be dismissed."

To date, QRS has not responded to the Board's Show Cause Order.

Board Decision:

Board Rule 4.4.2 states the following:

*All filings other than an appeal request or request to add issues (e.g., position papers and other responsive documents) **must be received by the Board no later than the date specified on the Board's notice** or, if silent, the date specified in these Rules. **If a party fails to file by the established due date, the Board may take action as described in 42 C.F.R. § 405.1868.** For example, Rule 23.4 addresses the timely filing of preliminary position papers and specifies that the Board will dismiss the appeal if the representative for the provider(s) fails to file their preliminary position paper or PJSO by the established due date. (Emphasis added.)*

Further, Board Rule 41.2 permits the Board to dismiss a case if it has a reasonable basis to believe that the issues have been fully settled or abandoned, or the group fails to comply with Board filing deadlines.³

After a review of the facts in this case, the Board finds dismissal of the group to be appropriate based on QRS' **late response** to the Comments Regarding Full Formation **and its failure to respond** to the Board's Show Cause Order. 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."⁴

³ Board Rule 41.2 Own Motion – The Board may dismiss a case or an issue on its own motion:

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

⁴ In fact - Case No. 24-1314GC which was filed from notice in the Federal Register, could have marked to be fully formed shortly after it was established. The 180-day appeal period, which expired on February 26, 2024, was just short of a year before the deadline (354 days) for submitting Comments Regarding Full Formation.

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 No. 24-1314GC 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:

5/9/2025

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, Esq., CPA, Federal Specialized Services



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***

Baylor Scott & White Medical Center Garland, Prov. No. 45-0280, FYE 12/31/2015
Case No. 19-1866

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-1866. Set forth below is the decision of the Board to dismiss the one remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Payment for Medicaid Eligible Days.

Background

A. Procedural History for Case No. 19-1866

On **October 12, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2015.

On **April 15, 2019**, the Board received the Provider's individual appeal request. The Individual Appeal Request contained ten (10) issues:

1. DSH Payment/SSI Percentage (Provider Specific)¹
2. DSH/SSI Percentage²
3. DSH/SSI Fraction Medicare Managed Care Part C Days³
4. DSH/SSI Fraction Dual Eligible Days⁴
5. DSH Payment – Medicaid Eligible Days
6. DSH/Medicaid Fraction Medicare Managed Care Part C Days⁵
7. DSH/Medicaid Fraction Dual Eligible Days⁶
8. Uncompensated Care ("UCC") Distribution Pool⁷

¹ On August 29, 2024, the Board issued a decision dismissing this issue from the appeal.

² On November 15, 2019, this issue was transferred to PRRB Case No. 18-1276GC.

³ On November 15, 2019, this issue was transferred to PRRB Case No. 18-1279GC.

⁴ On November 15, 2019, this issue was transferred to PRRB Case No. 18-1281GC.

⁵ On November 15, 2019, this issue was transferred to PRRB Case No. 18-1277GC.

⁶ On November 15, 2019, this issue was transferred to PRRB Case No. 18-1280GC.

⁷ On November 15, 2019, this issue was transferred to PRRB Case No. 18-1282GC.

9. 2 Midnight Census IPPS Payment Reduction⁸
10. Standardized Payment Amount⁹

On **May 8, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** state the material facts that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and provide arguments applying the material facts*** to the controlling authorities. This filing ***must include any exhibits the Provider will use to support its position*** and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.¹⁰

The Provider is commonly owned/controlled by Baylor Scott & White Health (hereinafter “BSWH”) and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **November 15, 2019**, the Provider transferred Issues 2, 3, 4, 6, 7, 8, 9, and 10 to BSWH CIRP groups.

On **December 6, 2019**, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 5 set forth therein:

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

The Sixth Circuit Court of Appeals, in *Jewish Hosp., Inc. v. Secretary of Health and Human Servs.* 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits...

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

⁸ On November 15, 2019, this issue was transferred to PRRB Case No. 18-1275GC.

⁹ On November 15, 2019, this issue was transferred to PRRB Case No. 20-0062GC.

¹⁰ (Emphasis added).

calculated to include all hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.

Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its 2015 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.¹¹

On **March 30, 2020**, the Medicare Contractor filed its preliminary position paper.

On **March 9, 2021**, the Medicare Contractor filed a jurisdictional challenge over Issue 1 in the appeal. In a decision issued **August 29, 2024**, the Board dismissed Issue 1 from the appeal.

On **May 9, 2023**, the Provider requested a Change of Representative to Quality Reimbursement Services, Inc.

On **August 20, 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.¹²

On **March 13, 2025**, the Provider timely filed its final position paper. The following is the Provider's ***complete*** position on Issue 5 set forth therein:

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

¹¹ Provider's Preliminary Position Paper at 7-8 (Dec. 6, 2019).

¹² (Emphasis added).

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 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 to follow), the Provider contends that the total number of days reflected in its 2015 cost report does not reflect an accurate number of Medicaid eligible days, as 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-3.¹³

On **April 4, 2025**, the Medicare Contractor timely filed its final position paper.

On **April 10, 2025**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 5. Board Rule 44.4.3. specifies that “[p]roviders must file a response within thirty (30) days of the Medicare contractor’s jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order” and “[f]ailure to respond will result in the Board making a jurisdictional determination with the information contained in the record.”¹⁴

On **February 17, 2025**, the Provider requested a Change of Representative to Quality Reimbursement Services, Inc

B. Description of Issue 5 in the Appeal Request

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

The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary’s Regulations.

The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.¹⁵

The Provider estimated the reimbursement impact of the issue at \$32,868 based on an increase of 50 additional Medicaid days but failed to include a list of the additional days.¹⁶

MAC’s Jurisdictional Challenge

Issue 5 – DSH Payment – Medicaid Eligible Days

The Medicare Contractor contends that this issue should be dismissed because the Provider failed to 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.

¹³ Provider’s Final Position Paper at 8-10 (Mar. 13, 2025) (emphasis added).

¹⁴ Board Rule 44.4.3, v. 3.2 (Dec. 2023).

¹⁵ Issue Statement at 5 (Apr. 15, 2019).

¹⁶ Issue Statement at 3 (Apr. 25, 2019).

The Medicare Contractor notes that a Medicaid eligible days listing was never received with the Provider's preliminary position paper nor the final position paper.¹⁷

The Medicare Contractor contends 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 and final position papers. 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. The Provider has not included a complete, unredacted list of additional Medicaid eligible days with its preliminary or final position papers or submitted such list under separate cover to the Medicare Contractor. The Provider has not submitted accurate and sufficient data to demonstrate that patients were eligible for Medicaid on the contested claimed patient hospital days or identified as to why the data is not yet available or when it will become available.¹⁸

Additionally, the Medicare Contractor argues the Provider is attempting to untimely and improperly add the issue of Section 1115 waiver days as a sub-issue via its final position paper filed on March 13, 2025. The Medicare Contractor issued the Provider's NPR on October 12, 2018. In accordance with 42 C.F.R. § 415.1835(e), the deadline for adding issues to the appeal was June 9, 2019. The issue was informally added through the Provider's final position paper, more than five years after the filing deadline to add an issue.¹⁹

The Medicare Contractor contends that the Section 1115 Waiver Days issue is one component of the DSH issue that must be appealed as a separate issue. The Medicare Contractor 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 appeal separately.²⁰

Provider's Jurisdictional Response

Issue 5 – DSH Payment – Medicaid Eligible Days

In its jurisdictional response, the Provider only responds to the Medicare Contractor'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. Whereas the Medicare Contractor states that the Section 1115 Waiver Days issue is one component of the DSH issue, the regulations at 42 C.F.R. § 405.1835 contain requirements for appealing an "issue" and a time limit on adding an "issue" – not on clarifying "sub-issues" or "components" of an issue. 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

¹⁷ Medicare Contractor's jurisdictional challenge at 2-4 (Apr. 10, 2025).

¹⁸ Medicare Contractor's jurisdictional challenge at 7 and 9 (Apr. 10, 2025).

¹⁹ Medicare Contractor's jurisdictional challenge at 10-11. (Apr. 10, 2025).

²⁰ Medicare Contractor's jurisdictional challenge at 12 (Apr. 10, 2025).

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. There is no dispute that the same cost report adjustment that affects other types of Medicaid eligible days also affects section 1115 waiver days.²¹

The Provider goes on to contend that the version of Board Rule 8 (July 1, 2015) that it alleges was effective when the Provider filed its appeal, makes no mention of “section 115 waiver days” nor even “Medicaid eligible days.” Thus, even if Rule 8’s extension to “components of issues” were valid (and the Provider contends it is not), the Provider had no notice that it was required to specify section 1115 waiver days in its appeal request, and it would be a denial of due process for the PRRB to dismiss the section 1115 waiver days component of its appeal of Medicaid eligible days.²²

Finally, the Provider contends that subsequent to the Provider’s Preliminary Position Paper, the Fifth Circuit ruled that the statute and CMS’s own regulations require that CMS regard inpatient days attributable to an uncompensated care pool population as Medicaid eligible days, *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019). The Medicare Contractor is required by specific command of CMS to accept and audit the Provider’s section 1115 waiver days in providers’ Medicaid Fractions. Following a string of litigation defeats, including those in *Forrest General Hospital* and *Bethesda Health, Inc. v. Azar*, 980 F.3d 121 (D.C. Cir.2020), CMS issued Change Request 12669, Transmittal No. 11912 (March 16, 2023). The Provider asserts that under this Transmittal, the Medicare Contractor has the duty to accept the Provider’s listing of section 1115 days and audit them. The Provider states that it submitted a redacted listing to the Board with their Supplement to position paper/redacted Medicaid Eligible Days Listing Submission on April 21, 2025, and an unredacted listing to the Medicare Contractor.²³

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.

A. DSH Payment – Medicaid Eligible Days

The Provider’s appeal request did not include a finalized list of the specific additional Medicaid eligible days that are in dispute in this appeal in either the initial appeal or the 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:

²¹ Provider’s jurisdictional response at 1-2 (May 5, 2025).

²² Provider’s jurisdictional response at 2-3 (May 5, 2025).

²³ Provider’s jurisdictional response at 3-4 (May 5, 2025).

No Access to Data

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

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

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

(3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.²⁴

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:

²⁴ (Bold emphasis added.)

Rule 25 Preliminary Position Papers²⁵

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on May 8, 2019 included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 5, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish *each Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(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.²⁶

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 December 6, 2019, the Provider filed its preliminary position paper in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.²⁷ Significantly, the position paper did *not* include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the “estimated impact” included with its appeal request (i.e., the estimated impact of \$32,868 based on an estimated 50 days).

On March 13, 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 will be submitted directly to the MAC. A redacted version of the list will be uploaded to the portal thereafter.” On April 21, 2025, the Provider uploaded a redacted copy of the additional Medicaid Eligible Days and 1115 Waiver Days listing. There is no indication that an unredacted listing was sent to the Medicare Contractor. The Listing was 22 pages with 3,618 Medicaid days. The Provider did not explain why the listing of days was being submitted at this late date, *more than 9 years after the fiscal year at issue had closed*. NOTE—the 3,618 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 5 years past the deadline for*

²⁶ (Emphasis added.)

²⁷ Provider’s Preliminary Position Paper at 10.

including it with its preliminary position paper since the position paper deadline was December 11, 2019.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (i.e., the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. 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”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 submit a finalized listing of Medicaid eligible days, notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is \$0.

Based on the above, the Board finds that the Provider has failed to comply with the Board’s procedures with regard to filing its position 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.²⁹

B. Section 1115 Waiver Days

The Board finds that the section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. The Provider failed to include section 1115 Waiver days as a cost

²⁸ (Emphasis added.)

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.

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 April of 2019 and the regulations required the following:

(b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing...must be submitted in writing to the Board, and the request must include...

(2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final...determination under appeal, including an account of...

(i) why the provider believes Medicare payment is incorrect for each disputed item...[and]

(ii) how and why the provider believes Medicare payment must be determined differently for each disputed item...³⁰

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,
 - why the adjustment is incorrect,
 - how the payment should be determined differently,
 - the reimbursement effect, and
 - the basis for jurisdiction before the Board.³¹

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

Several examples are identified below, but these examples are not exhaustive lists of categories or issues.

A. Disproportionate Share Hospital Payments

³⁰ 42 C.F.R. § 405.1835(b).

³¹ v. 2.0 (Aug. 2018).

Common examples include:...*Section 1115 waiver days (program/waiver specific)*³²

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.³³ 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, 2000.³⁴ Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program *and* not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction.²⁰ In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (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

³² (Bold and italic emphasis added).

³³ See 73 Fed. Reg. 30190 (May 23, 2008).

³⁴ 65 FR 47054, 47087 (Aug. 1, 2000).

plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

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

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

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

Regardless, even if the Provider had included in its appeal request (which it did not), the Provider failed to properly develop the issue in its position paper filings. First, the Provider's preliminary position paper does not even mention § 1115 waiver days (much less even identify the specific 1115 waiver day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (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* § 1115 waiver days sub-issue.

Finally, even in the Provider's final position paper, the Provider fails to identify what § 1115 waiver program(s) are involved and whether or not the § 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the final position paper is perfunctory in that it only makes perfunctory conclusions.³⁵

³⁵ 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

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 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*.³⁶ 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 . . ."³⁷ 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."³⁸ 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.³⁹ Here, the Board makes the same finding based on similarly *overly generalized language*.

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 27.2.⁴⁰ In the alternative, the Board finds that, even if it had been included as part of the appeal, the Board would find that the issue was not properly developed in the position paper process.

Based on the foregoing, the Board dismisses the sole remaining issue in this case – (Issue 5- DSH Payment – Medicaid Eligible Days. As no issues remain, the Board hereby closes Case No. 19-1866 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.

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."

³⁶ No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

³⁷ *Id.* at *11.

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ 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).

Board Members Participating:

Kevin D. Smith, CPA

Ratina Kelly, CPA

Nicole E. Musgrave, Esq.

Shakeba DuBose, Esq.

For the Board:

5/13/2025

X Ratina Kelly

Ratina Kelly, CPA

Board Member

Signed by: PIV

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



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. Jake Harper
Morgan, Lewis & Bockius, LLP
1111 Pennsylvania Ave., NW
Washington, DC 20004

RE: Suncrest Hospice San Diego (A1-1660)
Appealed Period: FFY 2025
PRRB Case No.: 25-4388

Dear Mr. Harper:

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 May 3, 2025, Morgan, Lewis & Bockius, LLP ("Morgan Lewis") filed the subject appeal request, on behalf of the above referenced Provider, for Federal Fiscal Year ("FFY") 2025. The proceedings for the appeal indicate that the Provider is filing the appeal based on a **Notice of Quality Reporting Program Noncompliance Decision Upheld** dated September 30, 2024. There is only one (1) issue being raised in the subject individual appeal, the 4% Reduction to the FFY 2025 Annual Payment.

As set forth below, the appeal was untimely filed since it was filed on the 215th day past the final determination date of September 30, 2024.

RULES/REGULATIONS:

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

Board Rule 4.4.1. states: **Due Dates for New Appeals** New appeals must be received by the Board *no later than 180 days* from the commencement of the appeal period as specified in Rule 4.3. See Rule 2.1.4 for instructions on requesting an extension under 42 C.F.R. § 405.1836 "due to extraordinary circumstance beyond [the party's] control."

Board Rule 4.4.3 states: **Due Date Exceptions** If the due date falls on a Saturday, a Sunday, a federal legal holiday, (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the Board is unable to conduct business in the usual manner (e.g., “if OH CDMS were down for the entire last day of a deadline” (85 Fed. Reg. 58432, 58987 (Sept. 18, 2020))), the deadline becomes the next day that is not one of the aforementioned days. See 42 C.F.R. § 405.1801(d)(3).

Board Rule 4.5 states: **Date of Receipt by the Board** The timeliness of a filing is determined based on the date of receipt by the Board. The date of receipt is presumed to be: A. The date of filing in OH CDMS as evidenced by the Confirmation of Correspondence generated by the system; or B. If the filing is permitted pursuant to an exemption under Rule 2.1.2, the date of receipt is: • The date of delivery to the Board as evidenced by the courier’s tracking bill for documents transmitted by a nationally recognized next-day courier. It is the responsibility of the provider to maintain a record of the delivery. See 42 C.F.R. § 405.1801(a)(2)(i). • The date stamped “received” by the Board on documents submitted by regular mail, hand delivery, or couriers not recognized as a national next-day courier. This provision also applies if the party is unable to supply the next-day courier’s tracking bill as noted above. See 42 C.F.R. § 405.1801(a)(2)(ii).

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

BOARD DETERMINATION:

As noted in the facts above, the final determination support document states that the subject appeal is based on a **Notice of Quality Reporting Program Noncompliance Decision Upheld** dated September 30, 2024. Allowing for the 180-day appeal period and a five-day presumption for mailing, the 185th day fell on Thursday, April 3, 2025. The date of delivery to the Board, as evidenced by the Confirmation of Correspondence generated by OH CDMS, is May 3, 2025. The subject appeal request was filed 215 days past the final determination date of September 30, 2024 and was, therefore, untimely filed.

As a result, the Board hereby dismisses case number 25-4388, 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:

5/16/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Federal Specialized Services
Danelle Decker, National Government Services, Inc. (J-K)



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***
Baylor University Medical Center (45-0021)
FYE: 06/30/2013
Case No.: 19-1853

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 19-1853. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider’s Disproportionate Share Hospital (“DSH”) Medicaid Eligible Days payment.

Background

A. Procedural History for Case No. 19-1853

On **October 9, 2018**, the Provider, Baylor University Medical Center (“Baylor”) was issued a Notice of Program Reimbursement (“NPR”) for the fiscal year ending June 30, 2013. The Provider is commonly owned by Baylor Scott & White Health (“BSWH”).

On **April 9, 2019**, Baylor filed an Individual Appeal Request appealing the following (8) issues:

1. DSH Payment SSI Percentage (“Provider Specific”)¹
2. DSH SSI Percentage (“Systemic Errors”)²
3. DSH Dual Eligible Part C Days-SSI Fraction³
4. DSH Dual Eligible Exhausted-SSI Fraction⁴
5. DSH Medicaid Eligible Days
6. DSH Dual Eligible Part C Days-Medicaid Fraction⁵
7. DSH Dual Eligible Exhausted-Medicaid Fraction⁶

¹ On April 15, 2025, this issue was withdrawn.

² On November 13, 2019, this issue was transferred to Case No. 17-1532GC.

³ On November 13, 2019, this issue was transferred to Case No. 17-1533GC

⁴ On November 13, 2019, this issue was transferred to Case No. 17-1535GC

⁵ On November 13, 2019, this issue was transferred to Case No. 17-1534GC

⁶ On November 13, 2019, this issue was transferred to Case No. 17-1536GC

8. Standardized Payment Amount⁷

As the Provider is commonly owned/controlled by BSWH, 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 **November 13, 2019**, the Provider transferred Issues 2, 3, 4, 6, 7 and 8 to BWSH CIRP groups.

After the transfers, two issues remained in the appeal: Issue 1, DSH – SSI Percentage (“Provider Specific”), Issue 5, DSH – Medicaid Eligible Days.⁸

On **May 6, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties’ preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

Provider’s Preliminary Position Paper – *For each issue*, the position paper **must** state the material facts that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and provide arguments applying the material facts*** to the controlling authorities. This filing **must** include ***any exhibits the Provider will use to support its position*** and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.⁹

On **December 2, 2019**, the Provider timely filed its preliminary position paper. With respect to Issue 5, Medicaid Eligible Days, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made, and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that “[b]ased on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its’ 2013 cost report does not reflect an accurate number of Medicaid eligible days. . . .”¹⁰ As a result, the Provider included, as an Exhibit, the original “estimated impact” for this issue of \$70,147 based on an *estimated* 150 days.

On **March 18, 2020**, the Medicare Contractor timely filed a Jurisdictional Challenge¹¹ with the Board over Issue 1, DSH SSI Percentage (“Provider Specific”) requesting that the Board dismiss

⁷ On November 13, 2019, this issue was transferred to Case No. 19-2455GC.

⁸ Issue 1 was withdrawn on April 15, 2025.

⁹ (Emphasis added.)

¹⁰ Provider’s December 2, 2019 Preliminary Position Paper at 8.

¹¹ Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled “Board Jurisdiction” but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a

the issue. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider *failed* to file any response.

