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

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

Michael Redmond
GuideWell Source
2020 Technology Parkway, Suite 100
Mechanicsburg, PA 17050

RE: ***Board Decision* – SSI Percentage (Provider Specific) & Uncompensated Care Distribution Pool Issues**
Northern Louisiana Medical Center (Provider Number 19-0086)
FYE: 09/30/2016
Case Number: 19-2777

Dear Mr. Summar and Mr. Redmond,

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

Background:

A. *Procedural History for Case No. 19-2777*

On **March 5, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2016.

On **August 28, 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[2]
4. UCC Distribution Pool
5. 2 Midnight Census IPPS Payment Reduction[3]

The Provider is commonly owned/controlled by Community Health Systems, Inc. (hereinafter "Community Health") and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **March 20, 2020**, the Provider transferred Issues 2 and 5 to Community Health groups. As a result, there are two (2) remaining issues in this

[1] On March 20, 2020, this issue was transferred to PRRB Case No. 19-1409GC.
[2] This issue was withdrawn on May 2, 2024. The Provider requested reinstatement, which was denied by the Board on June 26, 2024.
[3] On March 20, 2020, this issue was transferred to PRRB Case No. 19-1410GC.

appeal: Issue 1 (DSH Payment/SSI Percentage (Provider Specific)) and Issue 4 (UCC Distribution Pool).

On **May 1, 2024**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1, 3 and 4.[4]

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

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[5]

The group issue statement in Case No. 19-1409GC, CHS CY 2016 DSH SSI Percentage CIRP Group, to which the Provider transferred Issue 2 reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. §

[4] As previously noted, Issue No. 3 was subsequently withdrawn.
[5] Issue Statement at 1 (Aug. 28, 2019).

> 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[6]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $24,000.

On April 22, 2020, 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' 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 Louisiana and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Louisiana 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

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

> it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[7]

On April 5, 2024, the Provider filed its final position paper. 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 record 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]

<u>MAC's Contentions</u>

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

The MAC argues that the Provider failed to brief the SSI realignment issue in their preliminary and final position papers and should be considered withdrawn, as per Board Rule 25.3.[9]

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[7] Provider's Preliminary Position Paper at 8-9 (Apr. 22, 2020).
[8] Provider's Final Position Paper at 8-9 (Apr. 5, 2024).
[9] Jurisdictional Challenge at 6 (May 1, 2024).

If it is not considered withdrawn, the MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue for two reasons. 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 contractor determination issued as part of the NPR. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage and CMS issues a determination in response to the request. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available administrative remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[10]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are duplicates.[11]

Finally, the MAC argues the Provider failed to file a complete position paper, arguing:

> The MAC contends that the Provider violated 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 Baystate SSI Data Accuracy issue should be dismissed.[12]

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)."[13]

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[10] *Id*. at 6-7.
[11] *Id*. at 4-6.
[12] *Id*. at 9.
[13] *Id*. at 20.

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[14] The Provider 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. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

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

A. DSH Payment/SSI Percentage (Provider Specific)

The jurisdictional 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 PRRB Case No. 19-1409GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[15] 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 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."[17]

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[14] Board Rule 44.4.3, v. 3.2 (Dec. 2023).
[15] Issue Statement at 1.
[16] *Id.*
[17] *Id.*

The Provider's DSH/SSI Percentage (Systemic Errors) 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 the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 19-1409GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[18], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case 19-1409GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). 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] 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 can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-1409GC.

To this end, the Board also reviewed the Provider's Preliminary and Final Position Papers to see if they further clarified Issue 1. However, neither provided any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 19-1409GC, but instead referred to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary and Final Position Papers failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary and Final Position Papers 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**
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> *If documents necessary to support your position are still unavailable,* identify the missing documents, explain why the

[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).

> 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.[20]

The Board further notes that 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") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh. [21]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[22]

Additionally, in its Final Position Paper, the Provider stated, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3)."[23] The Board finds that this purported argument does not comply with the regulations and Board rules to *fully* develop the Provider's position in the Final

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[20] (Emphasis added).
[21] Last accessed July 1, 2024.
[22] Emphasis added.
[23] Provider's Final Position Paper at 9.

Position Paper, because the Provider merely lists a case name and does not explain further what the arguments are that it would like to incorporate into its appeal.

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 19-1409GC are the same issue.[24] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

42 C.F.R. § 405.1853 addresses position papers and specifies in pertinent part:

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

Therefore, the Board finds that the Provider did not comply with the Final Position Paper regulations and Board rules with respect to the purported *Advocate Christ* argument and dismisses that portion of the 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.

The Board finds that, under 42 C.F.R. § 412.106(b)(3), 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 . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal. Further, the Board notes that the Provider's cost reporting period ends on 9/30 and is, therefore, congruent with the Federal fiscal year. Thus, realignment of the SSI Percentage would have no effect on reimbursement in this case.

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

B. UCC Distribution Pool

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).[26]

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).[27]
>
> (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*"),[28] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[29] 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

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[26] The Provider was also a participant in PRRB Case No. 16-0769GC (appealing from the Fed. Reg. dated Aug. 17, 2015, covering service dates July 1, 2016 through Sept. 30, 2016). The CIRP Group appeal has been dismissed for a lack of jurisdiction.

[27] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.

[28] 830 F.3d 515 (D.C. Cir. 2016).

[29] 89 F. Supp. 3d 121 (D.D.C. 2015).

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."[30] 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.[31]

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.[32]

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*").[33] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[34] 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.[35]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[36] 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.[37] 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

[30] 830 F.3d 515, 517.
[31] *Id.* at 519.
[32] *Id.* at 521-22.
[33] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[34] *Id.* at 506.
[35] *Id.* at 507.
[36] 514 F. Supp. 249 (D.D.C. 2021).
[37] *Id.* at 255-56.

DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[38] 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.[39] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[40]

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.[41]

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."[42] 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.[43] For review to be available in these circumstances, the following criteria must 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.[44]

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

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[38] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[39] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.
[40] *Id.*
[41] *Id.* at 262-64.
[42] *Id.* at 265.
[43] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[44] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).

to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[45] 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*").[46] 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.[47] 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."[48] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[49] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[50]

The Board finds that the same findings are applicable to the Provider's challenge to their FFY 2016 UCC payments. The Providers here are challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2016. 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.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 19-1409GC and there is no

[45] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[46] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[47] *Id*. at *127.
[48] *Id.* at *134.
[49] 139 S. Ct. 1804 (2019).
[50] *Ascension* at *132 (bold italics emphasis added).

final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the UCC Distribution Pool issue as the Board does not have jurisdiction 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. As no issues remain pending, the Board hereby closes Case No. 19-2777 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:

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

For the Board:

7/1/2024

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Randall Gienko
Strategic Reimbursement Services, Inc.
360 W. Butterfield Road
Elmhurst, IL 60126

Lisa Ellis
Toyon Associates, Inc.
1800 Sutter Street, Suite 600
Concord, CA 94520

Re: ***Dismissal of Untimely Filed Duplicative Appeal***
Hollywood Presbyterian Medical Center, Prov. No. 05-0063, FYE 12/31/2019
Case Nos. 24-1924 and 24-2031

Dear Mr. Gienko and Ms. Ellis:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced appeals which were both filed for the same Provider based on the same final determination issued for FYE 12/31/2019. After review of the facts outlined below, the Board has determined that one of the appeals must be dismissed. The pertinent facts of these cases and the Board's determination are set forth below.