On **March 27, 2020**, the Medicare Contractor filed its preliminary position paper. Regarding Issue 5, DSH Medicaid Eligible Days, the Medicare Contractor's position paper noted that the Provider's Medicaid percentage was properly determined. It included all documented and audited Medicaid days in the calculation of the DSH payment.¹²

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

On **January 22, 2024**, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission." The Provider identified 207 additional Medicaid days as "Additional Medicaid Days – High Strata" and "Low Strata." Also, the Provider identified 17,368 additional section 1115 waiver as "1115 Waiver Days." QRS' filing did not explain why the listing of so many days was being submitted at this late date, *more than 11 years after the fiscal year at issue had closed*. NOTE—the roughly 17,575 included in this belated listing is *exponentially* larger than the original *estimated* impact of 150 days included with the appeal request.

On **February 13, 2025**, the Provider filed its Final Position Paper. With respect to Issue 5, DSH Medicaid Eligible Days, the Provider's position paper, for the first time, mentions section 1115 Waiver Days.

On **March 10, 2025**, the Medicare Contractor filed its Final Position Paper. Regarding Issue 5, DSH Medicaid Eligible Days, The Medicare Contractor noted that the provider had consolidated "section 1115 waiver days" with its Medicaid Eligible Days. As the "section 1115 waiver days" are not an issue in this appeal, the Medicare Contractor asserted that it would only consider Medicaid Eligible Days for a possible administrative resolution.¹³

On **March 13, 2025**, the Medicare Contractor filed a Jurisdictional Challenge with the Board over Issues 1, DSH SSI Percentage ("Provider Specific") and 5, DSH Medicaid Eligible Days including section 1115 waiver days requesting that the Board dismiss these issues.

On **April 7, 2025**, the Provider filed a response to the Medicare Contractor's Jurisdictional Challenge.

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

¹² Medicare Contractor's March 27, 2020 Preliminary Position Paper at 15.

¹³ Medicare Contractor's March 10, 2025 Final Position Paper at 15.

B. Description of Issue 5 in the Appeal Request

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

Statement of Issue

Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital (“DSH”) calculation.

Statement of the Legal Basis

The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary’s Regulations.

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

Audit Adjustment Number(s): 5, 24, S-D

Estimated Reimbursement Amount: \$70,000¹⁴

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the *Jewish Hospital* case¹⁵ and HCFA Ruling 97-2, “all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage” of the DSH payment adjustment.¹⁶

Medicare Contractor’s Contentions

Issue 5 – DSH Payment – Medicaid Eligible Days

The Medicare Contractor contends the Provider failed to file complete preliminary and final position papers including all supporting exhibits to document the merits of its argument and

¹⁴ Provider’s April 9, 2019 Individual Appeal Request, Issue Statement, Issue 5.

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

¹⁶ Provider’s December 2, 2019 Preliminary Position Paper at 7.

failed to properly develop its arguments within its preliminary and final position papers in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25 and 27. The Medicare Contractor argues the Provider has not submitted a complete auditable Medicaid Eligible Days listing and requests the Board dismiss the issue.

Additionally, the Medicare Contractor contends the Provider is attempting to add the section 1115 Waiver Days issue improperly and untimely as a sub-issue via its final position paper filed on February 13, 2025.¹⁷

Provider's Jurisdictional Response

The Provider contends that it appealed all Medicaid Eligible Days in its Appeal Request, including section 1115 Waiver Days. The Provider asserts, by definition, section 1115 Waiver Days are Medicaid eligible days. The Provider maintains although the Medicare Contractor contends that it is attempting to untimely add the issue of section 1115 Waiver Days, there exists no such issue. The Provider argues section 1115 Waiver Days are part and parcel of Medicaid Eligible Days.

The Provider maintains the regulation at 42 C.F.R. § 405.1835 contain requirements for appealing an “issue” and a time limit on adding an “issue” – not on clarifying a “sub-issue” or “components” of an issue. The Provider argues 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.¹⁸

Decision of the Board

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

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

A. DSH Payment – Medicaid Eligible Days

The Provider'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 preliminary position paper.

¹⁷ Medicare Contractor's March 13, 2025 Jurisdictional Challenge at 2,6,8.

¹⁸ Provider's April 7, 2025 Jurisdictional Response at 1-2.

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

No Access to Data

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

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

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

(3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.¹⁹

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

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

¹⁹ (Bold emphasis added.)

Rule 25 Preliminary Position Papers²⁰

COMMENTARY:

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

25.1 Content of Position Paper Narrative

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

25.1.1 The Provider's Position Paper

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

25.2 Position Paper Exhibits

25.2.1 General

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

²⁰ (Underline emphasis added to these excerpts and all other emphasis in original.)

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on May 6, 2019, included instructions on the content of the Provider's preliminary position paper consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

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

The hospital has the burden of furnishing data adequate to prove eligibility for *each* Medicaid patient *day claimed* under this

paragraph, *and of verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.²¹

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 December 2, 2019, the Provider filed its preliminary position paper in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.²² Significantly, the position paper did *not* include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the “estimated impact” included with its appeal request (i.e., the estimated impact of \$70,147 based on an estimated 150 days). The Provider’s complete briefing of this issue in its preliminary position paper is as follows:

Calculation of Medicaid Eligible Days

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

²¹ (Emphasis added.)

²² Provider’s December 2, 2019 Preliminary Position Paper at 8.

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

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

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

Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its’ 2013 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.²³

In its Jurisdictional Challenge, the Medicare Contractor asserts that the Provider has failed to submit a complete list of additional Medicaid eligible days with its preliminary or final position papers or submit such list under separate cover to it. The Provider has yet to submit complete, unredacted listings to it. The Medicare Contractor maintains the Provider has neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with the regulations and Board Rules.²⁴

The Medicare Contractor asserts in the Provider’s February 13, 2025 Final Position Paper, Exhibit P-1, the Provider included a redacted listing of 17, 368 days identified as “1115 Waiver

²³ Provider’s December 2, 2019 Preliminary Position Paper at 7-8.

²⁴ Provider’s March 13, 2025 Jurisdictional Challenge at 14.

Days” and 207 days identified as “Additional Medicaid Days – “High Strata” and “Low Strata.” As it relates to the Medicaid eligible days under appeal, the Provider’s exhibit states “A listing of the additional Medicaid Eligible days being claimed is being submitted directly to the MAC. A redacted version of this same list is being included with this position paper.” The Medicare Contractor contends to date, the provider has not submitted the referenced listing.²⁵

The Board finds the Provider’s filing does not explain why the listing of 17,575 days was being submitted at this late date *more than 11 years after the fiscal year at issue had closed*. NOTE—the roughly 17,575 days included in this belated listing is *exponentially* larger than the original estimate of 150 days included with the appeal request.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (i.e., the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(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).

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”²⁶ and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provide the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board 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.²⁷

²⁵ *Id.* at 7-8.

²⁶ (Emphasis added.)

²⁷ 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).

B. 1115 Waiver Days

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

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

(b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing...must be submitted in writing to the Board, and the request must include...

(2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final...determination under appeal, including an account of...

(i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]

(ii) How and why the provider believes Medicare payment must be determined differently for each disputed item...²⁸

Board Rule 7.2.1 (2019) elaborated on this regulatory requirement, instructing providers:

The following information and supporting documentation must be submitted for each issue raised in the appeal request.

- An issue title and a concise issue statement describing:
 - the adjustment, including the adjustment number,
 - the controlling authority,
 - why the adjustment is incorrect,
 - how the payment should be determined differently,

The 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.

²⁸ 42 C.F.R. § 405.1835(b).

- the reimbursement effect, and
- the basis for jurisdiction before the [Board].

Board Rule 8 (2019) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and “...each contested component must be appealed as a separate issue and described as narrowly as possible...”. The Rule goes on:

Several examples are identified below, but these are not exhaustive lists of categories or issues.

A. Disproportionate Share Hospital Payments

Common examples include: . . . ***Section 1115 waiver days (program/waiver specific)***. . .²⁹

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.³⁰

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, 2000.³¹ 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

²⁹ (Bold and italic emphasis added).

³⁰ See 73 Fed. Reg. 30190 (May 23, 2008).

³¹ 65 FR 47054, 47087 (Aug. 1, 2000).

waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

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

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

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

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

Regardless, even if the Provider had included in its appeal request (which it did not), the Provider failed to properly develop the issue in its position paper filings. First, the Provider's preliminary position paper does not even mention § 1115 Waiver Days (much less even identify the specific 1115 Waiver Day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25. As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to

prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.” Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the “burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue.” The Provider’s briefing fails to establish the merits of its position on the *alleged* § 1115 Waiver Days sub-issue.

Finally, even in the Provider’s final position paper, the Provider fails to identify what § 1115 waiver program(s) are involved and whether or not the § 1115 Waiver Days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as “days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act” and the patients underlying those days are “deemed eligible for Medicaid” based on “the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered.” Rather, the final position paper is perfunctory in that it only makes perfunctory conclusions.³² 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*.³³ 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 . . .”³⁴ 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.”³⁵ The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.³⁶ Here, the Board makes the same finding based on similarly *overly generalized language*

* * * * *

³² 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.”

³³ No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

³⁴ *Id.* at *11.

³⁵ *Id.*

³⁶ *Id.*

Notice of Dismissal for Baylor University Medical Center

Case No. 19-1853

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Based on the foregoing, the Board has dismissed the (1) remaining issue in this case – (Issue 5, Medicaid Eligible Days). As no issues remain, the Board hereby closes Case No. 19-1853 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:

5/16/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Michael Redmond, Novitas Solutions, Inc. c/o Guidewell Source
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

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

RE: ***Notice of Dismissal***

Bayfront Health Dade City, Prov. No. 10-0211, FYE 03/31/2018
Case No. 22-0133

Dear Mr. Summar:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 22-0133. Set forth below is the decision of the Board to dismiss the 3 remaining issues in this appeal challenging the Provider’s Disproportionate Share Hospital (“DSH”) for SSI Percentage (Provider Specific) and Medicaid Eligible Days payments.

Background

A. Procedural History for Case No. 22-0133

On **May 26, 2021**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end March 31, 2018. The Provider is commonly owned by Community Health Systems, Inc. (“CHS”).

On **November 12, 2021**, CHS filed the Provider’s individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH SSI Percentage (Systemic Errors)¹
3. DSH – Medicaid Eligible Days
4. DSH SSI & Medicaid Fraction / Medicare Managed Care Part C Days²
5. DSH SSI & Medicaid Fraction / Dual Eligible Days³

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 10, 2022**, the Provider transferred Issues 2, 4 and 5 to CHS CIRP groups. As a result of the case transfers, there are two (2) remaining issues in this appeal: Issue 1 (DSH – SSI Percentage Provider Specific) and Issue 3 (DSH – Medicaid Eligible Days).

¹ On October 22, 2019, this issue was transferred to Case No. 21-1206GC.

² On October 22, 2019, this issue was transferred to Case No. 20-2149GC.

³ On October 22, 2019, this issue was transferred to Case No. 21-0066GC.

On **November 15, 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 25.⁴*

On **July 6, 2022**, the Provider timely filed its preliminary position paper. With respect to Issue 3, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that “[b]ased on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its’ 2018 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.” As a result, the Provider included, as an Exhibit, the original “estimated impact” for this issue of \$21,860.

On **August 11, 2022**, the Medicare Contractor filed a Request for DSH Package in connection with Issue 3. The Medicare Contractor formally filed the 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 within 30 days. Notwithstanding the formal request, the Provider failed to file any response to the Medicare Contractor.

On **October 4, 2022**, the Medicare Contractor filed a Jurisdictional Challenge⁵ with the Board over Issues 1 and 3 requesting that the Board dismiss these issues. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **October 21, 2022**, the Medicare Contractor filed its preliminary position paper. With regard to Issue 3, the Medicare Contractor's position paper noted that: (1) the Provider had failed to

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).

include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position; and (2) the Provider had failed to respond to the Medicare Contractor's requests for the Medicaid eligible days listing.

A. 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 the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.

The Provider contends that its' 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

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).⁶

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?

⁶ Provider's Individual Appeal Request at 10 (Mar. 20, 2019).

Statement of the Legal Basis

The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

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

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.⁷

On July 6, 2022, the Board received the Provider's preliminary position paper in Case No. 22-0133. 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 the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Florida and the Provider that does not support the SSI percentage issued by CMS.

The Provider has worked with the State of Florida and has learned that similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.

The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to

⁷ Group Appeal Issue Statement in Case No. 21-1206GC.

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

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is \$5,245.

MAC's Contentions

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

The Medicare Contractor argues the following regarding Issue 1:

The MAC requests that the Board dismiss the portions of Issue 1 concerning SSI data accuracy and individuals who are eligible for SSI but did not receive SSI payment, as they are duplicative of the issue under appeal in Group Case Nos. 21-1206GC, "CHS CY 2018 DSH SSI Percentage Group". The Provider cannot have this issue in more than one appeal for the same fiscal year.

Further, the Provider's appeal over SSI realignment has been abandoned or withdrawn in accordance with Board Rule 25.3. Alternatively, the MAC requests the Board dismiss this issue consistent with other jurisdictional decisions cited previously. Lastly, the MAC contends that the Provider has failed to file a complete preliminary position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25. Therefore, the MAC respectfully requests that the Board dismiss this issue for the reasons stated above.⁹

Issue 3 – DSH Payment – Medicaid Eligible Days

Regarding Issue 3, the Medicare Contractor asserts the following arguments:

The MAC contends the Provider has abandoned the issue. The Provider has never submitted to the MAC a list of Medicaid eligible days in question. A complete list (if it exists) should have been made available to the MAC.

Again, the MAC contends that the Provider has failed to file a complete preliminary position paper in accordance with 42 C.F.R.

⁸ Provider's Preliminary Position Paper at 11-12 (Jul. 6, 2022).

⁹ Medicare Contractor's Jurisdictional Challenge at 12-13 (Oct. 4, 2022).

§ 405.1853(b)(2) and Board Rule 25. Therefore, the MAC respectfully requests that the Board dismiss this issue for the reasons stated above.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 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 should *dismiss* the only remaining issues in this appeal, Issues 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 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 disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in 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.

¹⁰ *Id.* at 13.

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 should find that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 22-0133 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 4.6¹⁵, the Board should dismiss 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 The Provider’s reliance upon referring to Issue 1 as “Provider Specific” and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged “provider specific” errors are specific to this provider. To this end, review of the Provider’s Preliminary Position Paper does not further clarify Issue 1. Provider fails 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 should find 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’ 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:

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.

25.2.2 Unavailable and Omitted Documents (Nov. 1, 2021)

If documents necessary to support your position are still unavailable, then provide the following information in the position papers:

1. *Identify* the missing documents;
2. *Explain why* the documents remain unavailable;
3. *State the efforts* made to obtain the documents; and
4. *Explain when* the documents will be available.

Once the documents become available, promptly forward them to the Board and the opposing party.¹⁸

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

<https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh>.¹⁹

This CMS webpage describes access to DSH data **from 1998 to 2022** and instructs providers to send a request via email to access their DSH data.”²⁰

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.

¹⁸ (Italics and underline emphasis added.)

¹⁹ Last accessed Nov. 12, 2024.

²⁰ (Emphasis added).

Accordingly, *based on the record before it*,²¹ the Board should find that the SSI Provider Specific issue in Case No. 22-0133 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 should dismiss 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—should be 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 should dismiss 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, Availability of Issue-Related Information and Basis for Dissatisfaction) (Nov. 2021) states:

No Access to Data

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

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

(b) *Position papers*. . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding the Board's jurisdiction over each remaining matter at issue in the**

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.

appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**

(3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.²²

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

Board Rule 25 (Nov. 2021) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

Rule 25 Preliminary Position Papers²³

COMMENTARY:

Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set 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 present the fully developed positions of the parties and expects that parties will be diligent in planning and conducting any required investigation, discovery, and analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the applicable sub-section.

25.1.1 The Provider's Position Paper

²² (Bold emphasis added.)

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

The provider's preliminary position paper must:

- A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
- B. For *each* issue that has not been fully resolved, provide a **fully** developed narrative that:
 - States the material facts that support the provider's claim.
 - Identifies the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
 - Provides a conclusion applying the material facts to the controlling authorities.
- C. Comply with Rule 25.2 addressing Exhibits.

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, then provide the following information in the position papers:

1. Identify the missing documents;
2. Explain why the documents remain unavailable;
3. State the efforts made to obtain the documents; and
4. Explain when the documents will be available.

Once the documents become available, promptly forward them to the Board and the opposing party.

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

The Board requires the parties file a *complete* preliminary position paper that includes a fully developed narrative (Rule 25.1), all exhibits (Rule 25.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn.

COMMENTARY: Note that the change to require a 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 November 15, 2021 included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

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

The hospital has the burden of furnishing data adequate to prove eligibility for *each* Medicaid patient *day claimed* under this paragraph, *and of verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.²⁴

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

²⁴ (Emphasis added.)

data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

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

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

On July 6, 2022, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.²⁵ Significantly, the position paper did *not* include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of \$21,860). 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:

²⁵ Provider's Preliminary Position Paper at 11 (Jul. 6, 2022).

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

Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2018 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

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

Notably, the Medicare Contractor sent a request for the Provider's list of Medicaid Eligible days (and also discussed the lack of the listing in the Medicare Contractor's own position paper filing). The notice was sent to the Provider on August 11, 2022. The Medicare Contractor informed the Provider in its request for information that the deadline to respond was 45 days from the date of the letter, or Monday, September 26, 2022. The Provider failed to file any response to the request.

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.²⁶

Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Jurisdictional Challenge. However, the Provider **failed** timely respond by the filing deadline (*i.e.*, 30 days after October 4, 2022).

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(iii). Specifically, the Board should find 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 should find that the Provider also failed to

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.

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

* * * * *

Based on the foregoing, the Board has dismissed the two (2) remaining issues in this case – (Issues 1 and 3). As no issues remain, the Board hereby closes Case No. 22-0133 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.

²⁷ (Emphasis added.)

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

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

Notice of Dismissal for Bayfront Health Dade City

Case No. 22-0133

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Board Members Participating:

Kevin D. Smith, CPA

Ratina Kelly, CPA

Nicole E. Musgrave, Esq.

Shakeba DuBose, Esq.

For the Board:

5/16/2025

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***

Houston Methodist West Hospital, Prov. No. 67-0067, FYE 12/31/2015
Case No. 19-2510

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 19-2510. 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. 19-2510

On **March 4, 2019**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end December 31, 2015.

On **August 27, 2019**, the Board received the Provider’s individual appeal request. The Individual Appeal Request contained nine (9) issues:

1. DSH Payment/SSI Percentage (Provider Specific)¹
2. DSH Payment/SSI Percentage (Systemic Errors)²
3. DSH/SSI Fraction Medicare Managed Care Part C Days³
4. DSH Medicaid Fraction Dual Eligible Days⁴
5. DSH Payment – Medicaid Eligible Days
6. DSH/SSI Fraction Medicaid Fraction (Managed Care Part C Days)⁵
7. DSH/SSI Fraction Dual Eligible Days⁶

¹ On March 31, 2025, this issue was withdrawn.

² On January 31, 2020, this issue was transferred to PRRB Case No. 20-0068GC.

³ On January 31, 2020, this issue was transferred to PRRB Case No. 20-0069GC.

⁴ On January 31, 2020, this issue was transferred to PRRB Case No. 20-0070GC.

⁵ On January 31, 2020, this issue was transferred to PRRB Case No. 20-0071GC.

⁶ On January 31, 2020, this issue was transferred to PRRB Case No. 20-0072GC.

8. Standardized Payment Amount⁷
9. Bad Debts⁸

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

Provider's Preliminary Position Paper – *For each issue*, the position paper **must** state the material facts that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and provide arguments applying the material facts*** to the controlling authorities. This filing **must** include ***any exhibits the Provider will use to support its position*** and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.⁹

On **April 22, 2020**, the Provider filed its preliminary position paper. The following is an excerpt of the Provider's position on Issue 5 set forth therein:

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.

HMWH is seeking reimbursement for an additional 177 Medicaid Eligible days. The Provider, in this appeal, contends that the documentation necessary to pursue DSH was not available from the State of Texas in time to include all DSH/Medicaid Eligible Days on the cost report.

⁷ On January 31, 2020, this issue was transferred to PRRB Case No. 20-0073GC.