Pertinent Facts:

On **June 17, 2024**, Toyon Associates, Inc. ("Toyon") filed an appeal with the Board on behalf of Hollywood Presbyterian Medical Center to establish Case No. 24-1924. The appeal was filed from a Notice of Program Reimbursement ("NPR") dated **December 22, 2023**.[1] The appeal includes eight issues:

1. Understatement of Outliers
2. DSH -Additional Medicaid Eligible Days
3. DSH Code 2 & 3 Medicaid Eligible Days
4. Medicare Part C Days SSI Ratio/DE Part C Days Medicaid Ratio
5. DSH- Accuracy of CMS Developed SSI Ratio
6. IPPS-Standardized Payment Rate
7. DSH- Disallowance of Capital DSH Payment
8. California Rural Floor Wage Index[2]

On **June 28, 2024**, Strategic Reimbursement Services, Inc. ("Strategic") filed an appeal with the Board on behalf of Hollywood Presbyterian Medical Center to establish Case No. 24-2031. The appeal was filed from the same **December 22, 2023** NPR.[3] The appeal, which included only the Rural Floor Wage Index issue, was filed 189 days after issuance of the NPR.

[1] The Representation letter was dated April 23, 2024 and was filed on the Provider's letterhead.
[2] On June 24, 2024, Toyon transferred the California Rural Floor Wage Index issue to Case No. 24-2001G.
[3] The Representation letter was dated June 28, 2024, but was not filed under the Provider's letterhead and did not include a signature from an authorized official of the Provider.

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.

Specifically, 42 C.F.R. § 405.1835(a)(3) indicates that, unless the Provider qualifies for a good cause extension, the Board must receive a Provider's hearing request ***no later than 180 days after the date of receipt of the final determination, with a five-day presumption for mailing.***[4]

With respect to duplicate filings, Board Rule 4.6.1 states that a provider may not appeal and pursue the same issue from a single final determination in more than one appeal (individual or group). As such, it has been the Board's longstanding policy to create one appeal per provider per fiscal year end.

Regarding the deficient Representative letter included with Strategic's appeal, Board Rule 5.4. indicates the Representative letter must be on letterhead and be signed by an authorizing official of the provider organization.

Finally, Board Rule 5.2 makes it clear that the Provider's representative is responsible for being familiar with Board Rules and Regulations, meeting the Board's deadlines and responding to correspondence or requests from the Board.

Board Determination:

After its review, the Board has determined that Strategic's appeal request filed on behalf of Hollywood Presbyterian Medical Center under Case No. 24-2031 is fatally flawed. The appeal was not timely filed in accordance with the regulations at 42 C.FR. §§ 405.1835(a)(3) and is duplicative of another appeal for the same provider previously filed by Toyon, that is pending on the Board's docket.

As noted in the facts above, the Medicare Contractor issued the NPR for Hollywood Presbyterian Medical Center on December 22, 2023. The 185th day fell on Monday, June 24, 2024. Toyon timely filed an individual appeal on June 17, 2024 under Case No. 24-1924. Eleven days later, on June 28, 2024, Strategic filed the second individual appeal for Hollywood Presbyterian Medical Center. Strategic's appeal was filed four ("4") days beyond the 185th day after the issuance of the final determination and is therefore, considered to be untimely.[5]

---

[4] Emphasis added.

[5] "Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination." There was no allegation of good cause filed with the request for appeal in any of the Provider's support documents.

Further, as the Parties have been advised, it is the Board's policy to establish only ***one*** (1) individual appeal per Provider per fiscal year end.[6] In this regard, Board Rule 5.1 specifies that there may be only one (1) representative ***per appeal***. Consequently, for purposes of Hollywood Presbyterian Medical Center and its FY 2019, the Board can have only one individual appeal and that appeal can have only one representative. The Board finds that not only was Strategic's appeal under Case No. 24-2031 untimely filed, but it included a deficient Representative letter. Additionally, the Board notes that the sole issue appealed by Strategic was the Rural Floor Wage Index and that issue has already been included in Toyon's appeal under Case No. 24-1924.

Accordingly, the Board hereby dismisses Case No. 24-2031 because it was not timely filed in accordance with 42 C.F.R.§ 405.1835(a)(3) and was duplicative of the filing under Case No. 24-1924. Therefore, Case No. 24-2031 is hereby closed and 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 105.1877.

<u>Board Members</u>:
Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

7/2/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: Ratina S. Kelly -S

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

[6] *See* Board Rules 4.6, 5.4, 7.1.1. *See also* 42 C.F.R. § 405.1835(a).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Michael Redmond
Novitas Solutions, Inc.
2020 Technology Parkway, Suite 100
Mechanicsburg, PA 17050

RE: ***Board Decision* – SSI Percentage (Provider Specific) and 1115 Waiver Days**
San Angelo Community Medical Center (Provider Number 45-0340)
FYE: 08/31/2015
Case Number: 18-1165

Dear Mr. Ravindran and Mr. Redmond,

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

Background:

A. Procedural History for Case No. 18-1165

San Angelo Community Medical Center ("Provider") submitted a request for hearing that was received by the PRRB on April 6, 2018, from a Notice of Program Reimbursement ("NPR") dated October 12, 2017. The hearing request included the following issues:

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

On **July 5, 2018**, the MAC filed its first Jurisdictional Challenge in this case over Issues 1, 4 and 5. The Provider did not file a response to this Jurisdictional Challenge.

As the Provider is owned by Community Health Systems, Inc. (hereinafter "Community Health") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2, 4 and 5 to Community Health groups on November 21, 2018 and withdrew issue 1 on July 3, 2024. The remaining issue in this appeal is issue 3.

[1] Issue was withdrawn on July 3, 2024.
[2] On November 21, 2018, this issue was transferred to CN 18-0552GC.
[3] On November 21, 2018, this issue was transferred to CN 18-0555GC.
[4] On November 21, 2018, this issue was transferred to CN 18-0554GC.

On **November 23, 2018**, the Provider filed its preliminary position paper.

On **March 7, 2019**, the Medicare Contractor filed its preliminary position paper.

On **October 9, 2023,** the Provider filed its Final Position Paper. Similarly, on **November 9, 2023**, the Medicare Contractor filed its Final Position Paper.

On **November 6, 2023**, the Medicare Contractor filed a Jurisdictional Challenge with the Board regarding Issue 1 that was previously challenged (and since withdrawn by the Provider) and over the aspect of Issue No. 3 – DSH Medicaid Eligible Days which pertains to § 1115 Waiver Days. In particular, the Medicare Contractor notes: "The MAC contends that the Provider is attempting to untimely and improperly add the issue of Section 1115 waiver days as a sub-issue via its final position paper, filed on 10/09/2023."[5]

On **December 8, 2023**, the Provider filed a response, two days after the deadline passed. In that response, the Provider argues that 1115 waiver days are Medicaid Eligible days and the appeal request encompassed more than paid days.

B. Description of Issue 3 in the Appeal Request

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

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

[5] MAC's Jurisdictional Challenge, page 2.