⁸ On April 7, 2025, this issue was withdrawn.

⁹ (Emphasis added).

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

Medicaid Eligible Days results change over time. For this reason, providers generally prefer to prepare listings as close in time to a Hearing, Audit or Settlement as possible. Accordingly, the number expressed here may not be the number presented at hearing or settlement, but at this time the Provider is seeking to include an additional 177 Medicaid Eligible Days in its cost report.¹⁰

On **July 21, 2020**, the Medicare Contractor filed its preliminary position paper.

On **October 27, 2023**, 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*** 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 27 for more specific content requirements.¹¹

On **February 29, 2024**, the Provider timely filed its final position paper. The Provider's position is very similar to that put forth in the preliminary position paper, however, the Provider went from requesting an additional 177 Medicaid eligible days to an additional **2,562** Medicaid eligible days:

The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.

The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after

¹⁰ Provider's Preliminary Position Paper at 5-7.

¹¹ (Emphasis added).

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

HMWH is seeking reimbursement for an additional 177 Medicaid Eligible days. The Provider, in this appeal, contends that the documentation necessary to pursue DSH was not available from the State of Texas in time to include all DSH/Medicaid Eligible Days on the cost report.

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

Medicaid Eligible Days results change over time. For this reason, providers generally prefer to prepare listings as close in time to a Hearing, Audit or Settlement as possible. Accordingly, the number expressed here may not be the number presented at hearing or settlement, but at this time the Provider is seeking to include an *additional 2,562 Medicaid Eligible Days* in its cost report.

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

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

The most common circumstance in which the State of Texas Medicaid agency is unable to verify Medicaid eligible days involves the retroactive eligibility situation. An individual's eligibility for Medicaid commences on the date of her/his application to the program, assuming that individual meets the eligibility qualifications for Medicaid at the time of application submission. However, there is frequently considerable lag time between the date on which an individual submits her/his application for Medicaid, and the date on which that individual is determined to be eligible for the program. This lag time typically involves several months, and in some cases, several years. In this circumstance, the State of Texas Medicaid agency will not have the data to verify an individual's eligibility for Medicaid as of the date of the Provider's filing of its Medicare cost report. Of the

additional 2,562 days, all days relate to the eligibility identified subsequent to cost report being filed but before cost report was finally settled.¹²

On **March 29, 2024**, the Medicare Contractor timely filed its final position paper.

On **May 9, 2024**, the Provider requested a Change of Representative to Quality Reimbursement Services, Inc.

On **November 23, 2024**, the Provider submitted to the Board a redacted listing of Medicaid eligible days.

On **November 26, 2024**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 5.¹³

On **December 5, 2024**, the Provider filed a response to the jurisdictional challenge.

B. Description of Issue 5 in the Appeal Request

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

The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(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.

HMWH is seeking reimbursement for an additional 177 Medicaid Eligible days. The Provider, in this appeal, contends that the documentation necessary to pursue DSH was not available from the State of Texas in time to include all DSH/Medicaid Eligible Days on the cost report.

¹² Provider's Final Position Paper at 6-9 (emphasis added).

¹³ The Medicare Contractor previously filed a jurisdictional challenge over the SSI Provider Specific issue, however that issue has since been withdrawn.

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

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

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

HMWH uses Meditech system ("Meditech") to accumulate all patient records, including but not limited to patient demographic information and medical record (admission date, discharge date, insurance, DRG, etc.). Meditech generates monthly and annual reports which show patient days/admissions in total as well as by insurance plan. An annual Meditech detailed data file is also generated to include detailed patient demographic information and medical records. The annual Meditech detailed data file is then validated against an annual Meditech summary report to ensure the completeness and accuracy of the detailed data file.

After validation, the detailed data file is then uploaded to a secure portal owned by Trinity, an outside service consultant, which then processes the data against the Medicaid Eligibility data file and returns a report of Medicaid eligible days to be included in the cost report DSH calculation (Trinity data matching). Trinity has access to multiple States' Medicaid records and this allows HMWH to identify as many days as possible by the time of cost report filing. In the case when Trinity does not have access to a specific State's Medicaid record, HMWH will work with Trinity to apply for the access to the specific State's Medicaid record. This process may take several weeks.

As Medicaid Eligibility data file is a dynamic database and changes as new beneficiaries are added or current beneficiaries are dropped, HMWH normally requests Trinity data matching close to the cost report filing deadline to capture as many eligible days as possible. For the 2015 cost report, the Trinity matching was done in April 2016. However, in spite of performing the eligibility

process described, HMWH was unable to include all eligible days in the cost report for various reasons outside of their control. For example, many patients have their Medicaid status pending and coverage was retroactively determined months or sometimes even years after the cost report was filed. There are numerous other reasons why a patient day cannot consistently be determined to be eligible by the filing date of the cost report. In any event, as already stated, it is beyond the Provider's ability to determine just why patient days or any particular patient day could not be matched by the State as eligible at one point in time (in this case, by the date of the cost report filing), but subsequently is matched as eligible by the State.

As noted above, practical impediments precluded the identification of all additional Medicaid Eligible Days. It is impossible for the Provider to claim all of its Medicaid Eligible Days at the time of filing its cost report.

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

Medicaid Eligible Days results change over time. For this reason, providers generally prefer to prepare listings as close in time to a Hearing, Audit or Settlement as possible. Accordingly, the number expressed here may not be the number presented at hearing or settlement, but at this time the Provider is seeking to include an additional 177 Medicaid Eligible Days in its cost report. . .¹⁴

The Provider estimated the reimbursement impact of the issue at \$17,543 based on an increase of 177 additional Medicaid days but failed to include a list of the additional days.¹⁵

MAC's Jurisdictional Challenge

Issue 5 – DSH Payment – Medicaid Eligible Days

The Medicare Contractor contends that this issue should be dismissed because the Provider failed to 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.

¹⁴ Issue Statement at 1-3 (August 27, 2019).

¹⁵ *Id.* at 3 (August 27, 2019).

The Medicare Contractor notes that a Medicaid eligible days listing was never received with the Provider's preliminary position paper. The Medicare Contractor further notes that the Provider failed to submit an unredacted listing of additional Medicaid eligible days with its final position paper.¹⁶

The Medicare Contractor contends 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 and final position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. The Provider has not submitted accurate and sufficient data to demonstrate that patients were eligible for Medicaid on the claimed patient hospital days or identified as to why the data is not yet available or when it will become available.¹⁷

Additionally, the Medicare Contractor argues this issue should be dismissed because the Provider is attempting to untimely and improperly add the issue of Section 1115 waiver days as a sub-issue via its final position paper filed on February 29, 2024. The Medicare Contractor issued the Provider's NPR on March 4, 2019. In accordance with 42 C.F.R. § 415.1835(e), the deadline for adding issues to the appeal was October 30, 2019. The issue was informally added through the Provider's final position paper, more than four years after the filing deadline to add an issue.¹⁸

The Medicare Contractor contends that the Section 1115 Waiver Days issue is one component of the DSH issue that must be appealed as a separate issue. The Medicare Contractor 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 appeal separately.¹⁹

Provider's Jurisdictional Response

Issue 5 – DSH Payment – Medicaid Eligible Days

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:

Section 1115 waiver days are part and parcel of Medicaid eligible days. And whereas the [Medicare Contractor] states that the Section 1115 Waiver Days issue is one component of the DSH

¹⁶ Medicare Contractor's Jurisdictional Challenge at 7 (Nov. 26, 2024).

¹⁷ *Id.* at 7-10.

¹⁸ *Id.* at 10-12.

¹⁹ *Id.* at 12-13.

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.²⁰

The Provider goes on to contend that the version of Board Rule 8 (July 1, 2015), that it alleges was effective when the Provider filed its appeal, makes no mention of “section 115 waiver days” nor even “Medicaid eligible days.” Thus, even if Rule 8’s extension to “components of issues” were valid (and the Provider contends it is not), the Provider had no notice that it was required to specify section 115 waiver days in its appeal request, and it would be a denial of due process for the PRRB to dismiss the section 115 waiver days component of its appeal of Medicaid eligible days.²¹

Finally, the Provider contends that prior to submission of the Provider’s Final Position Paper, the Fifth Circuit ruled that the statute and CMS’s own regulations require that CMS regard inpatient days attributable to an uncompensated care pool population as Medicaid eligible days, *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019). The Medicare Contractor is required by specific command of CMS to accept and audit the Provider’s section 115 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 Medicare Contractor has the duty to accept the Provider’s listing of section 115 days and audit them. The Provider states that it submitted a redacted listing to the Medicare Contractor on November 23, 2024.²²

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.

²⁰ Provider’s Jurisdictional Response at 3-4 (Dec. 5, 2024).

²¹ *Id.* at 4-5.

²² *Id.* at 6.

A. DSH Payment – Medicaid Eligible Days

1. Section 1115 Waiver Days

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

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

(b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing...must be submitted in writing to the Board, and the request must include...

(2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final...determination under appeal, including an account of...

(i) why the provider believes Medicare payment is incorrect for each disputed item...[and]

(ii) how and why the provider believes Medicare payment must be determined differently for each disputed item...²³

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,
 - why the adjustment is incorrect,
 - how the payment should be determined differently,
 - the reimbursement effect, and
 - the basis for jurisdiction before the Board.²⁴

²³ 42 C.F.R. § 405.1835(b).

²⁴ v. 2.0 (Aug. 2018).

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

Several examples are identified below, but these examples are not exhaustive lists of categories or issues.

A. Disproportionate Share Hospital Payments

Common examples include, but are not limited to:

...

- ***Section 1115 waiver days (program/waiver specific)***²⁵

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.²⁶

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, 2000.²⁷ Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program **and** not every inpatient day associated with beneficiary enrolled in an 1115

²⁵ (Bold and italic emphasis added).

²⁶ See 73 Fed. Reg. 30190 (May 23, 2008).

²⁷ 65 FR 47054, 47087 (Aug. 1, 2000).

waiver program qualifies to be included in the Medicaid fraction.²⁰ In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

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

Regardless, even if the Provider had included in its appeal request (which it did not), the Provider failed to properly develop the issue in its position paper filings. First, the Provider's preliminary position paper does not even mention § 1115 waiver days (much less even identify the specific 1115 waiver day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (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* § 1115 waiver days sub-issue.

Finally, even in the Provider’s final position paper, the Provider fails to identify what § 1115 waiver program(s) are involved and whether or not the § 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as “days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act” and the patients underlying those days are “deemed eligible for Medicaid” based on “the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered.” Rather, the final position paper is perfunctory. 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 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*.²⁸ 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 . . .”²⁹ 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.”³⁰ 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.³¹ Here, the Board makes the same finding based on similarly *overly generalized language*.

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 27.2.³² In the alternative, the Board finds that,

²⁸ No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

²⁹ *Id.* at *11.

³⁰ *Id.*

³¹ *Id.*

³² 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).

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.

2. Medicaid Eligible Days

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

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

No Access to Data

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

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

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

(3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.³³

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:

³³ (Bold emphasis added.)

Rule 25 Preliminary Position Papers³⁴

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.
- 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

³⁴ (Emphasis added.)

filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

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

Moreover, in connection with Issue 5, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish *each Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(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.³⁵

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

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

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

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

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

On April 22, 2020, the Provider filed its preliminary position paper in which no eligibility listing was submitted as an exhibit.³⁶ 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 \$17,543 based on an estimated 177 days).

On February 29, 2024, the Provider filed its final position paper. The position paper stated that a redacted version of the Provider’s Medicaid Eligible Days listing was being included with the paper, which was included as Exhibit 1. Subsequently, on November 23, 2024, the Provider again submitted a redacted Medicaid Eligible Days Listing to the Board. The Listing was 17 pages with 2,562 Medicaid eligible days. No explanation was provided as to why the listing of days was being submitted at this late date, *more than 8 years after the fiscal year at issue had*

³⁵ (Emphasis added.)

³⁶ Provider’s Preliminary Position Paper at 7.

closed. NOTE—the 2,562 days included in this belated listing is exponentially larger than the original estimate of 177 days included with the appeal request. Regardless, this filing, importantly, ***was more than 4 years past the deadline for including it with the preliminary position paper*** since the position paper deadline was April 23, 2020.

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

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof “to prove eligibility for ***each*** Medicaid patient day claimed”³⁷ and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to submit a finalized listing of Medicaid eligible days, notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is \$0.

Based on the above, the Board finds that the Provider has failed to comply with the Board’s procedures with regard to filing its position 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.³⁸

³⁷ (Emphasis added.)

³⁸ See also *Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022): The Board acts reasonably, and not arbitrarily and capriciously, when it applies its “claims-processing rules faithfully to [a provider’s] appeal.” *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide “[a]n explanation [] for each specific item under appeal.” 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that “[s]ome issues may have multiple components,” and that “[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible.” Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a “common example” of an appeal involving issues with “multiple components” that must be appealed as “separate issue[s] and described as narrowly as possible.” Board Rules §§ 8.1, 8.2.

Notice of Dismissal for Houston Methodist West Hospital

Case No. 19-2510

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Based on the foregoing, the Board dismisses the remaining issue, Issue 5, in this case. As no issues remain, the Board hereby closes Case No. 19-2510 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:

5/19/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Dismissal of Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Groups***
25-2361GC *et al.* (See Attached Listing of 195 Cases)

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the “Board”) has reviewed the appeal requests in the 195 above-referenced cases. Set forth below is the decision of the Board to dismiss the above-captioned common issue related party (“CIRP”) group appeals. The pertinent facts and the Board’s determination are set forth below.

Introduction:

Quality Reimbursement Services, Inc. (“QRS”) filed the above-referenced 195 CIRP group appeals in the Office of Hearings Case & Document Management System (“OH CDMS”). The issue statements in these groups are materially identical. The Providers contend that the Medicare/SSI Fractions published on CMS’ website on August 13, 2024, pursuant to CMS transmittal 12785, were determined incorrectly due to the “inclusion of Medicare Part C days in the denominator of the Fraction . . . and . . . exclusion of days from the numerator of the Medicare Fraction associated with individuals who were entitled to Supplemental Security Income (SSI) during their hospital stay but who were not in SSI pay status during such stays, or were in SSI pay status during their hospital stay but were not assigned payment status code C01, M01 or M02.”¹

Background:

A. Medicare DSH Payment and Realignment

Part A of the Medicare statute covers inpatient hospital services. Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system (“PPS”).² Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.³

¹ See e.g., Case No 25-2361GC, Providers’ Issue Statement at 1 (Feb. 10, 2025)

² See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

³ *Id.*

The PPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.⁴ This case involves the hospital-specific disproportionate share hospital (“DSH”) adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.⁵

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage (“DPP”).⁶ As a proxy for utilization by low-income patients, the DPP determines a hospital’s qualification as a DSH, and the amount of the DSH payment to be paid to a qualifying hospital.⁷ The DPP is defined as the sum of two fractions expressed as percentages.⁸ Those two fractions are referred to as the “Medicare/SSI fraction” and the “Medicaid fraction.”

This matter concerns the Medicare/SSI fraction.⁹ The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), defines the Medicare/SSI fraction as:

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services (“CMS”), and the Medicare contractors use CMS’ calculation to compute a hospital’s eligibility for and if eligible, the amount of any DSH payment adjustment.¹⁰ CMS calculates the Medicare/SSI Fractions used to calculate Medicare DSH payments based on discharges in the respective federal fiscal year, but hospitals are permitted under 42 C.F.R. § 412.106(b)(3) to request that CMS recalculate, or “realign,” their Medicare/SSI Fractions based on discharges in the hospital’s cost reporting period.

⁴ See 42 U.S.C. § 1395ww(d)(5).

⁵ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

⁶ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(l).

⁷ See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

⁸ See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

⁹ The other component of the DPP not at issue in this matter is the “Medicaid Fraction” which is the number of hospital patient days for patients eligible for medical assistance under a State Medicaid plan (*i.e.* a plan approved by the Secretary under 42 U.S.C. § 1396 *et seq.*) but who were not entitled to Medicare Part A, divided by the total number of hospital patient days. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). See also 42 C.F.R. § 412.106(b)(4).

¹⁰ 42 C.F.R. § 412.106(b)(2)-(3).

B. Appeal of Publication of Medicare/SSI Fraction Data Pursuant to CMS Transmittal 12785

The Providers in these groups state that they are appealing from the publication of Medicare/SSI Fractions on CMS’ website on August 13, 2024, that was done pursuant to CMS Transmittal 12785, “Instructions for Processing Requests for SSI Realignment for Cost Reporting Periods Starting Before October 1, 2013.” Transmittal 12785 replaced and updated Transmittal 12747 that was originally issued on July 26, 2024. The original Transmittal 12747 announced that CMS was resuming the processing of realignment requests for cost reporting periods starting before October 1, 2013. With realignment, hospitals are permitted under 42 C.F.R. § 412.106(b)(3) to request that CMS recalculate, or “realign,” their Medicare/SSI Fractions based on discharges in the hospital’s cost reporting period, rather than CMS’ calculated Medicare/SSI Fractions based on discharges in the respective federal fiscal year.

The original Transmittal 12747 which Transmittal 12785 updates describes how CMS temporarily halted the processing of realignment requests for cost reporting periods starting before October 1, 2013, due “to a lack of policy established through notice-and-comment rulemaking regarding the treatment of Part C days for that period of time.”¹¹ However, on June 9, 2023, CMS issued Final Rule CMS-1739-F, finalizing the treatment of Medicare Part C days in determining a hospital’s DPP, whereby such days are to be included in the Medicare/SSI Fraction and excluded from the numerator of the Medicaid fraction. Both transmittals announce that with the issuance of final rule CMS-1739-F, and the publication of provider Medicare/SSI Fractions on the CMS website, the agency was resuming the processing of realignment requests for such cost reporting periods.

The original Transmittal 12747 states that the Medicare/SSI Fractions available on the CMS website for cost reporting periods starting before October 1, 2013, like the federal fiscal year Medicare/SSI Fractions for the same period, were determined pursuant to final rule CMS-1739-F. The transmittal directs MACs to use such fractions to determine DSH payments for realignment requests in appropriate cases. The Transmittal explains that for realignment requests for such cost reporting periods, “CMS will calculate cost reporting period SSI ratios for all periods, for all hospitals, and post those ratios to the CMS DSH website”¹² Both Transmittal 12785 and the earlier Transmittal 12747 which it updates are nearly identical and focused on the realignment process. The *only* change in Transmittal 12785 from the earlier Transmittal 12747 is addressing a formatting change “to update the DSH Adjustment and Realignment files years 1988-2013, so that the SSI Ratio column is consistently rounded to four (4) decimals in all files. All other information remains the same.”¹³

Board Determination:

In these cases, the Providers maintain that CMS’ publication of Medicare Fraction data on its website pursuant to Transmittal 12785 on August 13, 2024, “constitutes ‘a final determination of

¹¹ CMS Transmittal 12747 at 3 (July 26, 2024).

¹² *Id.*

¹³ CMS Transmittal 12785 at 1 (Aug. 13, 2024).

the Secretary as to the amount of the payment under subsection . . . (d) of section 1886’ of the Social Security Act (the Act)” and because the Provider Group “is dissatisfied with this determination . . . the PRRB has jurisdiction over” the appeal.¹⁴ However, the publication of Medicare/SSI Fractions in conjunction with Transmittal 12785, which merely requires a formatting change to the Medicare/SSI Fraction data posted on CMS’ website so that the “SSI Ratio column is consistently rounded to four (4) decimals in all files” is not a “final determination” from which a provider may appeal. As explained below, the Board dismisses this matter for lack of jurisdiction over the Providers’ appeals in these 195 groups.

The Medicare statute authorizes providers to seek hearings before the PRRB in two sets of circumstances: First, where the provider is dissatisfied with “the amount of total program reimbursement” as set forth in a Notice of Program Reimbursement (“NPR”);¹⁵ and second, where the provider is dissatisfied with a “final determination” “as to the amount of the payment” under the prospective payment system.¹⁶ In this case, the Providers in these groups have not yet received NPRs and have based their appeals, pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(ii), on their dissatisfaction with Medicare/SSI Fraction data that was published on the CMS website in conjunction with Transmittal 12785.