> Audit Adjustment Number(s): 5, 6, 8, 9, 18, 23, and S-D. *See* Tab 4.
>
> Estimated Reimbursement Amount: $48,000. *See* Tab 5.[6]

Regarding the Medicaid eligible days issue, the Provider argues, in its Final Position Paper, that pursuant to the Jewish Hospital case[7] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[8] The Provider then, for the first time in this appeal, states it is seeking reimbursement for section 1115 waiver days as a part of the Medicaid eligible day issue. Specifically, the Provider states:

> [M]edicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).[9]

<u>MAC's Contentions</u>

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC contends that the Provider is attempting to untimely and improperly add the issue of Section 1115 waiver days as a sub-issue via its final position paper, filed on October 9, 2023.[10] The MAC asserts that the Provider did not mention section 1115 waiver days until the final position paper, along with which the Provider attached its listing of Medicaid eligible days described as "1115 Waiver and Additional ME Days Consolidated."[11] The MAC asserts that "[p]rior to its 10/09/2023 Final Position Paper, the Provider had not formally added the dispute to the appeal, nor had it otherwise raised the issue of section 1115 Waiver Days. The MAC contends that the Provider's attempt to add the issue of Section 1115 Waiver Days within its Final Position Paper is improper and untimely."[12] The MAC also cites 42 C.F.R. § 405.1835(e), which governs when specific Medicare payment issues may be added to the original hearing

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[6] Appeal Request at Issue 3.
[7] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[8] Provider's Final Position Paper at 9 (Oct. 9, 2023).
[9] *Id.* at 9-10.
[10] *Id*. at 13.
[11] *Id*. at 15.
[12] *Id.* at 15.

request, including a timeframe of no later than 60 days after the expiration of the applicable 180-day deadline to file an appeal.[13]

The MAC contends "the Section 1115 Waiver Days issue is one component of the DSH issue."[14] The MAC references Board Rule 8 (version 3.1), which lists Section 1115 waiver days (program/waiver specific) as a common example of issues with multiple components for which each contested component must be appealed as a separate issue and described as narrowly as possible. The MAC contends that the Board Rules "support the argument that the Section 1115 Waiver Days issue is a component of DSH different from the generic Medicaid eligible days issue and must be identified and appealed separately."[15]

The MAC requests that consistent with 42 C.F.R. § 405.1853(b) and 42 C.F.R. § 405.1853(e), the Board dismiss this added issue of section 1115 waiver days because the issue was not part of the appeal request and was not timely filed.[16]

Provider's Response

The Board notes that the Response to the MAC's motion was late. The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge/Motion must be filed within thirty (30) days of the filing of the Jurisdictional Challenge/Motion.[17] The Provider filed their response to the Jurisdictional Challenge on December 8, 2023, two days after the response was due. Board Rule 44.4 specifies: "The responding party must file a response within 30 days of the Intermediary's jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Issue 3 – DSH Payment - Medicaid Eligible Days

The Provider asserts that the MAC's "description of section 1115 waiver days as a "sub-issue" is tantamount to an admission that section 1115 waiver days is included within the issue of Medicaid eligible days."[18] The Provider contends that "the definition of Medicaid eligible days in 42 C.F.R. § 412.106(b)(4)(i) specifically includes section 1115 waiver days."[19] Further, as the MAC noted, the Provider's appeal statement said "all Medicaid eligible days, *including but not limited to* Medicaid paid days . . ." (emphasis added in Jurisdictional Challenge response).[20] Thus, the Provider asserts that as a technical matter, "the Provider appealed the failure to include any and all types of Medicaid eligible days, and [the MAC] was put on notice of that fact."[21]

With respect to the argument that the Provider has abandoned the issue of Medicaid eligible days, the Provider argues that "the Board Rules in effect governing the filing of the preliminary

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[13] *Id*. at 14.
[14] *Id.* at 12.
[15] *Id*. at 13.
[16] *Id*. at 16.
[17] Board Rule 44.4, v. 1.3 (Jul. 2015).
[18] *Id.* at 1.
[19] *Id.*
[20] *Id.*
[21] *Id.*

and final position papers is the July 1, 2015 version."[22] That version of the Board Rules states, at Board Rule 27.2, that the final position paper *should* address each remaining issue (emphasis added), not that it must do so, citing *Harris County Hospital v. Shalala*, 863 F. Supp. 404 (S.D. Tex. 1994) where the court found that the Provider Reimbursement Manual's use of 'should' was suggestive and not a requirement.[23] The Provider asserts that consistent with the regulatory meaning of "issue" and Board Rule 7.1, "the final position paper was not required to delve into "subparts" of an issue or specific arguments relating to the issue. Rather, the final position paper was required only to identify the issue and its reimbursement impact."[24] The Provider asserts that the more detailed requirements for preliminary and final position papers did not appear in the Board Rules until the 2018 version, which the Provider contends is only effective for appeals filed after its 2018 effective date.[25]

Analysis and 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.

Section 1115 Waiver Days

The Board finds that the § 1115 Waiver Days issue is *not* properly part of this appeal because it was not properly included in the original appeal request and it was not properly or timely added to the appeal. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the § 1115 Waiver Days as recognized by multiple Board, Administrator and Court decisions[26] (many of which were issued prior to the Provider's June 4, 2018 deadline for adding issues to this appeal).[27]

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[22] *Id.*
[23] *Id.* at 1-2.
[24] *Id.* at 2.
[25] *Id.*
[26] *See, e.g.*, *QRS 1993-2007 DSH/Iowa Indigent Patient /Charity Care (GA) Group v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Jan. 15, 2013), *affirming* PRRB Dec. No. 2013-D02 (Nov. 21, 2012)*; St. Dominic-Jackson Mem'l Hosp. v. Sebelius*, No. 3:12-cv-832, 2014 WL 8515280 (S.D. Miss. 2014); *Singing River Health Sys. v. Novitas Solutions, Inc.*, PRRB Dec. 2016-D19 (Sept. 20, 2016), *rev'd* CMS Adm'r Dec. (Nov. 18, 2016); *CCT&B 2005-2006 Hurricane Katrina § 1115 Waiver UCP Days Grp. v. Novitas Solutions, Inc*., PRRB Dec. 2016-D18 (Sep. 16, 2016), *rev'd* CMS Adm'r Dec. (Nov. 18, 2016), *aff'd sub nom. Forrest Gen. Hosp. v. Hargan*, No. 2:17-CV-8, 2018 WL 11434575 (S.D. Miss. Feb. 22, 2018), *rev'd & remanded Forrest Gen. Hosp. v. Azar*, 926 F.3d 221 (5th Cir. 2019); *Southwest Consulting UMass Mem'l Health Care & Steward Health 2009 DSH CCHIP Section 1115 Waiver Days Grps. v. Nat'l Gov't Servs., Inc*., PRRB Dec. 2017-D04 (Jan. 27, 2017), *rev'd* CMS Adm'r Dec. (Mar. 21, 2017), *vacated & remanded sub nom. HealthAlliance Hosps., Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. Oct. 26, 2018); *Florida Section 1115 LIP Rehab DSH Waiver Days Grps. v. First Coast Serv. Options*, PRRB Decs. 2018-D21, 2018-D22 (Feb. 8, 2018), *vacated by* Adm'r Dec. (Mar. 30, 2018), *rev'd by Bethesda Health Inc. v. Azar*, 389 F. Supp. 3d 32 (DDC 2019), *aff'd by* 980 F.3d 121 (D.C. Cir. 2020).
[27] Here, the NPR at issue was issued on October 2, 2017 and the Provider had until Thursday, April 5, 2018 to file the appeal (where receipt is presumed to be 5 days later and the Provider had 180 from that date to file an appeal request). Accordingly, the deadline to add issues is 60 days beyond that date, *i.e.*, Tuesday, June 4, 2018.