The Providers, in their Issue Statements, acknowledge that the Board “has taken the position that publication of [Medicare/SSI Fraction data on CMS’ website] is not a final determination.”¹⁷ But the Providers also note disagreement with the Board’s position, citing *Battle Creek Health Sys. v. Becerra*,¹⁸ and *Baylor All Saints Med. Ctr. v. Becerra*,¹⁹ decisions where courts held that providers met the requirements for a Board appeal before receiving a final appealable determination as to the amount of DSH payment.²⁰

For the Board, the court’s decision in *Battle Creek* is inapposite because, unlike in the instant cases, the challenged Transmittal and publication of data in that case was described by the court as being a “*fait accompli*.”²¹ The court in *Battle Creek* observed that the challenged Transmittal and publication of data there “provided, with some finality, ‘advance knowledge of the amount of [the DSH] payment.’”²² Yet, in the instant cases, the publication of the challenged Transmittal and accompanying Medicare/SSI Fraction data, provided by CMS for the purpose of informing provider choice as to whether to request realignment of the Medicare/SSI Fraction, does not definitively inform whether a provider qualifies for the DSH adjustment, much less the amount of DSH reimbursement that a provider could receive.

¹⁴ See e.g. Case No 25-2361GC, Providers’ Issue Statement at 1.

¹⁵ 42 U.S.C. § 1395oo(a)(1)(A)(i).

¹⁶ *Id.* § 1395oo(a)(1)(A)(ii).

¹⁷ See e.g. Case No 25-2361GC, Providers’ Issue Statement at 1.

¹⁸ 2023 WL 7156125 (D.D.C. Oct. 31, 2023), *appeal docketed*, No. 23-5310 (D.C. Cir. Dec. 29, 2023).

¹⁹ 2024 WL 3833278 (N.D. Tex. Aug. 15, 2024), *appeal docketed*, No. 24-10934 (5th Cir. Oct. 17, 2024).

²⁰ See e.g. Case No 25-2361GC, Providers’ Issue Statement at 1.

²¹ *Battle Creek*, 2023 WL 7156125 at *5.

²² *Id.*

In recent Board decisions, the Board has continued to notice its disagreement with *Battle Creek* and by extension, other court decisions like *Baylor All Saints*.²³ The Board has maintained that *Memorial Hospital v. Becerra*²⁴ is a better-reasoned decision and provides a more thoughtful analysis. In *Memorial Hospital*, a group of providers filed an appeal similar to the Providers' appeals in these 195 groups. The *Memorial Hospital* providers challenged CMS' publication of Medicare/SSI Fraction data, arguing that there are certain instances where a provider can file a Board appeal prior to receiving an NPR. The court in *Memorial Hospital* ultimately agreed with the Board that CMS' publication of Medicare/SSI Fractions was not an appealable final determination.

The court distilled the parties' positions as "boil[ing] down to a dispute about whether Plaintiffs have conflated a determination by the Secretary about one of several undetermined elements that eventually flows into the amount of payment and 'a final determination of the Secretary as to the amount of payment.'"²⁵ The court held that CMS' publication of Medicare/SSI Fractions, even if the publication of such fractions had been issued as "final," could and would not be a final determination "as to the amount of payment" because the Medicare/SSI Fractions are "just one of the variables that determines whether hospitals receive a DSH payment and, if so, for how much."²⁶ For the court, a challenge to an element of payment under 42 U.S.C. § 1395oo(a)(1)(A)(ii) is only appropriate if, as the D.C. Circuit has explained, "the Secretary ha[s] firmly established 'the only variable factor in the final determination as to the amount of payment under § 1395ww(d).'"²⁷

Using the reasoning in *Memorial Hospital*, given the nature of the DSH adjustment, the publication of hospitals' Medicare/SSI Fractions on CMS' website is not final a determination as to the amount of payment due to any provider because the Medicare/SSI Fraction alone does not determine the amounts hospitals will be paid under the adjustment. Instead, the Medicare/SSI Fraction is incorporated, along with the Medicaid Fraction, into the DPP, which is ultimately the calculation that determines eligibility for and the amount of any DSH adjustment. The DPP must also exceed certain thresholds to qualify for any DSH adjustment.²⁸ Thus, although CMS calculates and publishes the Medicare/SSI Fraction for every hospital that receives Medicare reimbursement, the determination of whether a hospital receives reimbursement is made only after the hospital submits its year-end cost report.

In this matter, the Providers contend that the Medicare/SSI Fractions published on CMS' website on August 13, 2024, pursuant to CMS transmittal 12785, were determined incorrectly due to the "inclusion of Medicare Part C days in the denominator of the Fraction" and . . . "exclusion of

²³ See, e.g., Board decisions in PRRB Case Nos. 24-0491, 24-1531GC, and 24-0413GC.

²⁴ 2022 WL 888190 (D.D.C. Mar. 25, 2022).

²⁵ *Id.* at *3.

²⁶ *Id.* at *9.

²⁷ *Id.* at *8 (quoting *Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807, 811 (D.C. Cir. 2001) (quoting *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 147 (D.C. Cir. 1986)) (emphasis added); see also *Samaritan Health Serv. v. Sullivan*, 1990 WL 33141 at *3 (9th Cir. 1990) (unpublished table decision) ("We have held that if the Secretary's classification of a hospital effectively fixes the hospital's reimbursement rate, then that decision is a 'final determination' as referred to 42 U.S.C. § 1395oo(a)(1)(A)(ii).").

²⁸ 42 C.F.R. § 412.106(d)(2)(i)-(ii).

days from the numerator of the Medicare Fraction associated with individuals who were entitled to [SSI] during their hospital stay but who were not in SSI pay status during such stays, or were in SSI pay status during their hospital stay but were not assigned payment status code C01, M01 or M02.”²⁹ Transmittal 12785 bears no connection to the issue under appeal as the Transmittal merely implements a formatting change to the SSI Fraction data that was previously made available through the earlier Transmittal 12747 in order to ensure that the SSI Ratio column is consistently rounded to four decimals in all files. This information is published so that providers have sufficient information available to inform whether they want to request realignment. Providers cannot claim that with publication of Medicare/SSI Fraction data on CMS’ website in a new decimal format pursuant to Transmittal 12785, they are somehow “dissatisfied with a final determination of Secretary as to the amount of payment.”³⁰

Neither the publication of the Medicare/SSI Fraction data, nor the decimal formatting change described in Transmittal 12785 informs whether a provider qualifies for the DSH adjustment, much less the amount of DSH reimbursement that a provider could receive. The Providers here have included no proof that they have requested realignment, nor even that with realignment they would be eligible for DSH reimbursement (changes in either the Medicare/SSI or Medicaid fractions could potentially result in a DPP below that required to qualify for the DSH adjustment). Moreover, appeal of Transmittal 12785 which only rounded the published Medicare/SSI Fraction data to four decimal places, concerns only one factor of the DPP and is almost certainly unlikely to result in a change in DSH reimbursement sufficient to meet the amount in controversy required for a group appeal (\$50,000 or more).³¹ That CMS is providing such information to inform a provider’s choice as to whether to request realignment of the Medicare/SSI Fraction that will be calculated for use in determining the DPP that ultimately determines whether a provider qualifies for DSH and how much they could receive, clearly indicates that the publication of SSI Fraction data is not a final determination as to the amount of payment.

Conclusion:

As the Medicare/SSI Fraction data published pursuant to Transmittal 12785 is not an appropriately appealable final determination, the Providers have failed to meet the jurisdictional requirements for a hearing and the Board dismisses the 195 group appeals and removes them from the Board’s docket.

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

²⁹ See *e.g.* Case No 25-2361GC, Providers’ Issue Statement at 1. Although the Providers characterize this as the “sole issue” under appeal, the issue statement appears to encompass two separate and distinct issues: 1) the inclusion of Medicare Part C days in the denominator of the Medicare/SSI Fraction; and 2) the exclusion of patient days for individuals eligible for both Medicare and SSI from the numerator of the Medicare/SSI Fraction. This conflation of issues is contrary to 42 C.F.R. § 405.1837(a)(2) which restricts a group appeal to a “single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group.” See also PRRB rule 13.

³⁰ See 42 U.S.C. § 1395oo(a)(1)(A)(ii).

³¹ See 42 U.S.C. § 1395oo(b); 42 C.F.R. § 405.1837(a)(3).

Board Members Participating:

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

FOR THE BOARD:

5/19/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA

Board Chair

Signed by: Kevin D. Smith -A

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Dana Johnson, Palmetto GBA c/o NGS, Inc.
Geoff Pike, First Coast Service Options, Inc. c/o Guidewell Source
Danelle Decker, National Government Services, Inc.
Cecille Huggins, Palmetto GBA

Listing of 195 Cases

25-2834GC	Baptist Health System CY 1988 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2837GC	Baptist Health System CY 1989 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2838GC	Baptist Health System CY 1990 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2839GC	Baptist Health System CY 1991 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2841GC	Baptist Health System CY 1992 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2842GC	Baptist Health System CY 1993 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2843GC	Baptist Health System CY 1994 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2844GC	Baptist Health System CY 1995 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2846GC	Baptist Health System CY 1996 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2847GC	Baptist Health System CY 1997 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2848GC	Baptist Health System CY 1998 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2849GC	Baptist Health System CY 1999 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2850GC	Baptist Health System CY 2000 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2851GC	Baptist Health System CY 2001 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2853GC	Baptist Health System CY 2002 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2332GC	Yale-New Haven CY 1996 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2334GC	Yale-New Haven CY 1997 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2335GC	Yale-New Haven CY 1998 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2336GC	Yale-New Haven CY 1999 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2338GC	Yale-New Haven CY 2000 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2339GC	Yale-New Haven CY 2001 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group

25-2341GC	Yale-New Haven CY 2002 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2342GC	Yale-New Haven CY 2003 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2343GC	Yale-New Haven CY 2004 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2345GC	Yale-New Haven CY 2005 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2346GC	Yale-New Haven CY 2006 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2347GC	Yale-New Haven CY 2007 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2350GC	Yale-New Haven CY 2008 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2352GC	Yale-New Haven CY 2011 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2354GC	Yale-New Haven CY 2012 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2375GC	Yale-New Haven CY 2014 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2376GC	Yale-New Haven CY 2015 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2383GC	Yale-New Haven CY 2016 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2385GC	Yale-New Haven CY 2017 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2388GC	Yale-New Haven CY 2018 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2390GC	Yale-New Haven CY 2019 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2391GC	Yale-New Haven CY 2020 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2393GC	Yale-New Haven CY 2021 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2395GC	Yale-New Haven CY 2022 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2440GC	Hartford Health CY 2004 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2441GC	Hartford Health CY 2005 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2442GC	Hartford Health CY 2006 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2443GC	Hartford Health CY 2007 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group

25-2445GC	Hartford Health CY 2008 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2447GC	Hartford Health CY 2011 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2448GC	Hartford Health CY 2012 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2449GC	Hartford Health CY 2013 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2456GC	Hartford Health CY 1996 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2458GC	Hartford Health CY 1997 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2459GC	Hartford Health CY 1998 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2460GC	Hartford Health CY 1999 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2461GC	Hartford Health CY 2000 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2462GC	Hartford Health CY 2001 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2464GC	Hartford Health CY 2002 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2465GC	Hartford Health CY 2003 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2466GC	Hartford Health CY 2009 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2468GC	Hartford Health CY 1992 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2470GC	Hartford Health CY 1993 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2471GC	Hartford Health CY 1994 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2472GC	Hartford Health CY 1995 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2639GC	Yale-New Haven CY 1995 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2640GC	Yale-New Haven CY 1994 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2642GC	Yale-New Haven CY 1993 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2643GC	Yale-New Haven CY 1992 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2644GC	Yale-New Haven CY 1991 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group

25-2645GC	Yale-New Haven CY 1990 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2647GC	Yale-New Haven CY 1989 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2232GC	Baptist Memorial CY 1996 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2239GC	Baptist Memorial CY 1997 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2243GC	Baptist Memorial CY 1998 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2245GC	Baptist Memorial CY 1999 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
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25-2251GC	Baptist Memorial CY 2001 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2253GC	Baptist Memorial CY 2002 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2256GC	Baptist Memorial CY 2003 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2257GC	Baptist Memorial CY 2004 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
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25-2263GC	Baptist Memorial CY 2007 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
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25-2266GC	Baptist Memorial CY 2009 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2267GC	Baptist Memorial CY 2010 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2268GC	Baptist Memorial CY 2011 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2269GC	Baptist Memorial CY 2012 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2270GC	Baptist Memorial CY 2013 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2413GC	DCH Health CY 2004 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2414GC	DCH Health CY 2007 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group

25-2416GC	DCH Health CY 2008 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
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25-2420GC	DCH Health CY 2010 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2423GC	DCH Health CY 2011 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2432GC	DCH Health CY 2012 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
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25-2632GC	Baptist Memorial CY 1990 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2633GC	Baptist Memorial CY 1989 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
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25-2732GC	Ballad Health CY 2002 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2733GC	Ballad Health CY 1989 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
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25-2745GC	Ballad Health CY 2003 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2755GC	Ballad Health CY 2005 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2764GC	Ballad Health CY 2006 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group

25-2765GC	Ballad Health CY 2007 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2766GC	Ballad Health CY 2013 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2784GC	Ballad Health CY 2008 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2791GC	Ballad Health CY 2009 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
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25-2361GC	Novant Health CY 2013 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2450GC	Advocate Health CY 2008 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
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25-2594GC	Advocate Health CY 2006 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2603GC	Advocate Health CY 2007 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Danelle Decker
National Government Services, Inc.
Mail point INA 102-AF42 P.O. Box 6474
Indianapolis, IN 46206

RE: ***Board Decision – DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues***
Norwalk Hospital Association (Provider No. 07-0034)
FYE 09/30/2018
Case No. 21-1773

Dear Mr. Ravindran and Ms. Decker,

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

Background:

A. Procedural History for Case No. 21-1773

On **March 18, 2021**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end September 30, 2018.

On **September 3, 2021**, 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 Days²
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 Days⁴
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. Standardized Payment Amount⁶
9. ATRA IPPS Payment Reduction⁷

¹ On April 14, 2022, this issue was transferred to PRRB Case No. 22-1001GC.

² On April 14, 2022, this issue was transferred to PRRB Case No. 22-1003GC.

³ On April 14, 2022, this issue was transferred to PRRB Case No. 22-0999GC.

⁴ On April 14, 2022, this issue was transferred to PRRB Case No. 22-1003GC.

⁵ On April 14, 2022 this issue was transferred to PRRB Case No. 22-1000GC.

⁶ On April 14, 2022, this issue was transferred to PRRB Case No. 22-1002GC.

⁷ This issue was withdrawn on April 14, 2022.

The Provider is commonly owned/controlled by Nuvance Health and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **April 14, 2022**, the Provider transferred Issues 2, 3, 4, 6, 7 and 8 to Nuvance 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 **September 21, 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 25.⁸

On **April 13, 2022**, the Provider changed its designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **May 2, 2022**, the Provider timely filed its preliminary position paper.

On **August 22, 2022**, the Medicare Administrative Contractor timely filed its preliminary position paper.

On **October 31, 2022**, the Medicare Administrative Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 5. 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. 22-1001GC

In their Individual Appeal Request, Provider summarizes its legal basis for the DSH Payment/SSI Percentage (Provider Specific) issue, 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.

...

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.⁹

On May 2, 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 the Provider's DSH calculation. This is based on certain data from the State of Connecticut and the Provider that does not support the SSI percentage issued by CMS.

The Provider has worked with the State of Connecticut and has learned that similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.

The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.¹⁰

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 \$94,000.

The group issue statement in Case No. 22-1001GC, Nuvance Health CY 2018 DSH SSI Percentage CIRP Group, to which the Provider transferred Issue 2 (Systemic Errors) reads, in part:

⁹ Issue Statement at 1 (Sept. 3, 2021).

¹⁰ Provider's Preliminary Position Paper at 8-9 (May 2, 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.¹¹

C. Description of Issue 5 in the Appeal Request

In 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

¹¹ Group Issue Statement, Case No. 22-1001GC.

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): 1,6,9,S-D

Estimated Reimbursement Amount: \$116,000¹²

In its Preliminary Position Paper, the Provider argues that pursuant to the *Jewish Hospital* case¹³ 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) 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.¹⁵

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 6-7 (Oct. 31, 2022).

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

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

...

The Provider's appeal is premature. The Provider's fiscal year end is the same as the federal fiscal year end and thus realignment is not applicable. Moreover, the Provider did not request to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.¹⁶

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.¹⁷

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.”¹⁸ 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.”¹⁹ Specifically the MAC avers:

Within the Provider's Preliminary Position Paper, the Provider makes the broad allegation that “The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation” yet offers no evidence or analysis to demonstrate that CMS calculated its SSI percentage inaccurately. The Providers failed to include any evidence to establish the material facts in this case relating to inaccuracies in the SSI Percentage calculation at issue or any evidence pertaining to the alleged systemic SSI ratio data match errors like those referenced in the *Baystate* case. The Provider merely repeats their appeal request which itself is a verbatim recitation of the deficiencies that the Board found in the *Baystate* case.²⁰

¹⁶ *Id.* at 7.

¹⁷ *Id.* at 4-6.

¹⁸ *Id.* at 8.

¹⁹ *Id.* at 9.

²⁰ *Id.* at 9-10.

Issue 5 – DSH Payment – Medicaid Eligible Days

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

The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.

Within its preliminary position paper, the Provider makes the broad allegation, “. . . the Provider contends that the total number of days reflected in its’ [sic] 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.²¹

Provider’s Jurisdictional Response

Board Rule 44.4.3 specifies: “Providers must file a response within thirty (30) days of the Medicare Administrative 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 October 31, 2022. The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed.

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare Administrative 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 remaining two (2) issues in the appeal.

A. DSH Payment/SSI Percentage (Provider Specific)

²¹ *Id.* at 11-12.

The analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider's disagreement with how the Medicare Administrative 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 Administrative 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. 22-1001GC.

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.”²² Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Administrative Contractor “did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i).”²³ 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 Administrative 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.”²⁴

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 22-1001GC also alleges that the Medicare Administrative 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. 22-1001GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6²⁵, 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 a particular 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.²⁶ Accordingly, Provider's reference to Issue 1 as “Provider Specific” and keeping it in an individual appeal is misplaced. In this respect,

²² Issue Statement at 1.

²³ *Id.*

²⁴ *Id.*

²⁵ PRRB Rules v. 2.0 (Aug. 2018).

²⁶ 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).

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. 22-1001GC.

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. 22-1001GC, 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 25²⁷ (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.²⁸

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule:

Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital’s patients eligible for both SSI and Medicare at the hospital’s request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the*

²⁷ PRRB Rules v. 3.1 (Nov. 2021).

²⁸ (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>.²⁹

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."³⁰

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 22-1001GC are the same issue.³¹ 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.

First, the Provider's FYE **is September 30**; therefore, it is already on the Federal fiscal year end. Second, 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage states, "[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[.]" There is nothing in the record indicating that the Provider submitted the written request or that the Medicare Administrative Contractor has made a final determination regarding DSH SSI Percentage

²⁹ Last accessed August 14, 2024.

³⁰ Emphasis added.

³¹ Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Nuvance Health CIRP group per 42 C.F.R. § 405.1837(b)(1).

realignment from which the Provider can appeal. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

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.³²

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

³² Individual Appeal Request, Issue 3.

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.*³³

Similarly, with regard to position papers,³⁴ Board Rule 25.2.1³⁵ requires that “the parties must exchange ***all*** available documentation as exhibits to fully support your position.”³⁶ 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:

³³ (Emphasis added).

³⁴ The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.

³⁵ PRRB Rules 3.1.

³⁶ (Emphasis added).

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.³⁷

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 3, 2021 (over 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 separate cover.³⁸ ***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.³⁹ Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 22-1001GC and because the purported realignment portion of the issue is premature in absence of a properly submitted written

³⁷ (Emphasis added).

³⁸ Provider's Preliminary Position Paper at 8.

³⁹ *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.

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. 21-1773 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:

5/19/2025

X Shakeba DuBose

Shakeba DuBose, Esq.

Board Member

Signed by: PIV

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



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

Via Electronic Delivery

Douglas Lemieux Jr., Sr. Director Hospital Reimbursement
Kaiser Foundation Health Plan and Hospitals
393 E Walnut Street
Pasadena, CA 91188

RE: ***Board Determination on MAC's Motion to Dismiss - Failure to File Rule 20 Certification***

Kaiser Health CY 2019 SSI Calculation Inaccuracy Data Matching Error CIRP Group
Case Number: 24-0465GC

Dear Mr. Lemieux:

The Provider Reimbursement Review Board (the "Board") has reviewed the Medicare Contractor's ("MAC's") Motion to Dismiss dated March 14, 2025, the MAC's Rule 22 Review Letter dated April 10, 2025, and the Group's response filed by Kaiser Foundation Health Plan and Hospitals ("Kaiser") dated March 28, 2025. The pertinent facts that were considered and the Board's determination are set forth below.