The appeal was filed with the Board in April of 2018 and 42 C.F.R. § 405.1835(b) (Sept. 2016) gives the following "contents" requirements for an initial appeal request for a Board hearing:

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing to the Board, and the request **must include** the elements described in paragraphs (b)(1) through (b)(4) of this section. **If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (b)(2), or (b)(3) of this section, the Board <u>may dismiss</u>** with prejudice the appeal or take any other remedial action it considers appropriate.
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the final contractor or Secretary determination under appeal.
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final contractor or Secretary determination under appeal, including an account of all of the following:
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
>
> (iii) If the provider self-disallows a specific item (as specified in §413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.
>
> (3) A copy of the final contractor or Secretary determination under appeal and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section.[28]

[28] (Italics emphasis in original and bold and underline emphasis added).

Board Rule 7.1 (Jul 1, 2015) elaborated on these regulatory "contents" requirements instructing providers:

> **Rule 7 – Issue Statement and Claim of Dissatisfaction**
>
> For each issue under appeal, give a brief summary of the determination being appealed and the basis for dissatisfaction. (*See* Rule 8 *for special instructions regarding multi-component disputes*.)
>
> **7.1 NPR or Revised NPR Adjustments**
>
> **A. Identification of Issue**
>
> Give a concise issue statement describing:
>
> - the adjustment, including the adjustment number,
> - why the adjustment is incorrect, and
> - how the payment should be determined differently.
>
> **B. No Access to Data**
>
> If the Provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.
>
> **7.2 – Self-Disallowed Items**
>
> **A. Authority Requires Disallowance**
>
> If the Provider claims that the item being appealed was not claimed on the cost report because a regulation, manual, ruling, or some other legal authority predetermined that the item would not be allowed, the following information must be submitted:
>
> - a concise issue statement describing the self-disallowed item
> - the reimbursement or payment sought for the item, and
> - the authority that predetermined that the claim would be disallowed. [*March 2013*]
>
> **B. 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.
>
> **C. Protest**
>
> Effective for cost reporting periods ending on or after December 31, 2008, items not being claimed under subsection A above must be adjusted through the protested cost report process. The Provider must follow the applicable procedures for filing a cost report under protest as contained in CMS Pub. 15-2, Section 115. See 42 C.F.R. § 405.1835(a)(1)(ii). [*March 2013*][29]

As explained above in Board Rule 7, Board Rule 8 (Jul. 1, 2015) provides "*special instructions*" for issue statements *involving* ***multi-component disputes***. In particular, 8.1 explains that, when framing issues for adjustments *involving multiple components*, that providers must "***specifically*** identify" each cost item in dispute, and "…each contested component must be appealed as a *separate* issue and described as ***narrowly as possible***…".[30] Board Rule 8. 2 (Jul. 1, 2015) gives common *examples* of different components of the Disproportionate Share Hospital payment calculation that may be in dispute. Specifically, Board Rule 8 states:

> **Rule 8 – Framing Issues for Adjustments Involving Multiple Components**
>
> **8.1 – General**
>
> Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7. See common examples below.
>
> **8.2 – Disproportionate Share Cases** (e.g., dual eligible, general assistance, charity care, HMO days, etc.)
>
> **8.3 – Bad Debts Cases** (e.g., crossover, use of collection agency, 120-day presumption, indigence determination, etc.)
>
> **8.4 – Graduate Medical Education/Indirect Medical Education** (e.g., managed care days, resident count, outside entity rotations, etc.)
>
> **8.5 – Wage Index** (e.g., wage vs. wage-related, rural floor, data corrections, etc.) [31]

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[29] (Italics emphasis in initial paragraph for Rule 7 added.)
[30] (Emphasis added.)
[31] Board Rules are available https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-rules-and-board-orders (last visited April 30, 2024).

Pursuant to the May 23, 2008 final rule, new Board regulations went into effect on August 21, 2008 *that limited the **addition** of issues to appeals*.[32] As a result of this final rule, 42 C.F.R. § 405.1835(e) (Sept. 2015) 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 –
>
> ****
>
> 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 establish that the Provider timely and properly added the § 1115 Waiver Days to the case. In this regard, the first discussion of § 1115 waiver days in this case occurred in the Provider's October 9, 2023 final position paper, well after the deadline for adding issues had passed.

In this regard, the Board notes that § 1115 Waiver days are *not* traditional Medicaid eligible days. Indeed, it was only effective January 20, 2000 that the Secretary incorporated, ***at her discretion** by regulation*, only ***<u>certain</u>*** types of § 1115 waiver days into the DSH calculation (*i.e.,* the Secretary maintains that no statute requires that days associated with § 1115 waiver/expansion programs be included in the DSH calculation and that she exercised her discretion to include only certain such days).[33] Rather, § 1115 waiver days relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to § 1115 waiver days. 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

[32] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[33] 65 Fed. Reg. 47054, 47087 (Aug. 1, 2000). *See also* 68 Fed. Reg. 45346, 45420 (Aug. 1, 2003) (stating: "On January 20, 2000, we issued an interim final rule with comment period (65 FR 3136), followed by a final rule issued on August 1, 2000 (65 FR 47086 through 47087), to allow hospitals to include the patient days of all populations that receive benefits under a section 1115 demonstration project in calculating the Medicare DSH adjustment. Previously, hospitals were to include only those days for populations under the section 1115 demonstration project who were, or could have been made, eligible under a State plan. Patient days of those expansion waiver groups who could not be made eligible for medical assistance under the State plan were not to be included for determining Medicaid patient days in calculating the Medicare DSH patient percentage. Under the January 20, 2000 interim final rule with comment period (65 FR 3137), hospitals could include in the numerator of the Medicaid fraction those patient days for individuals who receive benefits under a section 1115 expansion waiver demonstration project (effective with discharges occurring on or after January 20, 2000).").

> 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.[34]

*Significantly, **§ 1115 waiver programs can pertain** to not just Medicaid (Title XIX), but also **to other programs under Titles I, X, XIV, XIV or part A or D of Title IV of the Social Security Act***.[35] Hence, an important limitation is that the § 1115 waiver program receive Title XIX matching payments. Moreover, not every state Medicaid program has a qualifying § 1115 expansion program receiving Title XIX matching payments[36] and not every inpatient day associated with a beneficiary enrolled in such a § 1115 waiver program qualifies to be included in the numerator of the DSH Medicaid fraction.[37] In contrast, every state has a Medicaid state

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[34] (Bold emphasis added.)

[35] Section 1115 of the Social Security Act (42 U.S.C. § 1315] pertains to "experimental, pilot, or demonstration project[s] which, in the judgment of the Secretary, is likely to assist in promoting the objectives of ***title I, X, XIV, XVI, or XIX, or part A or D of title IV***, in a State or States." 1115(a) of the Social Security Act (emphasis added). As such, § 1115 waiver programs are not just limited to Title XIX Medicaid programs but may also relate to programs under Titles I, X, XIV, XVI, or part A or D of Title IV.

[36] Further, a specific approved state § 1115 waiver day program is not necessarily static and may vary from one year to the next.

[37] Unlike traditional Medicaid eligible days under a State Plan, the following discussion from the FY 2004 IPPS Final Rule, 68 Fed. Reg.at 45420-21 highlights that not all § 1115 waiver days can be included in the numerator of the Medicaid fraction and that factual determinations must be made regarding any § 1115 waiver day program to determine if 42 C.F.R. § 412.106(b)(4) is applicable to that program:

> Since that revision, we have become aware that there are certain section 1115 demonstration projects that serve expansion populations with benefit packages so limited that the benefits are not similar to the medical assistance available under a Medicaid State plan. These section 1115 demonstration projects extend coverage only for specific services and do not include inpatient care in the hospital. Because of the limited

plan; every state Medicaid plan includes inpatient hospital benefits; and by statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), the numerator of the DSH Medicaid fraction must include inpatient days of patients "who . . . were eligible for medical assistance ***under a State plan*** approved under subchapter XIX" but who were not entitled to Medicare Part A.[38]

In this regard, documentation needed to verify eligibility for a § 1115 waiver day is materially different than that for a traditional Medicaid eligible day[39] and, similarly, it is not a given that *all* § 1115 waiver days (even those under a program receiving Title XIX matching payments) necessarily would qualify under § 412.106(b)(4) as demonstrated by Board decisions and case law.[40] Here, 42 C.F.R. § 405.1835(b) and Board Rules 7 and 8 required each separate issue to be

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> nature of the coverage offered, the population involved may have a significantly higher income than traditional Medicaid beneficiaries.
>
> In allowing hospitals to include patient days related to section 1115 expansion waiver populations, our intention was to include patient days of section 1115 expansion waiver populations who receive benefits under the demonstration project that are similar to those available to traditional Medicaid beneficiaries, including inpatient benefits. Because of the differences between expansion populations in these limited benefit demonstrations and traditional Medicaid beneficiaries, in the May 19, 2003 proposed rule, we proposed that the Medicare DSH calculation should exclude from treatment as Medicaid patient days those patient days attributable to limited benefit section 1115 expansion waiver populations (proposed § 412.106(b)(4)(i)).
>
> For example, a State may extend a family planning benefit to an individual for 2 years after she has received the 60- day postpartum benefit under Medicaid, or a State may choose to provide a family planning benefit to all individuals below a certain income level, regardless of having previously received the Medicaid postpartum benefit. This is a limited, temporary benefit that is generally administered in a clinic setting (see section 1905(a)(4)(C) of the Act). Also, a number of States are developing demonstrations that are limited to providing beneficiaries an outpatient prescription drug benefit. Generally, these limited benefits under a demonstration project do not include inpatient benefits. If a hospital were to include the days attributable to patients receiving benefits under such a limited benefit, the hospital would be able to receive higher DSH payments, perhaps substantially, for patients who may otherwise be insured for inpatient care. For example, these limited demonstrations provide benefits that may be needed to supplement private insurance coverage for individuals who do not have incomes low enough to qualify for Medicaid under the State plan. We do not believe such patients should be counted in the DSH patient percentage as eligible for title XIX.
>
> ****
>
> Therefore, we proposed to revise § 412.106(b)(4)(i) to clarify that patients must be eligible for medical assistance inpatient hospital benefits under an approved State Medicaid plan (or similar benefits, including inpatient hospital benefits, under a section 1115 demonstration project) in order for their hospital inpatient days to be counted as Medicaid days in the calculation of a hospital's DSH patient percentage. Under the proposed clarification, hospital inpatient days attributed to patients who do not receive coverage for inpatient hospital benefits either under the approved State plan or through a section 1115 demonstration would not be counted in the calculation of Medicaid days for purposes of determining a hospital's DSH patient percentage.
>
> Under this reading, in the examples given above, the days associated with a hospital inpatient who receives coverage of prescription drugs or family planning services on an outpatient basis, but no inpatient hospital coverage, through either a Medicaid State plan or a section 1115 demonstration, would not be counted as Medicaid days for purposes of determining the DSH patient percentage.

[38] (Emphasis added.)

[39] In addition to providing proof that the patient at issue was eligible for the § 1115 waiver program for each day claimed, the Provider must also establish that the particular § 1115 waiver program at issue relates to Title XIX and qualified under 42 C.F.R. § 412.106(b)(4) as demonstrated by the preamble discussion in *supra* note 37 and litigation in *supra* note 26.

[40] *See* litigation in *supra* note 26.

identified in the appeal request. Here, the Provider failed to do so, notwithstanding including a ***detailed*** description of "The Process That The Provider Used To Identify And Accumulate The Actual Medicaid Paid And Unpaid Days That Were Reported And Filed On The Medicare Cost Report At Issue" to support its assertion that the Medicaid eligible days at issue in the appeal were ones that could not have been identified through that process.[41] Significantly, at the time of the appeal the Provider sought only 100 additional Medicaid eligible days. The listing of days attached to the final position paper were for 649 days and it is unclear why that amount increased more than six times over.

Regardless, of whether the Provider *properly* included the § 1115 waiver days issue in its appeal request (which it did not), the Provider failed to properly develop the merits of § 1115 waiver day issue in any of the Provider's position papers. Specifically, the Provider's preliminary position paper nor the final position paper mention, much less identify, the **specific state** § 1115 waiver program(s) at issue[42] or how any days under such program(s) would qualify under 42 C.F.R. § 412.106(b) to be included in the numerator of the DSH Medicaid fraction, notwithstanding its obligation to do so consistent with the position paper content requirements at 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules 25 and 27.[43] This is an independent basis for dismissal of the § 1115 waiver day issue. Specifically, the material facts and legal arguments needed to establish the merits of the Provider's claims regarding the § 1115 waiver days issue along with the relevant supporting documentation were not properly briefed and included in the position paper filings.

Finally, even if the Board were to find that Issue 3 encompassed § 1115 waiver days, there is no indication that any of the § 1115 waiver days included in the listing attached to the final position paper were included with the as-filed cost report and, if true, would make them an *unclaimed* cost and provide an independent basis for dismissal (*see* Board Alert 10). In raising this issue, the Board notes that it has found that when a class of days (*e.g.*, § 1115 waiver days) is excluded due to choice, error, and/or inadvertence from the as-filed cost report,[44] then that class of days is an

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[41] The Board recognizes that the appeal request states that "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." However, the "including but not limited to" phrase only pertained to traditional Medicaid eligible days and reasons why they may not have been included in the fraction. It did not expand to include other classes of days such as general assistance, State-only days or § 1115 waiver days. A generic catchall phrase cannot be used to essentially shoehorn in the later addition of an issue on an ***untimely*** basis in contravention of Board Rules and regulations. Indeed, neither the preliminary nor final position papers include any description (much less identification of) § 1115 waiver days as being an issue, notwithstanding the obligation to do so under the requirements for the content of position papers at 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules 25 and 27.