Pertinent Facts:

On **December 11, 2023**, Kaiser filed the "Kaiser Health CY 2019 SSI Calculation Inaccuracy Data Match Error CIRP Group" with two providers.

On **December 19, 2023**, the Board issued the Acknowledgement and Critical Due Dates notice ("ACDD") setting the due dates for the MAC to review the group formation and for the Group's Full Formation Comments. Kaiser was to advise Board of the group's status one year later, by **December 10, 2024**.

Between **December 26, 2023** and **August 7, 2024**, Kaiser added ten more providers to the group.

On **December 11, 2024**, after the Full Formation Comments due date had passed, the Board issued a Show Cause Order and deemed the group to be fully formed.

On **December 20, 2024**, the Board issued a Group Completion Notice in which it set the Parties' preliminary position paper deadlines.

On **December 23, 2024**, Kaiser responded to the Board's notice indicating that, although there was still a potential provider outstanding due to a MAC delay in issuing the Provider's final determination, Kaiser agreed with the Board's determination to deem the group complete.

On **January 21, 2025**, the Board reaffirmed its decision deeming the group complete and warned that if future deadlines were missed, the case could be dismissed.

On **February 17, 2025**, Kaiser timely filed its preliminary position paper. One of the exhibits, (P-1), included with the preliminary position paper, was a list of nine group participants in Case No. 24-0465GC. The list was not in the proper Schedule of Providers format and did not include all required information.

On **March 14, 2025**, the MAC filed a Motion to Dismiss Case No. 24-0465GC based on the Group's failure to timely file a "Rule 20 Certification" within 60 days of the *deemed* full formation date. The MAC also advised that, although there was a list of participants filed as an exhibit to the preliminary position paper, it included only nine providers. It did not include any explanation or withdrawal of three additional providers that are listed in the Office of Hearings Case & Document Management System ("OH CDMS").

On **March 28, 2025**, Kaiser filed its response to the MAC's motion in which it indicated that, because of unique circumstances surrounding this case (i.e., because it was *deemed* complete), Kaiser felt a separate (*participant*) listing was not required in addition to the list it provided as an Exhibit with its preliminary position paper. Kaiser also advised that it was not pursuing the three providers identified by the MAC (Prov. Nos. 12-0011, 05-0609 & 05-0686). Kaiser concluded that, should the Board determine the case would be allowed to remain open, it would file a Rule 20 Certification and withdraw the three providers in OH CDMS.

On **April 10, 2025**, the MAC filed its Rule 22 Review letter and reiterated its challenge regarding the Group's failure to file a Rule 20 Certification and the improper abandonment of three providers.

Board Determination:

Board Rule 4.4.2 states that "[a]ll filings other than an appeal request or request to add issues (e.g., position papers and other responsive documents) must be received by the Board no later than the date specified on the Board's notice or, if silent, the date specified in these Rules. If a party fails to file by the established due date, the Board may take action as described in 42 C.F.R. § 405.1868."

After a review of the facts in this case, the Board **grants** the MAC's motion to dismiss Case No. 24-0465GC. The Board finds that the Group Representative was warned, on December 11, 2024, when the Board first deemed the group to be fully formed, that further failure to comply with the Board rules could result in dismissal of the case. In addition, the Board notes that Kaiser has properly filed Rule 20 Certifications in other cases in the past. In fact, based on the filings in other appeals, it is apparent that Kaiser was aware of the Rule 20 Certification requirements. This group, which was filed within the last year, is a recent case and the Rule 20 Certification requirements have been in effect for years now.¹

¹ On November 1, 2021, the Board issued revised instructions regarding the filing of appeals in light of mandatory electronic filing that went into effect as of November 1, 2021. Specifically, regarding Group Schedules of Providers and supporting documentation, the Board changed its procedure based on the mandatory usage of the

The Board has considered Kaiser's argument that it didn't think it could file anything because the group had been fully formed and finds this to be an unconvincing justification for failing to file a Rule 20 Certification. The Rule 20 Certification is required AS A RESULT of the group's full formation; it does not mean that no other support can be filed in the case, rather it only restricts the addition/transfer of more providers to the group. If Kaiser had any question as to if the filing was required, it also could have reached out to Board staff and asked, but failed to do so.

Consequently, the Board finds that the group has failed to comply with Board rules, despite being warned on multiple occasions to file the Rule 20 Certification. Pursuant to Board Rule 41.2, the Board may dismiss a case if it has a reasonable basis to believe that the issues have been abandoned, or the group fails to comply with Board filing deadlines. Therefore, the Board hereby dismisses Case No. 24-0465GC and removes it from the docket.

Board Members:

Kevin D. Smith, CPA

Ratina Kelly, CPA

Nicole E. Musgrave, Esq.

Shakeba DuBose, Esq.

For the Board:

5/20/2025

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)
Wilson C. 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

Michelle Stone-Smith, Director
Epic Care Health, LLC
1012 Market Street, Suite 307
Fort Mill, SC 29708

Re: *Dismissal for Failure to Meet Minimum Filing Requirements*

Epic Care Health, LLC, Provider No. 42-1644, FFY 2025, Case No. 25-4199

Dear Ms. Stone-Smith:

The Provider Reimbursement Review Board (“Board”) has reviewed the above-referenced appeal request. After review of the pertinent facts outlined below, the Board has determined that the appeal request was not filed in accordance with the regulations and Board Rules.

Pertinent Facts:

On **March 31, 2025**, Epic Care Health, LLC (the “Provider”) filed an appeal with the Board to establish Case No. 25-4199. The appeal was filed from a determination entitled “Notice of Quality Reporting Program NonCompliance Decision Upheld” (“QRP Determination”) dated September 30, 2024.

The Provider’s appeal request did not, however, include:

- a proper Letter of Representation (Board Rule 5.4) and
- an Issue Statement (42 C.F.R. § 405.1835(b) and Board Rules 6, 7 & 8).¹

On **April 3, 2025**, the Board issued an Acknowledgement and Critical Due Dates (“ACDD”) Notice in which it set a briefing schedule for the Parties to file preliminary position papers and requested a corrected Representation Letter and a corrected Issue Statement. The deadline for the required support documents was set for **April 18, 2025**.

On **April 22, 2025**, the Board issued a final request for the Information and gave the Provider a deadline of **May 6, 2025**.

To date, the Provider has not complied with either of the Board’s Requests for Information.

¹ Board Rules Version 3.2 (Dec 15, 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 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.

42 C.F.R. § 405.1835 establishes the right to a Board hearing and the required contents for an appeal request. Specifically, 42 C.F.R. § 405.1835(a)(2) requires that “[t]he amount in controversy (as determined in accordance with § 405.1839) must be \$10,000 or more.” Board Rules 5.4 and 6 through 8 further address individual appeal requirements related to Representative letters and Issue Support. Finally, Board Rule 6.1.1 indicates that the Board will dismiss appeal requests that do not meet the *minimum* filing requirements as identified in 42 C.F.R. § 405.1835(b).

Board Determination:

The Board has determined that the Provider’s appeal request was not filed in accordance with the regulations at 42 C.F.R. § 405.1835 and with the Board Rules.

First, the Provider’s appeal request failed to include a proper Representation Letter as required in Board Rule 5.4. A letter of representation is required to be uploaded even if the Provider is representing itself or a parent organization is representing an affiliated provider. In this case, the document submitted as the Representative letter was a two-sentence statement that indicated it would not obtain legal counsel and indicated that Michelle Stone Smith would file information on the Provider’s behalf. The statement was not filed on company letterhead, did not provide the required contact information and was not signed by an owner/officer of the company.

In addition, the appeal request is missing a proper Issue Statement. The document uploaded and labeled as the “Issue Statement” (and also used as audit adjustment support) was an additional copy of the QRP Determination. Although there were additional uploads labeled as “Other Issue Support,” none of the uploads included an issue statement. Instead, the Provider included copies of various Help Desk emails; Copies of Declarations of State of Emergency; Federal Register and FEMA notices dated October 10, 2023; as well as the MAC's acknowledgement of the Provider’s Medicare enrollment application.

Finally, the Board finds that the Provider was afforded two separate opportunities to cure the noted deficiencies and failed to respond to either the Board’s April 3, 2025 or April 22, 2025 Requests. Accordingly, the Board hereby dismisses Case No. 25-4199 since the appeal request does not meet the *minimum* filing requirements as outlined above and for failure to timely respond to the Board’s Requests for Information. Based on the above, the Board closes this 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:

Kevin D. Smith, CPA

Ratina Kelly, CPA

Nicole E. Musgrave, Esq.

Shakeba DuBose, Esq.

For the Board:

5/20/2025

X Ratina Kelly

Ratina Kelly, CPA

Board Member

Signed by: PIV

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

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***

North Okaloosa Medical Center, Prov. No. 10-0122, FYE 03/31/2017
Case No. 20-0380

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 20-0380. Set forth below is the decision of the Board to dismiss the 3 remaining issues in this appeal challenging the Provider’s Disproportionate Share Hospital (“DSH”) for SSI Percentage (Provider Specific), Medicaid Eligible Days, and Uncompensated Care (“UCC”) payments.

Background

A. Procedural History for Case No. 20-0380

On **May 9, 2019**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end March 31, 2017. The Provider is commonly owned by Community Health Systems, Inc. (“CHS”).

On **October 31, 2019**, 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. Uncompensated Care (“UCC”) Distribution Pool
5. 2 Midnight Census IPPS Payment Reduction²

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party (“CIRP”) group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **May 26, 2020**, the Provider transferred Issues 2 and 5 to CHS CIRP groups.

As a result of the case transfers, there are three (3) remaining issues in this appeal: Issue 1 (the DSH – SSI Percentage Provider Specific), Issue 3 (the DSH – Medicaid Eligible Days), and Issue 4 (UCC Distribution Pool).

¹ On May 26, 2020, this issue was transferred to Case No. 20-0997GC.

² On May 26, 2020, this issue was transferred to Case No. 20-0999GC.

On **November 21, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

Provider's Preliminary Position Paper – *For each issue, the position paper **must** state the material facts that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), **and provide arguments applying the material facts** to the controlling authorities. This filing **must** include **any exhibits the Provider will use to support its position** and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.³*

On **June 22, 2020**, the Provider timely filed its preliminary position paper. With respect to Issue 3, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that “[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its’ 2017 cost report does not reflect an accurate number of Medicaid eligible days.” As a result, the Provider included, as an Exhibit, the original “estimated impact” for this issue of \$70,107 based on an *estimated* 100 days.

On **January 4, 2023**, the Medicare Contractor filed a request for DSH Medicaid Eligible Days Support in connection with Issue 3 and requested a response within 45 days.

On **August 5, 2020**, the Medicare Contractor timely filed a Jurisdictional Challenge⁴ with the Board over Issues 1 and 4 requesting that the Board dismiss these issues. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **October 15, 2020**, 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

³ (Emphasis added.)

⁴ Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled “Board Jurisdiction” but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement *per se*, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) (“*Auburn*”). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. See also Board Rule 4.1 (“The Board will dismiss appeals that fail to *meet the timely filing requirements and/or jurisdictional requirements.*”); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

under Board Rules to file a fully developed position paper with all available documentation necessary to support its position; and (2) the Provider had failed to respond to any of the Medicare Contractor's requests for that Medicaid eligible days listing.

On **January 6, 2023**, the Medicare Contractor filed its 2nd and Final Request for DSH Package in connection with Issue 3. In this filing, the Medicare Contractor noted that, on June 30, 2020 (1st request), it had previously requested that the Provider send it a DSH package to resolve Issue 3. As no response was received, the Medicare Contractor formally filed the 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 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 24, 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 3. 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 25, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **November 10, 2023**, almost 3 months after the deadline for responding to the Motion to Dismiss Issue 3, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the *caveat* that the "Listing [is] *pending finalization* upon receipt of State eligibility data."⁵ The Listing was 7 pages with roughly 899 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 899 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 899 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. 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.

⁵ (Emphasis added.)

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).⁶

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

Statement of the Issue:

Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

Statement of the Legal Basis

The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

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

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.⁷

⁶ Issue Statement at 1 (Oct. 31, 2019).

⁷ Group Appeal Issue Statement in Case No. 20-0997GC.

On June 22, 2020, the Board received the Provider's preliminary position paper in 20-0380. The following is the Provider's *complete* position on Issue 1 set forth therein:

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation based on the Provider's Fiscal Year End (March 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).⁸

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is \$35,000.

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

⁸ Provider's Preliminary Position Paper at 8-9 (Jun. 22, 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): 5,8,9,S-D

Estimated Reimbursement Amount: \$70,000⁹

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the Jewish Hospital case¹⁰ and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.¹¹

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue for two reasons. First, the MAC argues that the SSI realignment portion of the 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 intermediary 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 MAC contends that the Board does not have jurisdiction over the realignment portion of Issue 1 and respectfully requests 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.

Board to dismiss it from this appeal consistent with recent jurisdictional decisions.¹²

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are duplicates.¹³

Issue 3 – 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 furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable.
- b. That the Provider has made affirmative statements in its Preliminary Position Paper 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 and 25.2.2.
- d. That the Provider has effectively abandoned its claim for additional Medicaid Eligible Days.
- e. That the Provider’s claim for additional Medicaid Eligible Days is therefore dismissed.¹⁴

Accordingly, the Medicare Contractor requests that the Board dismiss Issue 3.

Issue 4 – UCC Distribution Pool

The MAC argues “that the Board does not have jurisdiction over the UCC DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).”¹⁵

The MAC also contends that this issue is a duplicate of PRRB Case Nos. 16-0769GC and should therefore, be dismissed.¹⁶

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.¹⁷ The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board

¹² Jurisdictional Challenge at 7-8 (Aug. 5, 2020).

¹³ *Id.* at 6.

¹⁴ Motion to Dismiss at 4-5 (July 24, 2023).

¹⁵ Jurisdictional Challenge at 10.

¹⁶ *Id.* at 11.

¹⁷ 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.”

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

Decision of the Board

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

As set forth below, the Board hereby *dismisses* the Provider’s three (3) remaining issues.

A. DSH Payment/SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage; and (2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider’s disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Case No. 20-0997GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns “[w]hether the Medicare Administrative Contractor (“MAC”) used the correct Supplemental Security Income (“SSI”) percentage in the Disproportionate Share Hospital (“DSH”) calculation.”¹⁸ Per the appeal request, the Provider’s legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor “did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i).”¹⁹ The Provider argues 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.”²⁰

¹⁸ Issue Statement at 1.

¹⁹ *Id.*

²⁰ *Id.*

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. 20-0380 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 4.6²¹, 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.²² 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 25.2.²³ Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Aug. 29, 2018), the Board requires position papers "to be *fully* developed and include *all available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

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:

²¹ PRRB Rules v. 2.0 (Aug. 2018).

²² The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. See *Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). See also *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

²³ 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.

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.²⁴

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

<https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh>.²⁵

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.”²⁶

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.

²⁴ (Italics and underline emphasis added.)

²⁵ Last accessed Oct. 15, 2024.

²⁶ (Emphasis added).

Accordingly, *based on the record before it*,²⁷ the Board finds that the SSI Provider Specific issue in Case No. 20-0380 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) (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**

²⁷ Again, the Board notes that the Provider failed to respond to the Jurisdictional Challenge and the Board must make its determination based on the record before it.

of the provider's Medicare payment claims for each remaining issue.

(3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.²⁸

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

Board Rule 25 (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 Papers²⁹

COMMENTARY:

Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will 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.

²⁸ (Bold emphasis added.)

²⁹ (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 <u>complete</u> preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (<i>See</i> Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on November 21, 2019 included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

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

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

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

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

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

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

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

On June 22, 2020, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.³¹ Significantly, the position paper did *not* include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the

³⁰ (Emphasis added.)

³¹ Provider's Preliminary Position Paper at 8.

“estimated impact” included with its appeal request (i.e., the estimated impact of \$70,107 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.

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 June 30, 2020. The second, final request was filed formally with the Board in OH CMDS on January 6, 2023, *nearly six years after the end of the Provider's cost reporting period*. The Medicare Contractor also informed the Provider in its final request for information that the deadline to respond was 30 days from the filing. The Provider failed to file any response to the request.

Due to the non-responsiveness of the Provider, on **July 24, 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 request 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 regulations and the Board Rules.³²

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 23, 2023 filing deadline (*i.e.*, 30 days after July 24, 2023).

However, on November 10, 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 7 pages with roughly 899 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 899 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 899 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 3½ year past the deadline for including it with its preliminary position paper* since the position paper deadline was June 27, 2020.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and

³² See also Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

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 nearly 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 10, 2023 filing as a “Supplement to Position Paper” and does not accept that filing because:

1. The alleged “Supplement” was filed *roughly 3½ years after the deadline* for that exhibit to be included with its preliminary position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)). Indeed, the Provider failed to timely reply to the Medicare Contractor’s Motion to Dismiss Issue 3 and the alleged “Supplement” was filed *nearly 3 months after the deadline* for filing a response to the Motion to Dismiss Issue 3.
2. The alleged “Supplement” fails to explain the following critical information: (a) *why* it was being filed so late (*i.e.*, upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the roughly 899 days was not previously available, *in whole or in part* (*i.e.*, it is not clear why the Provider failed to identify a single day at issue until more than 4 years after this appeal was filed and more than 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 21, 2019 Case Acknowledgment and Critical Due Dates permit the Provider to file a “Supplement” to its preliminary position paper (nor did the Provider allege in the “Supplement” filing that they do).
4. Given the fact that the *material* facts (*e.g.*, the days at issue) and all available exhibits were required to be part of the position paper filing, if the Board were to accept a “Supplement,” it would need to be either be a *refinement* of its preliminary position paper or a supplement of documents that were identified in the preliminary position paper as being unavailable consistent with Board Rule 25.2.2. However, neither the preliminary position paper nor the alleged “Supplement” identified any “unavailable” exhibits consistent with Board Rule 25.2.2. Further, the alleged “Supplement” cannot be considered a refinement of the position paper since no specific days or listing were included with the preliminary position paper (indeed the *tentative* 899 days listed in the alleged “Supplement” is, without explanation, *exponentially* larger than the original estimated 100 days included with the appeal request).³³

³³ 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.”

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”³⁴ 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.³⁵

C. UCC Distribution Pool

Last, the Board finds that it does not have jurisdiction over the DSH UCC payment issue in the above-referenced appeal because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).

1. Bar on Administrative Review

The Board does not generally have jurisdiction over Uncompensated Care DSH payment issues because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation. Based on these provisions, judicial and administrative review is precluded under 42 U.S.C. §§ 1395ff and 1395oo for:

- (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).³⁶

³⁴ (Emphasis added.)

³⁵ 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.

³⁶ Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential

(B) Any period selected by the Secretary for such purposes.

2. *Interpretation of Bar on Administrative Review*

a. *Tampa General v. Sec’y of HHS*

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec’y of Health & Human Servs.* (“*Tampa General*”),³⁷ the U.S. Court of Appeals for the District of Columbia Circuit (“D.C. Circuit”) upheld the D.C. District Court’s decision³⁸ that there is no judicial or administrative review of uncompensated care DSH payments. In that case, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit found that there was specific language in the statute that precluded administrative or judicial review of the provider’s claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an “estimate” used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that “the bar on judicial review of the Secretary’s estimates precludes review of the underlying data as well.”³⁹ The D.C. Circuit also rejected the provider’s argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are “indispensable” and “integral” to, and “inextricably intertwined” with, the Secretary’s estimate of uncompensated care.⁴⁰

The D.C. Circuit went on to address the provider’s attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the “general rules leading to the estimate rather than as a challenge to the estimate itself []” because it was merely an attempt to undo a shielded determination.⁴¹

b. *DCH Regional Med. Ctr. v. Azar*

The D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* (“*DCH v. Azar*”).⁴² In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review

to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.

³⁷ 830 F.3d 515 (D.C. Cir. 2016).

³⁸ 89 F. Supp. 3d 121 (D.D.C. 2015).

³⁹ 830 F.3d 515, 517.

⁴⁰ *Id.* at 519.

⁴¹ *Id.* at 521-22. See also *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9 (2nd Cir. 2022) (citing to *Tampa General*); *Ascension Providence v. Becerra*, No. 21-cv-369, 2023 WL 2042176 (N.D. Ind. 2023) (citing to *Tampa General*).

⁴² 925 F.3d 503 (D.C. Cir. 2019) (“*DCH v. Azar*”).

applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that “a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves” and that there is “no way to review the Secretary’s method of estimation without reviewing the estimate itself.”⁴³ It continued that allowing an attack on the methodology “would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology.” Recalling that it had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is “inextricably intertwined” with the estimates themselves, the D.C. Circuit found the same relationship existed with regard to the methodology used to generate the estimates.⁴⁴

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* (“*Scranton*”),⁴⁵ the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.⁴⁶ For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.⁴⁷ Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.⁴⁸ Nevertheless, the Secretary used each hospital’s shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.⁴⁹

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was “inextricably intertwined” with the Secretary’s estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a “period selected by the Secretary,” which is also barred from review.⁵⁰

⁴³ *Id.* at 506.

⁴⁴ *Id.* at 507.

⁴⁵ 514 F. Supp. 249 (D.D.C. 2021).

⁴⁶ *Id.* at 255-56.

⁴⁷ *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).

⁴⁸ *Id.* One provider had a cost report for the 6-month period from July 1, 2011 to December 31, 2011 and another for the 12-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the 9-month period from October 1, 2011 to June 30, 2012 and another for the 12-month period from July 1, 2012 to June 30, 2013.

⁴⁹ *Id.*

⁵⁰ *Id.* at 262-64.

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."⁵¹ While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.⁵² For review to be available in these circumstances, the following criteria must be satisfied:

- (i) the statutory preclusion of review is implied rather than express;
- (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.⁵³

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.⁵⁴ The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

d. Ascension Borgess Hospital v. Becerra

Even more recently, the D.C. Circuit revisited, once again, the judicial and administrative bar on review of uncompensated care DSH payments again in *Ascension Borgess Hospital v. Becerra* ("*Ascension*").⁵⁵ In *Ascension*, the providers sought an order declaring the Worksheet S-10 audit protocol was unlawful, vacating the payments based on the Worksheet S-10 audit, requiring the Secretary to recalculate those payments, and setting aside the Board decisions refusing to exercise jurisdiction over their appeals.⁵⁶ Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the providers' claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a 'functional approach' focused on whether the challenged action was 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."⁵⁷ The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs.*⁵⁸ noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol

⁵¹ *Id.* at 265.

⁵² *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).

⁵³ *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).

⁵⁴ *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).

⁵⁵ Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).

⁵⁶ *Id.* at *4.

⁵⁷ *Id.* at *9.

⁵⁸ 139 S. Ct. 1804 (2019).

establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision.***⁵⁹

The Board concludes that the same findings are applicable to the Provider’s challenge to their FFY 2017 UCC payments. The Provider is challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2017. The challenge to CMS’ notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider’s arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as “inextricably intertwined” with the actual estimates as the underlying data, and barred from review.

* * * * *

Based on the foregoing, the Board has dismissed the three (3) remaining issues in this case – (Issues 1, 3 and 4). As no issues remain, the Board hereby closes Case No. 20-0380 and removes it from the Board’s docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

For the Board:

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

5/20/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

⁵⁹ *Ascension* at *8 (bold italics emphasis added).



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***

Houston Methodist Willowbrook Hospital, Prov. No. 45-0084, FYE 12/31/2015
Case No. 19-1194

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 19-1194. 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. 19-1194

On **August 24, 2018**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end December 31, 2015.

On **February 18, 2019**, the Board received the Provider’s individual appeal request. The Individual Appeal Request contained eight (8) issues:

1. DSH Payment/SSI Percentage (Provider Specific)¹
2. DSH Payment/SSI Percentage (Systemic Errors)²
3. DSH/SSI Fraction Medicare Managed Care Part C Days³
4. DSH Medicaid Fraction Dual Eligible Days⁴
5. DSH Payment – Medicaid Eligible Days
6. DSH/SSI Fraction Medicaid Fraction (Managed Care Part C Days)⁵
7. DSH/SSI Fraction Dual Eligible Days⁶

¹ On January 26, 2025, this issue was withdrawn.

² On January 31, 2020, this issue was transferred to PRRB Case No. 20-0068GC.

³ On January 31, 2020, this issue was transferred to PRRB Case No. 20-0069GC.

⁴ On January 31, 2020, this issue was transferred to PRRB Case No. 20-0070GC.

⁵ On January 31, 2020, this issue was transferred to PRRB Case No. 20-0071GC.

⁶ On January 31, 2020, this issue was transferred to PRRB Case No. 20-0072GC.

8. Standardized Payment Amount⁷

On **March 28, 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 15, 2019**, the Provider filed its preliminary position paper. The following is an excerpt of the Provider's position on Issue 5 set forth therein:

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.

HMWBH is seeking reimbursement for an additional 253 Medicaid Eligible days. The Provider, in this appeal, contends that the documentation necessary to pursue DSH was not available from the State of Texas in time to include all DSH/Medicaid Eligible Days on the cost report.

⁷ On January 31, 2020, this issue was transferred to PRRB Case No. 20-0073GC.

⁸ (Emphasis added).

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

Medicaid Eligible Days results change over time. For this reason, providers generally prefer to prepare listings as close in time to a Hearing, Audit or Settlement as possible. Accordingly, the number expressed here may not be the number presented at hearing or settlement, but at this time the Provider is seeking to include an additional 253 Medicaid Eligible Days in its cost report.⁹

On **February 7, 2020**, the Medicare Contractor filed its preliminary position paper.

On **April 5, 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*** 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 27 for more specific content requirements.¹⁰

On **May 9, 2024**, the Provider requested a Change of Representative to Quality Reimbursement Services, Inc.

On **August 26, 2024**, the Provider timely filed its final position paper. The following is the Provider's ***complete*** position on Issue 5 set forth therein:

Specifically, the Provider disagrees with the MAC's calculation of the 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

⁹ Provider's Preliminary Position Paper at 5-7.

¹⁰ (Emphasis added).

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 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, the Provider contends that the total number of days reflected in its 2015 cost report does not reflect an accurate number of Medicaid eligible days, as 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. *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”).¹¹

On **September 25, 2024**, the Medicare Contractor timely filed its final position paper.

On **October 29, 2024**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 5.¹²

On **November 5, 2024**, the Provider submitted to the Board a redacted listing of Medicaid eligible days.

On **December 19, 2024**, the Provider filed a response to the jurisdictional challenge.

On **January 6, 2025**, the Provider withdrew Issue 1.

B. Description of Issue 5 in the Appeal Request

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

The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(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.

HMWBH is seeking reimbursement for an additional 253 Medicaid Eligible days. The Provider, in this appeal, contends that the documentation necessary to pursue DSH was not available from the State of Texas in time to include all DSH/Medicaid Eligible Days on the cost report.

¹¹ Provider’s Final Position Paper at 9-10 (emphasis added).

¹² The Medicare Contractor also previously filed a jurisdictional challenge over Issue 1, however that issue has since been withdrawn.

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

Medicaid Eligible Days results change over time. For this reason, providers generally prefer to prepare listings as close in time to a Hearing, Audit or Settlement as possible. Accordingly, the number expressed here may not be the number presented at hearing or settlement, but at this time the Provider is seeking to include an additional 253 Medicaid Eligible Days in its cost report.¹³

The Provider estimated the reimbursement impact of the issue at \$23,533 based on an increase of 253 additional Medicaid days but failed to include a list of the additional days.¹⁴

MAC's Jurisdictional Challenges

Issue 5 – DSH Payment – Medicaid Eligible Days

The Medicare Contractor contends that this issue should be dismissed because the Provider failed to 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.

The Medicare Contractor notes that a Medicaid eligible days listing was never received with the Provider's preliminary position paper. The Medicare Contractor further notes that the Provider failed to submit an unredacted listing of additional Medicaid eligible days with its final position paper.¹⁵

The Medicare Contractor contends 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 and final position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. The Provider has not submitted accurate and sufficient data to demonstrate that patients were eligible for Medicaid on the claimed patient hospital days or identified as to why the data is not yet available or when it will become available.¹⁶

¹³ Issue Statement at 1-3 (Feb. 18, 2019).

¹⁴ *Id.* at 3 (Feb. 18, 2019).

¹⁵ Medicare Contractor's Jurisdictional Challenge at 7 (Oct. 29, 2024).

¹⁶ *Id.* at 8-11.

Additionally, the Medicare Contractor argues this issue should be dismissed because the Provider is attempting to untimely and improperly add the issue of Section 1115 waiver days as a sub-issue via its final position paper filed on August 26, 2024. The Medicare Contractor issued the Provider's NPR on August 24, 2018. In accordance with 42 C.F.R. § 415.1835(e), the deadline for adding issues to the appeal was April 21, 2019. The issue was informally added through the Provider's final position paper, more than four years after the filing deadline to add an issue.¹⁷

The Medicare Contactor contends that the Section 1115 Waiver Days issue is one component of the DSH issue that must be appealed as a separate issue. The Medicare Contractor 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 appeal separately.¹⁸

Provider's Jurisdictional Responses

Issue 5 – DSH Payment – Medicaid Eligible Days

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:

Section 1115 waiver days are part and parcel of Medicaid eligible days. And whereas the [Medicare Contractor] states that the Section 1115 Waiver Days issue is one component of the DSH issue, the regulations at 42 C.F.R. § 405.1835 contain requirements for appealing an “issue” and a time limit on adding an “issue” – not on clarifying “sub-issues” or “components” of an issue. 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.¹⁹

The Provider goes on to contend that the version of Board Rule 8 (July 1, 2015), that it alleges was effective when the Provider filed its appeal, makes no mention of “section 115 waiver days” nor even “Medicaid eligible days.” Thus, even if Rule 8's extension to “components of issues” were valid (and the Provider contends it is not), the Provider had no notice that it was required to

¹⁷ *Id.* at 11-13.

¹⁸ *Id.* at 13-15.

¹⁹ Provider's Jurisdictional Response at 3-4 (Dec. 19, 2024).

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.²⁰

Finally, the Provider contends that prior to submission of the Provider's Final Position Paper, the Fifth Circuit ruled that the statute and CMS's own regulations require that CMS regard inpatient days attributable to an uncompensated care pool population as Medicaid eligible days, *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019). The Medicare Contractor is required by specific command of CMS to accept and audit the Provider's section 1115 waiver days in providers' Medicaid Fractions. Following a string of litigation defeats, including those in *Forrest General Hospital* and *Bethesda Health, Inc. v. Azar*, 980 F.3d 121 (D.C. Cir.2020), CMS issued Change Request 12669, Transmittal No. 11912 (March 16, 2023). The Provider asserts that under this Transmittal, the Medicare Contractor has the duty to accept the Provider's listing of section 1115 days and audit them. The Provider states that it submitted a redacted listing to the Medicare Contractor on November 23, 2024.²¹

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

1. Section 1115 Waiver Days

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

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

(b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing...must be submitted in writing to the Board, and the request must

²⁰ *Id.* at 4-5.

²¹ *Id.* at 5-6.

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...²²

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,
 - why the adjustment is incorrect,
 - how the payment should be determined differently,
 - the reimbursement effect, and
 - the basis for jurisdiction before the Board.²³

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

Several examples are identified below, but these examples are not exhaustive lists of categories or issues.

A. Disproportionate Share Hospital Payments

Common examples include, but are not limited to:

...

- ***Section 1115 waiver days (program/waiver specific)***²⁴

²² 42 C.F.R. § 405.1835(b).

²³ v. 2.0 (Aug. 2018).

²⁴ (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.²⁵ 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, 2000.²⁶ Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program *and* not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction.²⁰ In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid

²⁵ See 73 Fed. Reg. 30190 (May 23, 2008).

²⁶ 65 FR 47054, 47087 (Aug. 1, 2000).

plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

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

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

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

Regardless, even if the Provider had included in its appeal request (which it did not), the Provider failed to properly develop the issue in its position paper filings. First, the Provider's preliminary position paper does not even mention § 1115 waiver days (much less even identify the specific 1115 waiver day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (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* § 1115 waiver days sub-issue.

Finally, even in the Provider's final position paper, the Provider fails to identify what § 1115 waiver program(s) are involved and whether or not the § 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the final position paper is perfunctory. 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 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*.²⁷ 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 . . ."²⁸ 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."²⁹ 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.³⁰ Here, the Board makes the same finding based on similarly *overly generalized language*.

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 27.2.³¹ 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.

2. Medicaid Eligible Days

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

²⁷ No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

²⁸ *Id.* at *11.

²⁹ *Id.*

³⁰ *Id.*

³¹ 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).

payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

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

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

(3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.³²

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:

³² (Bold emphasis added.)

Rule 25 Preliminary Position Papers³³

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.
- 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

³³ (Emphasis added.)

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 March 28, 2019 included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 5, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish *each Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(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.³⁴

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 October 15, 2019, the Provider filed its preliminary position paper in which no eligibility listing was submitted as an exhibit.³⁵

On August 26, 2024, the Provider filed its final position paper. The position paper stated that a redacted version of the Provider’s Medicaid Eligible Days listing “will be submitted directly to the MAC. A redacted version of the list will be uploaded to the portal thereafter.”³⁶

Subsequently, over two months later, on November 5, 2024, the Provider submitted a redacted Medicaid Eligible Days Listing to the Board. The Listing was 24 pages with 3,869 Medicaid eligible days. No explanation was provided as to why the listing of days was being submitted at this late date, *more than 8 years after the fiscal year at issue had closed*. NOTE—the 3,869 days included in this belated listing is exponentially larger than the original estimate of 253 days included with the appeal request. Regardless, this filing, importantly, *was more than 5 years past*

³⁴ (Emphasis added.)

³⁵ Provider’s Preliminary Position Paper at 7.

³⁶ Provider’s Final Position Paper at 10 and Exhibit P-1 at P0002.

the deadline for including it with the preliminary position paper since the position paper deadline was October 16, 2019.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (i.e., the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. 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”³⁷ and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to submit a finalized listing of Medicaid eligible days, notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is \$0.

Based on the above, the Board finds that the Provider has failed to comply with the Board’s procedures with regard to filing its position 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.³⁸

Based on the foregoing, the Board dismisses the remaining issue, Issue 5, in this case. As no issues remain, the Board hereby closes Case No. 19-1194 and removes it from the Board’s

³⁷ (Emphasis added.)

³⁸ 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.

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:

5/21/2025

X Ratina Kelly

Ratina Kelly, CPA

Board Member

Signed by: PIV

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



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***
Scott & White Hospital Brenham (45-0187)
FYE: 12/31/2016
Case No.: 19-2574

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 19-2574. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider’s Disproportionate Share Hospital (“DSH”) Medicaid Eligible Days payment.

Background

A. Procedural History for Case No. 19-2574

On **February 21, 2019**, the Provider, Scott & White Hospital Brenham (“Scott”) was issued a Notice of Program Reimbursement (“NPR”) for the fiscal year ending December 31, 2016. The Provider is commonly owned by Baylor Scott & White Health (“BSWH”).

On **August 21, 2019**, Scott filed an Individual Appeal Request appealing the following (9) issues:

1. DSH Payment SSI Percentage (“Provider Specific”)¹
2. DSH SSI Percentage (“Systemic Errors”)²
3. DSH Managed Care Part C Days; Medicare Fraction³
4. DSH Part A Dual Eligible Exhausted Days; Medicare Fraction⁴
5. DSH Medicaid Eligible Days
6. DSH Managed Care Part C Days; Medicaid Fraction⁵
7. DSH Part A Dual Eligible Exhausted Days; Medicaid Fraction⁶
8. 2 Midnight Census IPPS Payment Reduction⁷
9. Standardized Payment Amount⁸

¹ On April 15, 2025, this issue was withdrawn.

² On March 30, 2020, this issue was transferred to Case No. 19-2456GC.

³ On March 30, 2020, this issue was transferred to Case No. 19-2457GC.

⁴ On March 30, 2020, this issue was transferred to Case No. 19-2458GC.

⁵ On March 30, 2020, this issue was transferred to Case No. 19-2459GC.

⁶ On March 30, 2020, this issue was transferred to Case No. 19-2460GC.

⁷ On March 30, 2020, this issue was transferred to Case No. 19-2760GC.

⁸ On March 30, 2020, this issue was transferred to Case No. 19-2462GC.

As the Provider is commonly owned/controlled by BSWH, 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 **November 13, 2019**, the Provider transferred Issues 2, 3, 4, 6, 7,8 and 9 to BSWH CIRP groups.

After the transfers, two issues remained in the appeal: Issue 1, DSH – SSI Percentage (“Provider Specific”), Issue 5, DSH – Medicaid Eligible Days.⁹

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

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

On **May 6, 2020**, the Provider timely filed its preliminary position paper. With respect to Issue 5, Medicaid Eligible Days, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made, and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that “[b]ased on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its’ 2016 cost report does not reflect an accurate number of Medicaid eligible days. . . .”¹¹ As a result, the Provider included as an exhibit the original “estimated impact” for this issue of \$23,593 based on an *estimated* 50 days.

On **June 11, 2020**, the Medicare Contractor filed a Jurisdictional Challenge¹² with the Board over Issue 1, DSH SSI Percentage (“Provider Specific”) requesting that the Board dismiss the

⁹ Issue 1 was withdrawn on April 15, 2025.

¹⁰ (Emphasis added).

¹¹ Provider’s May 6, 2020 Preliminary Position Paper at 8.

¹² 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).

issue. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider *failed* to file any response.

On **July 24, 2020**, the Medicare Contractor filed its preliminary position paper. Regarding Issue 5, DSH Medicaid Eligible Days, the Medicare Contractor's position paper noted that the Provider had failed to include a Medicaid Eligible Days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position. Also, the Provider's Medicaid percentage was properly determined; it included all documented and audited Medicaid days in the calculation of the DSH payment.¹³

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

On **February 18, 2025**, the Provider filed its final position paper. With respect to Issue 5, DSH Medicaid Eligible Days, the Provider's final position paper, for the first time, mentions section 1115 Waiver Days. The Provider included a redacted Medicaid Eligible Days listing with its filing at Exhibit P-1 entitled "Additional ME & 1115 Waiver Days."

On **March 10, 2025**, the Medicare Contractor filed a Jurisdictional Challenge with the Board over Issues 1, DSH SSI Percentage ("Provider Specific") and 5, DSH Medicaid Eligible Days including section 1115 waiver days, requesting that the Board dismiss these issues.

On **March 17, 2025**, the Medicare Contractor filed its Final Position Paper. Regarding Issue 5, DSH Medicaid Eligible Days, The Medicare Contractor noted that the provider had consolidated "section 1115 waiver days" with its Medicaid Eligible Days issue. As the "section 1115 waiver days" are not an issue in this appeal, the Medicare Contractor asserted that it would only consider Medicaid Eligible Days for a possible administrative resolution.¹⁴

On **April 1, 2025**, the Provider filed a response to the Medicare Contractor's Jurisdictional Challenge.

B. Description of Issue 5 in the Appeal Request

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

Statement of Issue

Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.

Statement of the Legal Basis

The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C.

¹³ Medicare Contractor's July 24, 2020 Preliminary Position Paper at 15-16.

¹⁴ Medicare Contractor's March 17, 2025 Final Position Paper at 17.

§1395ww(d)(5)(F)(i). Specifically, the Provider disagrees 34460with [sic] 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, 18, 22, S-D

Estimated Reimbursement Amount: \$23,000¹⁵

Regarding the Medicaid Eligible Days issue, the Provider argues in its Preliminary Position Paper that pursuant to the *Jewish Hospital* case¹⁶ 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.¹⁷

Medicare Contractor's Contentions

Issue 5 – DSH Payment – Medicaid Eligible Days

The Medicare Contractor contends the Provider failed to file complete preliminary and final position papers including all supporting exhibits to document the merits of its argument and failed to properly develop its argument within its position papers in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25 and 27. The Medicare Contractor argues the Provider has not submitted a auditable Medicaid Eligible Days listing and requests the Board dismiss the issue.