[42] In failing to identify the specific state § waiver program(s) at issue, the Provider fails to address whether such § 1115 waiver program(s) are under Titles I, X, XIV, XVI, XIX, or IV and whether such § 1115 waiver program(s) received Title XIX matching funds and would otherwise qualify under 42 C.F.R. § 412.106(b) to counted in the numerator of the DSH Medicaid fraction.

[43] 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25 (Aug. 2018) required a fully-developed preliminary position paper that includes the legal merits and material facts of the Provider's position as well as all available supporting documents as required Board Rule 25.2 (Aug. 2018).

[44] CMS Transmittal 11912 (Mar. 16, 2023) makes clear that hospitals must maintain records on § 1115 waiver days:

> Each provider with an approved [§] 1115 waiver program ***has a method for identifying the days*** that are applicable to such waiver for reimbursement from the Medicaid program. As such, ***the provider is responsible for maintaining the appropriate supporting documentation*** *for the*

unclaimed cost for which the Board would lack jurisdiction under 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835(a)(1)(i)-(ii) (2012) as clarified by CMS Ruling 1727-R.[45] The Provider's briefings generally address this jurisdictional issue by generically asserting that its process did not identify certain Medicaid eligible days. However, this discussion did not identify or discuss the class of days involving § 1115 waiver days and whether that class of days were included on the cost report. In this regard, if the Provider purposefully excluded § 1115 waiver days from the as-filed cost report, then CMS Ruling 1727-R confirms that the Provider only had a right to appeal those days if it "***had a good faith belief*** *that claiming reimbursement for [the § 1115 waiver days at issue] in the cost report would be futile because [the § 1115 waiver days at issue] was subject to a regulation or other payment policy* ***that bound the Medicare contractor and left the contractor with no authority or discretion to make payment in the manner sought by the provider***."[46] Here the Provider has failed to specifically address or discuss the Board's jurisdiction over this unique class of days. This is an independent basis for the Board to dismiss the § 1115 waiver days issue (*i.e.*, in addition to and independent from dismissal for failure to properly include the issue in its appeal request or properly brief and develop the issue).

In summary, as the DSH Medicaid Eligible Days issue as stated in the original appeal request did not include the § 1115 waiver days and was not timely added to the appeal, the Board dismisses it from this appeal. Because the Provider did not raise the § 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. Indeed, even if the Provider had properly included the issue as part of its appeal request, there are multiple independent bases upon which the Board would dismiss the issue, namely the failure to establish the Board's jurisdiction over the issue and the failure to properly develop the merits of the issue in its position paper filings.

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Based on the foregoing, the Board has dismissed Issue the § 1115 Waiver Days portion of Issue 3. The appeal remains open for Issue 3-DSH Medicaid Eligible Days. Given the dismissal of the 1115 waiver days portion of this issue, the Board hereby orders that, ***by no later than Thursday, July 11, 2024***, the Provider:

> *accrual of the days associated with [§] 1115 waiver reimbursements*. Providers *typically keep this information in the form of a listing* of specific patient accounts for each individual acute hospital stay ([§] 1115 log) that is subject to [§] 1115 reimbursement. This [§] 1115 log is similar to a provider's DSH Medicaid eligible days listing. (Emphasis added.)

[45] *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 06-1852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days 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* decisions under PRRB Dec. Nos. 2012-D14 and 2014-D03 is not applicable (available at: https://www.cms.gov/regulations-and-guidance/review-boards/prrbreview/downloads/jd-2017-11.pdf (last accessed July 3, 2024)).

[46] CMS Ruling 1727-R (emphasis added).

(1) Review Exhibit P-1(A) (entitled "Additional Days Log") as attached to its final position paper and to file an updated version of that exhibit that ***excludes*** *any § 1115 waiver days*;[47] and

(2) After conferring with the opposing party, file a status update on Issue 3 to confirm whether the Provider is still pursuing this issue *as it relates to the remaining days in dispute, if any, in this updated listing* and: (a) if so, address whether the parties are engaged in discussions to potentially administratively resolve the issue and whether the parties are requesting postponement of the hearing currently scheduled for Friday, July 17, 2024; or (b) if not, file withdrawal of the issue.

If the Provider fails to timely file its response by the deadline (without a Board-approved extension), the Board will take remedial action to dismiss Issue 3 for abandonment. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members Participating:

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

For the Board:

7/3/2024

X Kevin D. Smith, CPA

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

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

[47] Note the Board is not giving the Provider leave to otherwise add any additional days to this listing. Rather, the Board is requesting that the Provider update the list to exclude certain types of days to ensure that it includes only Medicaid eligible days covered under a State Medicaid plan (*i.e*., not waiver programs). *See* HCFA Ruling 97-2.

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***
Baylor Medical Center Grapevine (Provider Number 45-0563)
FYE: 06/30/2016
Case Number: 19-1378

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-1378. Set forth below is the Board's decision to dismiss 2 issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) and Uncompensated Care ("UCC") payments.

Background

A. *Procedural History for Case No. 19-1378*

On **August 10, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2016. The Provider is commonly owned by Baylor Scott & White Health ("BS & W Health").

On **February 8, 2019**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained ten (10) issues:

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

[1] On September 30, 2019, this issue was transferred to Case No. 19-2456GC.
[2] On September 30, 2019, this issue was transferred to Case No. 19-2457GC.
[3] On September 30, 2019, this issue was transferred to Case No. 19-2458GC.

6. DSH Medicaid Fraction / Medicare Managed Care Part C Days[4]
7. DSH Medicaid Fraction / Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[5]
8. Uncompensated Care ("UCC") Distribution Pool
9. 2 Midnight Census IPPS Payment Reduction[6]
10. Standardized Payment Amount[7]

As the Provider is commonly owned/controlled by BS & W Health, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **September 30, 2019**, the Provider transferred Issues 2, 3, 4, 6, 7, 9 and 10 to BS & W Health 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 5 (the DSH – Medicaid Eligible Days), and Issue 8 (UCC Distribution Pool).

On **March 12, 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 2, 2019**, the Provider timely filed its preliminary position paper.

On **January 31, 2020**, the Medicare Contractor filed its preliminary position paper.

[4] On September 30, 2019, this issue was transferred to Case No. 19-2459GC.
[5] On September 30, 2019, this issue was transferred to Case No. 19-2460GC.
[6] On September 30, 2019, this issue was transferred to Case No. 19-2760GC.
[7] On September 30, 2019, this issue was transferred to Case No. 19-2462GC.
[8] (Emphasis added.)

On **March 2, 2021**, the Medicare Contractor timely filed a Jurisdictional Challenge[9] with the Board over Issues 1 and 8 requesting that the Board dismiss these issues. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **May 9, 2023**, the Provider changed its 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. 19-2456GC – BS & W Health 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 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 [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).[10]

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[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 timeliness 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] Provider's Initial Appeal – Issue 1 (Feb. 8, 2019).

The Group issue Statement in Case No. 19-2456GC, to which the Provider transferred Issue No. 2, reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[11]

On October 2, 2019, the Board received the Provider's preliminary position paper in 19-1378. 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

[11] Group Appeal Issue Statement in Case No. 19-2456GC.

> all patients that were entitled to SSI benefits in the Provider's DSH calculation based on the Provider's Fiscal Year End (June 30).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services,* No. CV-94-0055 (C.D. Cal June 2, 1995), the SSI entitlement of individuals can be ascertained from [s]tate records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), 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).[12]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $60,000.