Additionally, the Medicare Contractor contends the Provider is attempting to add the section 1115 Waiver Days issue improperly and untimely as a sub-issue via its final position paper filed on February 13, 2025.¹⁸

Provider's Jurisdictional Response

The Provider contends that it appealed all Medicaid Eligible Days in its Appeal Request, including section 1115 Waiver Days. The Provider asserts, by definition, section 1115 Waiver Days are Medicaid Eligible Days. The Provider maintains although the Medicare Contractor contends that it is attempting to untimely add the issue of section 1115 Waiver Days, there exists no such issue. The Provider argues section 1115 Waiver Days are part and parcel of Medicaid Eligible Days.

The Provider maintains the regulation at 42 C.F.R. § 405.1835 contains requirements for appealing an "issue" and a time limit on adding an "issue" – not on clarifying a "sub-issue" or "components" of an issue. The Provider argues both a June 25, 2004 proposed rule (69 Fed. Reg.

¹⁵ Provider's August 21, 2019 Individual Appeal Request, Issue Statement, Issue 5.

¹⁶ *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994).

¹⁷ Provider's May 6, 2020 Preliminary Position Paper at 7.

¹⁸ Medicare Contractor's March 10, 2025 Jurisdictional Challenge at 2,7.

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.¹⁹

Decision of the Board

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

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

A. DSH Payment – Medicaid Eligible Days

The Provider’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 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:

No Access to Data

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

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

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

(3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider’s Medicare payment claims may be submitted in a**

¹⁹ Provider’s April 1, 2025 Jurisdictional Response at 1-2.

timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions.²⁰

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

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

Rule 25 Preliminary Position Papers²¹

COMMENTARY:

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

25.1 Content of Position Paper Narrative

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

25.1.1 The Provider's Position Paper

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

25.2 Position Paper Exhibits

25.2.1 General

²⁰ (Bold emphasis added.)

²¹ (Underline emphasis added to these excerpts and all other emphasis in original.)

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

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

Moreover, in connection with Issue 5, Medicaid Eligible Days, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish *each Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(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 carries the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue.”

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

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

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

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

On May 6, 2020, the Provider filed its preliminary position paper in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.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 \$23,593 based on an estimated 50 days). The Provider’s complete briefing of this issue in its preliminary position paper is as follows:

Calculation of Medicaid Eligible Days

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

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

²² (Emphasis added.)

²³ Provider’s May 6, 2020 Preliminary Position Paper at 8.

for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F. 3d 1261 (9th Cir. 1996).

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

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

Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its’ 2016 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.²⁴

In its March 10, 2025 Jurisdictional Challenge, the Medicare Contractor asserts that the Provider has failed to submit an auditable list of additional Medicaid eligible days with its preliminary or final position papers or submit such list under separate cover to it. The Medicare Contractor maintains the Provider has neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with the regulations and Board Rules.²⁵

The Medicare Contractor asserts in the Provider’s February 18, 2025 Final Position Paper, Exhibit P-1, the Provider included a redacted listing of 258 days entitled “Additional ME & 1115 Waiver Days.” As it relates to the Medicaid Eligible Days under appeal, the Provider’s exhibit states “A listing of the additional Medicaid Eligible days being claimed is being submitted directly to the MAC. A redacted version of this same list is being included with this position paper.” The Medicare Contractor contends, to date, the provider has not submitted a listing of auditable Medicaid Eligible Days.²⁶

The Board finds the Provider’s filing does not explain why the listing of 258 days was being submitted at this late date *more than 8 years after the fiscal year at issue had closed*. NOTE—

²⁴ *Id.* at 7-8.

²⁵ Provider’s March 13, 2025 Jurisdictional Challenge at 7-8.

²⁶ *Id.* at 7.

the roughly 258 days included in this belated listing is *exponentially* larger than the original estimate of 50 days included with the appeal request.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (i.e., the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(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).

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 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 preliminary position paper filing (much less provide the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board 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

A. 1115 Waiver Days

The Board finds that the section 1115 Waiver Days issue is not a part of this appeal as it was not properly or timely added. The Provider failed to include section 1115 Waiver Days as a cost issue in its appeal request and failed to timely and properly add this additional issue to the

²⁷ (Emphasis added.)

²⁸ See also *Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022): The Board acts reasonably, and not arbitrarily and capriciously, when it applies its “claims-processing rules faithfully to [a provider’s] appeal.” *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide “[a]n explanation []for each specific item under appeal.” 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that “[s]ome issues may have multiple components,” and that “[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible.” Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a “common example” of an appeal involving issues with “multiple components” that must be appealed as “separate issue[s] and described as narrowly as possible.” Board Rules §§ 8.1, 8.2.

appeal. While the Provider appealed Medicaid Eligible Days, this issue is separate and distinct from the section 1115 Waiver Days.

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

(b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing...must be submitted in writing to the Board, and the request must include...

(2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final...determination under appeal, including an account of...

(i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]

(ii) How and why the provider believes Medicare payment must be determined differently for each disputed item...²⁹

Board Rule 7.2.1 (2019) elaborated on this regulatory requirement, instructing providers:

The following information and supporting documentation must be submitted for each issue raised in the appeal request.

- An issue title and a concise issue statement describing:
 - the adjustment, including the adjustment number,
 - the controlling authority,
 - why the adjustment is incorrect,
 - how the payment should be determined differently,
 - the reimbursement effect, and
 - the basis for jurisdiction before the [Board].

Board Rule 8 (2019) 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

²⁹ 42 C.F.R. § 405.1835(b).

Common examples include: . . . ***Section 1115 waiver days (program/waiver specific).*** . . .³⁰

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.³¹

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

(e) Adding issues to the hearing request. After filing a hearing request . . . a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –

. . .

(3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

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

In this regard, the Board notes that section 1115 Waiver Days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.³² Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver Days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program and not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

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

³⁰ (Bold and italic emphasis added).

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

³² 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.

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

Finally, even in the Provider's final position paper, the Provider fails to identify what § 1115 waiver program(s) are involved and whether or not the § 1115 Waiver Days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered."³³ Rather, the final position paper is perfunctory in that it only makes perfunctory conclusions.³³

³³ For example, QRS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that "the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." However, QRS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is QRS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? QRS fails to brief the merits of its claims and fails to establish the Board's jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the final position paper references "uncompensated care pool."

Again, the Provider failed to so develop its position paper notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Nov. 2021) as applied via Board Rule 27.2.

The Board's finding that neither the appeal request nor final position paper met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.³⁴ In that case, the provider's issue was tied to improper calculation 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 . . ."³⁵ The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."³⁶ The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.³⁷ Here, the Board makes the same finding based on similarly *overly generalized language*.

* * * * *

Based on the foregoing, the Board has dismissed the (1) remaining issue in this case – (Issue 5, Medicaid Eligible Days). As no issues remain, the Board hereby closes Case No. 19-2574 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

For the Board:

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

5/21/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Michael Redmond, Novitas Solutions, Inc. c/o Guidewell Source
Wilson Leong, FSS

³⁴ No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

³⁵ *Id.* at *11.

³⁶ *Id.*

³⁷ *Id.*



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

Leslie Goldsmith
Bass, Berry & Sims, PLC
1201 Pennsylvania Avenue NW, Suite 300
Washington, DC 20004

RE: ***Request for Reconsideration of Board's Dismissal of Appeal***
Univ. of PA Health System CY 2017 Direct Graduate Med Education (DGME) Penalty
to FTE Count CIRP Group
Case Number: 21-1133GC

Dear Ms. Goldsmith,

The Provider Reimbursement Review Board ("Board") has reviewed the Request for Reconsideration of Board's Dismissal of Appeal submitted by Bass, Berry & Sims, PLC on behalf of the University of Pennsylvania Health System on March 11, 2025. The decision of the Board is set forth below.

Pertinent Facts:

On **March 18, 2021**, the Board received a request to form a CIRP Group Appeal from the then-Group Representative; Baker, Donelson, Bearman, Caldwell & Berkowitz. The appeal request had one provider, Pennsylvania Hospital (Provider Number 39-0226, FYE 06/30/2017).

On **July 1, 2021**, the Provider Representative added Penn Presbyterian Medical Center (Prov. No. 39-0223, FYE 06/30/2017).

On **January 9, 2022**, the Provider Group changed its designated representative to Ms. Goldsmith of Bass, Berry & Sims, PLC.

On **November 21, 2023**, the Board issued a CIRP Group Status Request letter, inquiring whether the group was fully formed as no participants were added since July 1, 2021. The Group Representative responded on **December 18, 2023**, indicating that the group was fully formed.

On **January 9, 2024**, the Board issued a CIRP Group Fully Formed and Critical Due Dates notice giving the Provider Group a due date of March 9, 2024, for its Preliminary Position Paper.

On **January 10, 2024**, the Group Representative submitted a Preliminary Position Paper Extension Request, stating as there was a high probability of settlement, that it would be a waste of resources for position papers. Accordingly, the Group Representative requested, joined by the MAC, that the Board grant a six-month extension for the due dates of the position papers to allow the parties to further pursue settlement.

On **January 12, 2024**, the Board issued an updated Critical Due Dates notice, which included a due date of September 9, 2024, for the Provider Group's Preliminary Position Paper.

On **June 7, 2024**, the Group Representative submitted an "Extension Request," however, *erroneously* uploaded a Rule 20 certification. On **June 11, 2024**, the Board issued a notice indicating that the Group Representative must either re-submit an actual request for extension or re-submit the Rule 20 certification under the correct type of filing. The Group Representative filed a Rule 20 certification on **June 11, 2024**.

On **August 7, 2024**, the Group Representative filed a Preliminary Position Paper Extension Request. The Group Representative stated, verbatim, the same reason for extension as the January 10th request, and again, requested a six-month extension for the due dates of the parties' papers to allow the parties to further pursue settlement.

On **August 13, 2024**, the Board granted the request for an additional six-month extension. On **August 14, 2024**, the Board issued a third Critical Due Dates Notice, which included a due date of March 10, 2025, for the Provider Group's Preliminary Position Paper.

On **March 11, 2025**, the Board issued a Dismissal Letter for failure to meet the Preliminary Position Paper filing deadline and closed the appeal.

In the late evening of **March 11, 2025**, the Group Representative filed its Preliminary Position Paper. Additionally, the Group Representative filed a request for reinstatement, stating

Unfortunately, due to the repeated need for extensions, the undersigned's involvement in extenuating family issues (my daughter's in-laws lost a very sick child this week) and the undersigned being sick this week, the paper was inadvertently not filed on time. Specifically, the Providers' Preliminary Position Paper ("Paper") was due yesterday, March 10, 2025. The Paper is being filed at this time, less than 24 hours after the due date expired.

There has been no prejudice to the MAC or the Board due to this late filing. Furthermore, it is an extreme penalty to dismiss the Providers' statutory appeal rights as a result of a non-prejudicial filing made less than 24 hours late under the circumstances discussed above.

Board's 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 intermediary, the amount in controversy is \$10,000 or more (or \$50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

Bass, Berry & Simms has filed a motion requesting that the Board reinstate the case.¹ Board Rule 47 governs motions for reinstatement of an issue or case and states the following, in pertinent part:

Rule 47 Reinstatement

47.1 Motion for Reinstatement

A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s) (see 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (see Rule 44 governing motions). The Board will not reinstate an issue(s)/case if the provider was *at fault*. If an issue(s)/case was remanded pursuant to a CMS ruling (e.g., CMS Ruling 1498-R), the provider must address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board reinstates an issue(s) or case, the provider will have the same rights (no greater and no less) that it had in its initial appeal. . . .

47.3 Dismissals for Failure to Comply with Board Procedures

Upon written motion demonstrating good cause, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, administrative oversight, settlement negotiations or a change in representative will not be considered good cause to reinstate. If the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, the motion for reinstatement must, as a prerequisite,

¹ The required preliminary position paper and exhibits were filed with the request for reinstatement.

include the required filing before the Board will consider the motion.²

Board Rule 47.1 states that the Board will not reinstate if the provider was at fault and Board Rule 47.3 further clarifies that, when the dismissal is based on the failure to comply with Board Procedures (such as filing a required position paper) the Board *may* reinstate for good cause which does not include administrative oversight. Here, the Board finds that the Provider was at fault due to administrative oversight issues, since the Representative failed to meet the preliminary position paper deadline due to its own error and inadvertence.

In summary, pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b), the Board denies Bass, Berry & Sims's request for reinstatement of Case No. 21-1133GC. The Board finds that the Representative is at fault and failed to establish good cause under Board Rules 47.1 and 47.3 as it admitted its fault and failed to provide the required Medicare Contractor's concurrence. Therefore, the Board declines to exercise its discretion to reinstate Case No. 21-1133GC and it thereby remains closed.

Board Members Participating:

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

For the Board:

5/27/2025

X Kevin D. Smith, CPA

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

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

² (Italics and underline emphasis added.)



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

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

RE: **EJR Determination HRS LSU Outlier Threshold CIRP Groups**
13-3489GC *HRS LSU 2007 Outlier Threshold CIRP Group*
13-3485GC *HRS LSU 2008 Outlier Threshold CIRP Group*
14-2102GC *HRS LSU 2010 Outlier Threshold Payments CIRP Group*
14-3003GC *HRS LSU 2011 Outlier Threshold Payments CIRP Group*
15-0545GC *HRS LSU 2012 Outlier Threshold Payments CIRP Group*

Dear Ms. Goron:

The Provider Reimbursement Review Board (“Board”) has reviewed the Providers’ Requests for Expedited Judicial Review (“EJR”) filed May 6, 2025 in the above-referenced appeals. The Board’s decision with respect to EJR is set forth below.

I. Background

These five appeals were filed between September 2013 and December 2014. The issue statements in Cases 13-3489GC, 13-3485GC, 14-2102GC, and 14-3003GC are identical, and the Board notes that they **incorrectly** assert that they are appealing their outlier threshold payments for **fiscal year 2004**, though they actually concern fiscal years ending between 2007 and 2011. Cases 13-3489GC, 13-3485GC, 14-2102GC, and 14-3003GC describe the group issue as:

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 group issue statement for Case 15-0545GC is materially identical except that it omits any reference to the particular fiscal year it is appealing from. The parties have filed preliminary and final position papers in all five (5) cases. Each group is fully formed and the Providers' representative has confirmed, pursuant to Board Rule 20, that the group is fully populated in OH CDMS. On **May 6, 2025**, the Providers filed identical requests for Expedited Judicial Review ("EJR") in each case.

¹ See, e.g., Case No. 13-3489GC, Group Issue: Outlier Payments – Fixed Loss Threshold at 1 (Sep. 5, 2013).

II. Relevant Law

A. Outlier Threshold

Part A of the Medicare Act covers “inpatient hospital services.” Originally, Medicare reimbursed hospitals based on the “reasonable costs” of these services.² Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system (“PPS”).³ Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.⁴ These predetermined, standardized amounts are calculated by the Secretary first determining a nationwide average allowable cost per discharge,⁵ which is then further adjusted based on a wage index specific to the locality of the hospital.⁶ Each discharge is also adjusted based on the severity of illness, which are classified as distinct diagnosis-related groups (“DRGs”).⁷ These DRGs are intended to weight the reimbursement based on “the relationship between the cost of treating patients within that group and the average cost of treating all Medicare patients.”⁸

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

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

² See 42 U.S.C. § 1395f(b)(1).

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

⁴ *Id.*

⁵ 42 U.S.C. § 1395ww(d)(2)(A)-(C).

⁶ 42 U.S.C. § 1395ww(d)(2)(H).

⁷ 42 U.S.C. § 1395ww(d)(4).

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

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

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

¹¹ 42 U.S.C. § 1395ww(d)(5)(A)(ii).

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

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

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

¹⁵ 42 U.S.C. § 1395ww(d)(5)(A)(iv).

threshold.”¹⁶ Hospitals are typically paid 80% of the costs above the applicable outlier threshold.¹⁷

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

B. Revised NPR Appeals

The Code of Federal Regulations provides for an opportunity for a reopening and Revised Notice of Program Reimbursement (“RNPR”) at 42 C.F.R. § 405.1885 (2009), 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) of this subpart) may be reopened, for 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 (2009)²⁰ 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.

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

¹⁷ 42 C.F.R. § 412.84(k).

¹⁸ *Billings Clinic v. Azar*, 901 F.3d 301, 306 (D.C. Cir. 2018) (citing *Banner Health v. Price*, 867 F.3d at 1333).

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

²⁰ 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[.]”²¹

III. Positions of the Parties

As noted above, the Providers’ group issue statements outline 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.²² They take issue with the outlier thresholds set by the Secretary because she failed to consider relevant data which would have impacted their cost-to-charge ratios; failed to consider use of the more accurate “charge methodology” versus the “cost methodology”; and failed to require mid-year adjustments to the threshold or adjustments to the reconciliation process.²³

The Providers have filed Final Position Papers in each of the five (5) cases which are materially identical. They allege that CMS set the cost outlier threshold too high and “withheld 5.1% of DRG payments from Providers to fund outlier payments. However, CMS failed to return 5.1% to Providers.”²⁴ 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[.]”²⁵

The Providers note that, for the fiscal years at issue in these appeals, outlier payments were set at 5.1 percent of operating DRG payments, but outlier payments ultimately totaled less than this.²⁶ They argue the “outlier thresholds are contrary to the statute and/or are otherwise substantially or procedurally invalid.”²⁷ 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 valid comments and adjust the thresholds to achieve the 5.1% target; and failed to provide relevant data used in calculating the thresholds.²⁸ While they acknowledge that the Secretary’s methodology was affirmed by the D.C. Circuit using the Supreme Court’s *Chevron*²⁹ interpretive rules, they

²¹ 42 C.F.R. § 405.1889(b)(1).

²² 5 U.S.C. § 706(2).

²³ See, e.g., Case No. 13-3489GC, Group Issue: Outlier Payments – Fixed Loss Threshold at 1.

²⁴ E.g., Case No. 13-3489GC, Provider’s Final Position Paper at 2 (Mar. 7, 2025).

²⁵ *Id.* at 14-15.

²⁶ *Id.* at 18 (per the applicable Final Position Papers in each of the cases, FFY 2007 total outlier payments were 4.64%; FFY 2008 were 4.8%; FFY 2010 were 4.7%; FFY 2011 were 4.8%; and FFY 2012 were 5.0%).

²⁷ *Id.* at 19.

²⁸ *Id.* at 21.

²⁹ *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).

suggest that the new standard in *Loper Bright*³⁰ may result in a finding that the Secretary's interpretation of the governing statute is invalid.³¹

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*.³² It asks the Board to adopt the reasoning of the court and affirm the adjustments to outlier payments or, in the alternative, allow the Providers to seek expedited judicial review in accordance with 42 C.F.R. § 405.1842.³³

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 EJР 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 the final determinations of the Medicare Contractor;³⁴
- 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;³⁵
- 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.³⁶

³⁰ *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024).

³¹ *E.g.*, Case No. 13-3489GC, Provider's Final Position Paper at 21-22.

³² *E.g.*, Case No. 13-3489GC, Medicare Contractor's Final Position Paper at 7 (Mar. 27, 2025) (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).

³³ Medicare Contractor's Final Position Paper at 8.

³⁴ 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).

³⁵ 42 U.S.C. § 1395oo(a)(3).

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

In Case 14-2102GC, University of Medical Center New Orleans (Provider No. 19-0005) appealed from a Revised NPR that only adjusted Medicaid Eligible Days. 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[.]”³⁷ No adjustment was made related to outlier payments and, therefore, the Board hereby *dismisses* University of Medical Center New Orleans (Provider No. 19-0005) from Case 14-2102GC.

For all other Providers in these five (5) CIRP Group cases, the Providers’ documentation shows that the appeal requests were timely filed from original NPRs and the estimated amount in controversy exceeds \$50,000, as required for a group appeal.³⁸

a. Dissatisfaction - FYEs Prior to December 31, 2008 (Bethesda)

Cases 13-3489GC and 13-3485GC involve Providers with FYEs June 30, 2007 and June 30, 2008, respectively.

For purposes of Board jurisdiction over a participant’s appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming an issue as a “self-disallowed cost,” pursuant to the Supreme Court’s reasoning set out in *Bethesda Hospital Association v. Bowen*.³⁹ In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary’s rules and regulations does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.⁴⁰

The Board has determined that that the Outlier Threshold methodology at issue in this case is governed by 42 U.S.C. § 1395ww(d)(2) and 42 C.F.R. § 412.84, which are statutory and regulatory provisions that left the Medicare Contractors without the authority to make the payment in the manner sought by the Providers in these cases. As such, since the Providers filed their cost reports in compliance with this regulation/policy, the Outlier Threshold issue is governed by the ruling in *Bethesda* and the Providers are not barred from claiming dissatisfaction with the amount of reimbursement allowed by the regulation/policy.