<u>MAC's Contentions</u>

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

The MAC argues that the Board should dismiss the DSH – SSI Percentage (Provider Specific) issue for two reasons. First, the MAC argues that the appeal is duplicative:

> According to the Provider's appeal request, Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the portions of Issue 1 related to SSI data accuracy and individuals who are eligible for SSI but did not receive SSI payment are duplicates of Issue 2, which was transferred to Group Case No. 19-2456GC, "BS&W Health CY 2016 DSH SSI Percentage CIRP Group" and should be dismissed.

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[12] Provider's Preliminary Position Paper at 8-9 (Oct. 2, 2019).

With respect to the portion of Issue 1 related to SSI data accuracy, the Provider states:

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.

With respect to the portion of Issue 1 related to individuals who are eligible for SSI but did not receive SSI payment, the Provider states:

> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.

This component of Issue 1 is repeated by the Provider, word-for-word, within Issue 2. The Provider describes in Issue 2 as follows:

> The Provider contends that the Lead MAC's determination for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. §

> 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The Provider further contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") fail to address all the deficiencies as described in Baystate Medical Center v. Michael O. Leavitt, 545 F. Supp. 2d 20, as amended, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.
>
> …

Within Issue 1 and Issue 2, the Provider is disputing the accuracy of its SSI percentage as well as CMS's policy concerning individuals who are eligible for SSI but did not receive SSI payment.

As previously noted, Issue 2 has been transferred to Group Case No. 19-2456GC. This means that the Provider is appealing an issue from a single final determination in more than one appeal. The Board's Rules are clear on this matter. No duplicate filings. Board Rule 4.6.1, states:

> A provider may not appeal an issue from a single final determination in more than one appeal.

> Consistent with the Board's previous jurisdictional decisions the MAC respectfully requests the Board dismiss the portions of Issue 1 concerning data accuracy and individuals who are eligible for SSI but did not receive SSI payment.[13]

The MAC also argues that the appeal is premature because the Provider has not requested realignment in accordance with 42 C.F.R. § 412.106(b)(3):

> 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 the reimbursement impact.
>
> …
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[14]

Issue 8 – UCC Distribution Pool

The MAC argues that "[t]he 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 previously dismissed PRRB Case Nos. 15-1258GC and 16-1097GC and should therefore also be dismissed.[16]

<u>Provider's Jurisdictional Response</u>

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 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."

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[13] Jurisdictional Challenge at 4-6 (Mar. 2, 2021).
[14] *Id.* at 7.
[15] *Id.* at 10.
[16] *Id*. at 11.
[17] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

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*** two (2) of 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 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. 19-2456GC.

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]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 19-2456GC 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. 19-1378 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 19-2456GC. Because the issue is

[18] Issue Statement at 1.
[19] *Id.*
[20] *Id.*

duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[21], 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] 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, 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. 19-2456GC, 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 this can be done, to explain how that information is relevant, and whether such a review was done for purposes of the year in question, consistent with its obligations under Board Rule 25.2.[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:

> **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, <u>*and*</u> *explain when* the documents will be available.

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[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 BS & W Health providers subject to the CIRP rules or something that is provider specific because, if it was a common systemic issue, it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

> Once the documents become available, promptly forward them to the Board and the opposing party.[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 MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule,

> [b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year.

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh. [25]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[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. 19-2456GC.

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[24] (Italics and underline emphasis added.)
[25] Last accessed July 9, 2024.
[26] Emphasis added.

Accordingly, *based on the record before it*,[27] the Board finds that the SSI Provider Specific issue in Case No. 19-1378 and the group issue from the BS & W Health CIRP group under Case No. 19-2456GC 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 . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board dismisses this aspect of the appeal.

B. 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).[28]

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[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.

[28] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.

(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*"),[29] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[30] 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."[31] 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.[32]

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.[33]

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*").[34] 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

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[29] 830 F.3d 515 (D.C. Cir. 2016).
[30] 89 F. Supp. 3d 121 (D.D.C. 2015).
[31] 830 F.3d 515, 517.
[32] *Id.* at 519.
[33] *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*").
[34] 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."[35] 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.[36]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[37] 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.[38] 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.[39] 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.[40] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[41]

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

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[35] *Id.* at 506.
[36] *Id.* at 507.
[37] 514 F. Supp.3d 249 (D.D.C. 2021).
[38] *Id.* at 255-56.
[39] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[40] *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.
[41] *Id.*

another was also a challenge to a "period selected by the Secretary," which is also barred from review.[42]

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."[43] 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.[44] For review to be available in these circumstances, the following criteria must 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.[45]

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.[46] 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*").[47] 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.[48] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the provider's 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

[42] *Id.* at 262-64.
[43] *Id.* at 265.
[44] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[45] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[46] *Id.* at 264-65 (quoting *DCH v. Azar*, 925 F.3d at 509).
[47] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[48] *Id*. at *127.

"categorical distinction between inputs and outputs."[49] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[50] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[51]

The Board concludes that the same findings are applicable to the Provider's challenge to their FFY 2016 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 2016. 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 dismisses two (2) of the three (3) remaining issues in this case – (Issues 1 and 8). Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members Participating:

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

For the Board:

7/9/2024

X Kevin D. Smith, CPA

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

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

[49] *Id.* at *134.
[50] 139 S. Ct. 1804 (2019).
[51] *Ascension* at *132 (bold italics emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Cecile Huggins
Palmetto GBA
P.O. Box 100307 Internal Mail Code 380
Camden, SC 29202-3307

RE: ***Board Decision* – SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**
Crestwood Medical Center (Provider Number 01-0131)
FYE: 06/30/2019
Case Number: 23-1077

Dear Mr. Summar and Ms. Huggins,

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

Background:

A. ***Procedural History for Case No. 23-1077***

On **September 23, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2019.

On **March 6, 2023**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

Issue 1: Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage- Provider Specific
Issue 2: DSH- SSI Unduly Narrow Definition of SSI entitlement[1]
Issue 3: DSH Medicaid Eligible Days
Issue 4: Medicare Managed Care Part C Days- SSI and Medicaid Fractions[2]
Issue 5: Dual Eligible Days- SSI and Medicaid Fractions[3]

As the Provider is owned by Community Health Systems, Inc. (hereinafter "Community Health") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the

[1] On October 11, 2023, the Provider transferred the issue to PRRB Case No. 22-1031GC.
[2] On October 11, 2023, the Provider transferred the issue to PRRB Case No. 23-0078GC.
[3] On December 14, 2014, the Provider transferred the bifurcated Medicaid Fraction Dual Eligible Days issue to PRRB Case No. 23-0079GC and the bifurcated SSI Fraction Dual Eligible Days issue to PRRB Case No. 22-1006GC.

Provider transferred Issues 2, 4, and 5 to Community Health groups. The remaining issues in this appeal are Issues 1 and 3.

On **October 30, 2023**, the Provider timely filed its preliminary position paper.

On **January 30, 2024**, the Medicare Contractor timely filed its preliminary position paper.

On **March 13, 2024**, the Medicare Contractor filed a Jurisdictional Challenge, requesting the dismissal of Issues 1 and 3. To date the Provider has not responded.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 22-1031GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[4]

The group issue statement in Case No. 22-1031GC, CHS CY 2019 DSH SSI Percentage CIRP Group, to which the Provider transferred Issue 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?