³⁷ 42 C.F.R. § 405.1889(b)(1).

³⁸ See 42 C.F.R. § 405.1837.

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

⁴⁰ *Bethesda* at 1258-59.

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

Cases 14-2102GC, 14-3003GC, and 15-0545GC involve Providers with FYEs June 30, 2010, June 30, 2011, and June 30, 2012, respectively.

On August 21, 2008, new regulations governing the Board were effective.⁴¹ 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, that 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*”).⁴² 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.⁴³

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 Providers are challenging the policy as set forth in 42 U.S.C. § 1395ww(d)(2) and 42 C.F.R. § 412.84 and that Board review of the issues is not otherwise precluded by statute or regulation.

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

⁴² 201 F.Supp.3d 131 (D.D.C. 2016).

⁴³ *Id.* at 142.

V. Board's Decision Regarding the EJ Request

The Board finds that:

- 1) In Case 14-2102GC, University of Medical Center New Orleans (Provider No. 19-0005) appealed from a Revised NPR that did not make any specific adjustments related to the Outlier Threshold issue and is hereby *dismissed* from Case 14-2102GC;
- 2) It has jurisdiction over the matter for the subject years and that the remaining participants in Cases 13-3489GC, 13-3485GC, 14-2102GC, 14-3003GC, and 15-0545GC are entitled to a hearing before the Board;
- 3) Based upon the participants' assertions regarding the Outlier Threshold issue as governed by 42 U.S.C. § 1395ww(d)(2) 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)(2) 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)(2) and 42 C.F.R. § 412.84 properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' EJ Request for the issue and the subject years in Cases 13-3489GC, 13-3485GC, 14-2102GC, 14-3003GC, and 15-0545GC, except for Case 14-2102GC, University of Medical Center New Orleans (Provider No. 19-0005). 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 five (5) cases, the Board hereby closes the case.

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.

HRS LSU Outlier Threshold CIRP Groups

EJR Determination

PRRB Case Nos.: 13-3489GC, 13-3485GC, 14-2102GC, 14-3003GC, & 15-0545GC

Page 10

Board Members Participating:

Kevin D. Smith, CPA

Ratina Kelly, CPA

Nicola E. Musgrave, Esq.

Shakeba DuBose, Esq.

FOR THE BOARD:

5/28/2025

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 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***
Dupont Hospital LLC, Prov. No. 15-0150, FYE 03/31/2017
Case No. 20-0405

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 20-0405. Set forth below is the decision of the Board to dismiss the 2 remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) and Medicaid Eligible Days.

Background

A. Procedural History for Case No. 20-0405

On **May 15, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end March 31, 2017.

On **November 8, 2019**, 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 Pool²
5. 2 Midnight Census IPPS Payment Reduction³

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 **June 15, 2020**, the Provider transferred Issues 2 and 5 to Community Health groups.

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 June 15, 2020, this issue was transferred to PRRB Case No. 20-0997GC.

² This issue was withdrawn on May 4, 2021.

³ On June 15, 2020, this issue was transferred to PRRB Case No. 20-0999GC.

On **November 26, 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 25.⁴*

On **June 29, 2020**, the Provider timely filed its preliminary position paper. With respect to Issue 3, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that “[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its’ 2017 cost report does not reflect an accurate number of Medicaid eligible days.” As a result, the Provider included, as an Exhibit, the original “estimated impact” for this issue of \$17,137 based on an *estimated* 100 days.

On **July 13, 2020**, the Medicare Contractor requested from the Provider all documentation necessary to resolve Issue 3 (DSH Payment – Medicaid Eligible Days).

On **August 17, 2020**, 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 **October 30, 2020**, 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 **January 6, 2023**, the Medicare Contractor filed its 2nd and Final Request for DSH Package in connection with Issue 3. In this filing, the Medicare Contractor noted that, on July 13, 2020 (1st request), it had previously requested that the Provider send it a DSH package to resolve Issue 3. 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

⁴ (Emphasis added.)

(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 24, 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 3. 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 26, 2023**, the Provider changed its designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. (“QRS”).

On **November 8, 2023**, almost 3 months after the deadline for responding to the Motion to Dismiss Issue 3, QRS filed a “Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission” and added the *caveat* that the “Listing [is] *pending finalization* upon receipt of State eligibility data.”⁵ The Listing was 3 pages with roughly 492 Medicaid eligible days. QRS’ filing did not explain why the listing of so many days (again around 492 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 492 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.

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

⁵ (Emphasis added.)

⁶ Issue Statement at 1 (Nov. 8, 2019).

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

Statement of the Issue:

Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

Statement of the Legal Basis

The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

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

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.⁷

On June 29, 2020, the Board received the Provider's preliminary position paper in 20-0405. The following is the Provider's *complete* position on Issue 1 set forth therein:

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation based on the Provider's Fiscal Year End (March 31).

⁷ Group Appeal Issue Statement in Case No. 20-0997GC.

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).⁸

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is \$10,000.

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.⁹

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 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.

⁸ Provider's Preliminary Position Paper at 8-9 (Jun. 29, 2020).

⁹ Medicare Contractor's Jurisdictional Challenge at 7 (Aug. 17, 2020).

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

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

Decision of the Board

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

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

A. DSH Payment/SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage; and (2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Case No. 20-0997GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."¹¹ 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

¹⁰ Board Rule 44.4.3, v. 2.0 (Aug. 2018).

¹¹ Issue Statement at 1.

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. 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. 20-0405 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 4.6¹⁴, 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.¹⁵ 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 25.2.¹⁶ Moreover, the Board finds that the Provider’s Preliminary Position Paper failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Aug. 29, 2018), the Board requires position papers “to be *fully* developed and include *all* *available* documentation necessary to provide a *thorough understanding* of the parties’

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 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 (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 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.

¹⁷ (Italics and underline emphasis added.)

¹⁸ Last accessed Oct. 15, 2024.

¹⁹ (Emphasis added).

Accordingly, *based on the record before it*,²⁰ the Board finds that the SSI Provider Specific issue in Case No. 20-0405 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) (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**

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

of the provider's Medicare payment claims for each remaining issue.

(3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.²¹

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 Papers²²

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.

²¹ (Bold emphasis added.)

²² (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.)

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.²³

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

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

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

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

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

On June 29, 2020, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.²⁴ 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 \$17,137 based on an estimated 100 days). The Provider's complete briefing of this issue in its position paper is as follows:

²³ (Emphasis added.)

²⁴ Provider's Preliminary Position Paper at 8.

Calculation of Medicaid Eligible Days

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

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

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

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

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

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

Notably, the Medicare Contractor sent 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 July 13, 2020 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 24, 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.²⁵

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 23, 2023 filing deadline (*i.e.*, 30 days after July 24, 2023).

However, on November 8, 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 3 pages with roughly 492 Medicaid eligible days. QRS’ filing did not explain why the listing of so many days (again around 492 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 492 included in this belated listing is *significantly* larger than the original estimate of 100 days included with the appeal request. Regardless, this filing was more than 3 months past the deadline for responding to the Motion to Dismiss *and, more importantly, was roughly 3½ year past the deadline for including it with its preliminary position paper* since the position paper deadline was July 5, 2020.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(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).

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.

The fact that the Listing was filed less than 4 months after the Provider changed its designated representative to QRS does not excuse the Provider for its failure to include the information with its preliminary position paper or its failure to timely respond to the 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 8, 2023 filing as a “Supplement to Position Paper” and does not accept that filing because:

1. The alleged “Supplement” was filed *roughly 3½ years after the deadline* for that exhibit to be included with its preliminary position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)). Indeed, the Provider failed to timely reply to the Medicare Contractor’s Motion to Dismiss Issue 3 and the alleged “Supplement” was filed *more than 2 months after the deadline* for filing a response to the Motion to Dismiss Issue 3.
2. The alleged “Supplement” fails to explain the following critical information: (a) *why* it was being filed so late (*i.e.*, upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the roughly 492 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 4 years after this appeal was filed and more than 5.5 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 November 26, 2019 Case Acknowledgment and Critical Due Dates permit the Provider to file a “Supplement” to its preliminary position paper (nor did the Provider allege in the “Supplement” filing that they do).
4. Given the fact that the *material* facts (*e.g.*, the days at issue) and all available exhibits were required to be part of the position paper filing, if the Board were to accept a “Supplement,” it would need to be either be a *refinement* of its preliminary position paper or a supplement of documents that were identified in the preliminary position paper as being unavailable consistent with Board Rule 25.2.2. However, neither the preliminary position paper nor the alleged “Supplement” identified any “unavailable” exhibits consistent with Board Rule 25.2.2. Further, the alleged “Supplement” cannot be considered a refinement of the position paper since no specific days or listing were included with the preliminary position paper (indeed the *tentative* 492 days listed in the alleged “Supplement” is, without explanation, *significantly* larger than the original estimated 100 days included with the appeal request).²⁶

Finally, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof “to prove eligibility for *each* Medicaid patient day claimed”²⁷ and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provider the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations

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

²⁷ (Emphasis added.)

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

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

* * * * *

Based on the foregoing, the Board has dismissed the two (2) remaining issues in this case – (Issues 1 and 3). As no issues remain, the Board hereby closes Case No. 20-0405 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:

5/28/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Byron Lamprecht, WPS Government Health Administrators (J-8)
Wilson Leong, FSS

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.



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***
Merit Health Biloxi, Prov. No. 25-0007, FYE 09/30/2017
Case No. 21-0221

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 21-0221. 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. 21-0221

On **March 9, 2020**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end September 30, 2017.

On **August 28, 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 Days²
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 Days⁴
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 Reduction⁶

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 17, 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 18, 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 **April 22, 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 \$36,866 based on an *estimated* 100 days.

On **April 23, 2021**, the Medicare Contractor requested from the Provider all documentation necessary to resolve Issue 5 (DSH Payment – Medicaid Eligible Days).

On **June 7, 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 30, 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 April 23, 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 24, 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 26, 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 17 pages with roughly 3,320 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 3,320 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 3,392 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. 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 April 22, 2021, the Board received the Provider's preliminary position paper in 21-0221. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Provider Specific

⁹ Issue Statement at 1 (Aug. 28, 2020).

¹⁰ Group Appeal Issue Statement in Case No. 20-0997GC.

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Mississippi and the Provider that does not support the SSI percentage issued by CMS.

The Provider has worked with the State of Mississippi 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 individual 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 the 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

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is \$26,000.

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

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

¹¹ Provider's Preliminary Position Paper at 8-9 (Apr. 22, 2021).

¹² Medicare Contractor's Jurisdictional Challenge at 7 (Jun. 7, 2021).

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 44.3¹⁴ 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.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security

¹³ Board Rule 44.4.3, v. 2.0 (Aug. 2018).

¹⁴ Board Rules, v. 3.1 (Nov. 2021).

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. 20-0405 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 4.6¹⁸, 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 finds that the Provider’s Preliminary Position Paper failed to comply with Board Rule 25 (Aug.

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 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.

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

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

²¹ (Italics and underline emphasis added.)

²² Last accessed Oct. 15, 2024.

²³ (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. 20-0997GC.

Accordingly, *based on the record before it*,²⁴ the Board finds that the SSI Provider Specific issue in Case No. 20-0405 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) (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**

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.

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 Papers²⁶

COMMENTARY:

Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, 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

²⁵ (Bold emphasis added.)

²⁶ (Underline emphasis added to these excerpts and all other emphasis in original.)

material facts that support the provider's claim.

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

25.2 Position Paper Exhibits

25.2.1 General

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

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

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available.

Once the documents become available, promptly forward them to the Board and the opposing party.

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on November 18, 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)(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.

On April 22, 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 \$36,866 based

²⁷ (Emphasis added.)

²⁸ Provider's Preliminary Position Paper at 8.

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.

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 April 23, 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 24, 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 23, 2023 filing deadline (*i.e.*, 30 days after July 24, 2023).

However, on November 24, 2023 (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 17 pages with roughly 3,320 Medicaid eligible days. QRS’ filing did not explain why the listing of so many days (again around 3,320 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 3,320 included in this belated listing is *exponentially* larger than the original estimate of 100 days included with the appeal request. Regardless, this filing was 3 months past the deadline for responding to the Motion to Dismiss *and*, *more importantly*, **was roughly 3½ year past the deadline for including it with its preliminary position paper** since the position paper deadline was April 25, 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)(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).

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.

The fact that the Listing was filed 4 months after the Provider changed its designated representative to QRS does not excuse the Provider for its failure to include the information with its preliminary position paper or its failure to timely respond to the 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 3½ 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 *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 3,320 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 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 18, 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* 3,320 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

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.)

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. 21-0221 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

For the Board:

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

5/28/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

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.



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***
Woodland Heights Medical Center, Prov. No. 45-0484, FYE 12/31/2017
Case No. 21-0576

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 21-0576. 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. 21-0576

On **July 30, 2020**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end December 31, 2017.

On **January 14, 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. (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 24, 2021**, the Provider transferred Issue 2 to a Community 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 21, 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

¹ On August 24, 2021, this issue was transferred to PRRB Case No. 20-0997GC.

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 **April 28, 2021**, the Medicare Contractor requested from the Provider all documentation necessary to resolve Issue 3 (DSH Payment – Medicaid Eligible Days).

On **July 14, 2021**, the Medicare Contractor requested for the 2nd time all documentation necessary to resolve Issue 3 (DSH Payment – Medicaid Eligible Days).

On **September 7, 2021**, the Provider timely filed its preliminary position paper. With respect to Issue 3, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that “[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its’ 2017 cost report does not reflect an accurate number of Medicaid eligible days.” As a result, the Provider included, as an Exhibit, the original “estimated impact” for this issue of \$55,304 based on an *estimated* 100 days.

On **January 3, 2022**, the Medicare Contractor filed its preliminary position paper. With regard to Issue 3, the Medicare Contractor’s position paper noted that: (1) the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position; and (2) the Provider had failed to respond to any of the Medicare Contractor’s requests for that Medicaid eligible days listing.

On **January 5, 2023**, the Medicare Contractor filed its 3rd and Final Request for DSH Package in connection with Issue 3. In this filing, the Medicare Contractor noted that, on April 28, 2021 (1st request) and on July 14, 2021 (2nd request), it had previously requested that the Provider send it a DSH package to resolve Issue 3. As no response was received, the Medicare Contractor formally filed the 3rd and Final Request for DSH Package to formally request that a listing of the Medicaid eligible days at issue plus supporting documentation be provided to the Medicare Contractor on or before February 4, 2023 (*i.e.*, within 30 days). Notwithstanding the formal request, the Provider failed to file any response to the Medicare Contractor.

² (Emphasis added.)

As no response was received from the Provider, on **August 17, 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 3. 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 **September 19, 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. A response was filed on October 8, 2024, nearly a year after the deadline to respond.

On **September 21, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. (“QRS”).

On **November 24, 2023**, over 2 months after the deadline for responding to the Motion to Dismiss Issue 3, QRS filed a “Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission” and added the *caveat* that the “Listing [is] *pending finalization* upon receipt of State eligibility data.”³ The Listing was 6 pages with roughly 953 Medicaid eligible days. QRS’ filing did not explain why the listing of so many days (again around 953 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, *nearly 6 years after the fiscal year at issue had closed*. NOTE—the roughly 953 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.

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

³ (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).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 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.⁵

On September 7, 2021, the Board received the Provider's preliminary position paper in 21-0576. The following is the Provider's *complete* position on Issue 1 set forth therein:

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH

⁴ Issue Statement at 1 (Jan. 14, 2021).

⁵ Group Appeal Issue Statement in Case No. 20-0997GC.

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 [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).⁶

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is \$32,000.

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.⁷

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."⁸ The MAC posits that the Provider "failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its Preliminary Position Paper."⁹

⁶ Provider's Preliminary Position Paper at 8-9 (Sept. 7, 2021).

⁷ Medicare Contractor's Jurisdictional Challenge at 6-7 (Sept. 19, 2023).

⁸ *Id.* at 7 (Emphasis added).

⁹ *Id.* at 9.

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 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.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.”

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

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, 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.

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 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).”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. 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. 21-0576 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 4.6¹⁴, 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.¹⁵ 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 25.2.¹⁶ Moreover, the Board

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

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.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") 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

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.

¹⁷ (Italics and underline emphasis added.)

¹⁸ Last accessed Oct. 15, 2024.

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. 20-0997GC.

Accordingly, *based on the record before it*,²⁰ the Board finds that the SSI Provider Specific issue in Case No. 21-0576 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) (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.

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

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.²¹

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 Papers²²

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

²¹ (Bold emphasis added.)

²² (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 January 21, 2021 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.²³

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

²³ (Emphasis added.)

- upon failure to appear for a scheduled hearing.

On September 7, 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.²⁴ 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 \$55,304 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

²⁴ Provider’s Preliminary Position Paper at 8.

of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

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

Notably, the Medicare Contractor sent three (3) separate requests for the Provider's list of Medicaid Eligible days (and also discussed the lack of the listing in the Medicare Contractor's own position paper filing). The first notice was sent to the Provider on April 28, 2021 and the second notice was sent to the Provider on July 14, 2021. The third, final request was filed formally with the Board in OH CDMS on January 5, 2023, *five years after the end of the Provider's cost reporting period*. The Medicare Contractor also informed the Provider in its final request for information that the deadline to respond was February 4, 2023. The Provider failed to file any response to the 3rd and final request.

Due to the non-responsiveness of the Provider, on **August 17, 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 3 separate times after that). The Medicare Contractor thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the Board Rules.²⁵

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 17, 2023 filing deadline (*i.e.*, 30 days after September 16, 2023).

However, on November 24, 2023 (over 2 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 953 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 953 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, ***nearly 6 years after the fiscal year at issue had closed***. NOTE—the roughly 953 included in this belated listing is *significantly* larger than the original estimate of 100 days included with the appeal request. Regardless, this filing was more than 2 months past the deadline for responding to the Motion to Dismiss ***and, more importantly, was over 2 years past the deadline for***

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.

including it with its preliminary position paper since the position paper deadline was September 11, 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)(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 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 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 **over 2 years after the deadline** for that exhibit to be included with its preliminary position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)). Indeed, the Provider failed to timely reply to the Medicare Contractor’s Motion to Dismiss Issue 3 and the alleged “Supplement” was filed **more than 2 months after the deadline** for filing a response to the Motion to Dismiss Issue 3.
2. The alleged “Supplement” fails to explain the following critical information: (a) *why* it was being filed so late (i.e., upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the roughly 953 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 3 years after this appeal was filed and nearly 6 years after the fiscal year at issue had closed); and (c) why the listing still was **not** a “*final*” listing at this late date.
3. Neither the Board Rules nor the January 21, 2021 Case Acknowledgment and Critical Due Dates permit the Provider to file a “Supplement” to its preliminary position paper (nor did the Provider allege in the “Supplement” filing that they do).
4. Given 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* 953 days listed in the alleged “Supplement” is, without explanation, *significantly* larger than the original estimated 100 days included with the appeal request).²⁶

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

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

* * * * *

Based on the foregoing, the Board has dismissed the two (2) remaining issues in this case – (Issues 1 and 3). As no issues remain, the Board hereby closes Case No. 21-0576 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.

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

²⁷ (Emphasis added.)

²⁸ See also *Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022): The Board acts reasonably, and not arbitrarily and capriciously, when it applies its “claims-processing rules faithfully to [a provider’s] appeal.” *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide “[a]n explanation [] for each specific item under appeal.” 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that “[s]ome issues may have multiple components,” and that “[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible.” Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a “common example” of an appeal involving issues with “multiple components” that must be appealed as “separate issue[s] and described as narrowly as possible.” Board Rules §§ 8.1, 8.2.

Notice of Dismissal for Woodland Heights Medical Center

Case No. 21-0576

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Board Members Participating:

Kevin D. Smith, CPA

Ratina Kelly, CPA

Nicole E. Musgrave, Esq.

Shakeba DuBose, Esq.

For the Board:

5/29/2025

X Ratina Kelly

Ratina Kelly, CPA

Board Member

Signed by: PIV

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