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[4] Issue Statement at 1 (March 6, 2023).

> **<u>Statement of the Legal Basis</u>**
>
> 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]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $67,648.

On October 30, 2023, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Issue #1: Provider Specific**
>
> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> 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

[5] Group Issue Statement, Case No. 22-1031GC.

> 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).[6]

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:

> **<u>Statement of Issue</u>**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **<u>Statement of the Legal Basis</u>**
>
> 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.[7]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper filed seven months later that pursuant to the Jewish Hospital case[8] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid

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[6] Provider's Preliminary Position Paper at 8-9 (Oct 30, 2023).
[7] Appeal Request at Issue 3.
[8] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).

percentage" of the DSH payment adjustment.[9] The Provider then, for the first time in this appeal, states it is seeking reimbursement for section 1115 waiver days as a part of the Medicaid eligible day issue. Specifically, the Provider states:

> [M]edicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).[10]

The Provider also states, in the Preliminary Position Paper, that a listing of the additional Medicaid Eligible days will be submitted directly, under separate cover, to the MAC.

<u>MAC's Contentions</u>

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

The MAC argues that the Board lacks jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue. First, the MAC argues that the Provider has abandoned the SSI realignment sub-issue: "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."[11] 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. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the

[9] Provider's Preliminary Position Paper at 9.
[10] *Id.* at 9-10.
[11] Jurisdictional Challenge at 6 (Mar. 13, 2024).

> Board dismiss this issue consistent with recent jurisdictional decisions.[12]

In addition, the MAC argues the DSH Payment/SSI Percentage (Provider Specific) issue and the DSH/SSI Unduly Narrow Definition of SSI Entitlement issue, which has been transferred to PRRB Case No. 22-1031GC, are considered the same issue by the Board, is in violation of PRRB Rule 4.6, and should be dismissed.[13]

Lastly, Issue 1 should be dismissed because the Provider failed to file a complete position paper 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.[14]

Issue 2 – DSH Payment – Medicaid Eligible Days

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

a. That the Provider has "failed to sufficiently develop and set for the relevant facts and arguments regarding the merits of its claim in its preliminary position paper."
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 state the efforts made to obtain documents that are missing and/or remain unavailable) is in violation of PRRB Rule 25.2.2.
d. That the Provider has effectively abandoned its claim for additional Medicaid Eligible Days.
e. The Provider's attempt to add the issue of Section 1115 waiver days via its preliminary position paper was improper and untimely.
f. That the Provider's claim for additional Medicaid Eligible Days should therefore be dismissed by the Board.[15]

Accordingly, the Medicare Contractor requests that the Board dismiss Issue 3.

<u>Provider's Response</u>

The Board Rules require that Provider Responses to the MAC's Jurisdictional/Motion Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[16] The Provider

[12] *Id*. at 6-7.
[13] *Id*. at 4-6.
[14] *Id*. at 7-10.
[15] *Id.* at 10-13.
[16] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

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. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

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

A. DSH Payment/SSI Percentage (Provider Specific)

The jurisdictional analysis for Issue 1 has several relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period; and 3) the Provider incorporating the arguments from *Advocate Christ*[17] into its appeal. As set forth below, the Board dismisses all aspects of Issue 1.

1. First and Third Aspects of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Unduly Narrow Definition of SSI Entitlement issue that was appealed in PRRB Case No. 22-1031GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[18] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[19] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[20]

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[17] The Provider has included the Appellants' Reply Brief in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214 (D.C. Cir.), which is on appeal from the decision in *Advocate Christ Med. Ctr. V. Azar*, 17-cv-1519 (TSC), 2022 WL 2064830, (D.D.C. June 8, 2022).
[18] Issue Statement at 1.
[19] *Id.*
[20] *Id.*

The Provider's DSH/SSI Unduly Narrow Definition of SSI Entitlement issue in group Case No. 22-1031GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Unduly Narrow Definition of SSI Entitlement issue in Case No. 22-1031GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6,[21] the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations, and to that end, the Provider is pursuing that issue as part of the group under Case No. 22-1031GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). 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] 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 can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 22-1031GC.

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. 22-1031GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

[21] PRRB Rules v. 3.1 (Nov. 2021).

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

25.2.2 Unavailable and Omitted Documents

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[23]

The Board further notes that 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") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh. [24]

[23] (Emphasis added).
[24] Last accessed July 10, 2024.

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[25]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 22-1031GC.

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 22-1031GC are the same issue.[26] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

Additionally, in its Preliminary Position Paper, the Provider stated, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3)."[27] The Board finds that this purported argument does not comply with the regulations and Board rules to *fully* develop the Provider's position in the Preliminary Position Paper, because the Provider merely lists a case name and does not explain further what the arguments are that it would like to incorporate into its appeal or how they apply to its specific situation.

42 C.F.R. § 405.1853 addresses position papers and specifies in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[28]

Therefore, the Board finds that the Provider did not comply with the Preliminary Position Paper regulations and Board rules with respect to the purported *Advocate Christ* argument, and dismisses that portion of the issue.

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[25] Emphasis added.
[26] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Community Health CIRP group per 42 C.F.R. § 405.1837(b)(1).
[27] Provider's Preliminary Position Paper at 8-9.
[28] (Emphasis added).

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.

The Board finds that, under 42 C.F.R. § 412.106(b)(3), 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 . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

1. *Section 1115 Waiver Days*

The Board finds that the § 1115 Waiver Days issue is *not* properly part of this appeal because it was not properly included in the original appeal request and it was not properly or timely added to the appeal. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the § 1115 Waiver Days as recognized by multiple Board, Administrator and Court decisions[29] (many of which were issued prior to the Provider's June 4, 2018 deadline for adding issues to this appeal).[30]

The appeal was filed with the Board in April of 2018 and 42 C.F.R. § 405.1835(b) (Jan. 2016) gives the following "contents" requirements for an initial appeal request for a Board hearing:

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

[29] *See, e.g.*, *QRS 1993-2007 DSH/Iowa Indigent Patient /Charity Care (GA) Group v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Jan. 15, 2013), *affirming* PRRB Dec. No. 2013-D02 (Nov. 21, 2012)*; St. Dominic-Jackson Mem'l Hosp. v. Sebelius*, No. 3:12-cv-832, 2014 WL 8515280 (S.D. Miss. 2014); *Singing River Health Sys. v. Novitas Solutions, Inc.*, PRRB Dec. 2016-D19 (Sept. 20, 2016), *rev'd* CMS Adm'r Dec. (Nov. 18, 2016); *CCT&B 2005-2006 Hurricane Katrina § 1115 Waiver UCP Days Grp. v. Novitas Solutions, Inc*., PRRB Dec. 2016-D18 (Sep. 16, 2016), *rev'd* CMS Adm'r Dec. (Nov. 18, 2016), *aff'd sub nom. Forrest Gen. Hosp. v. Hargan*, No. 2:17-CV-8, 2018 WL 11434575 (S.D. Miss. Feb. 22, 2018), *rev'd & remanded Forrest Gen. Hosp. v. Azar*, 926 F.3d 221 (5th Cir. 2019); *Southwest Consulting UMass Mem'l Health Care & Steward Health 2009 DSH CCHIP Section 1115 Waiver Days Grps. v. Nat'l Gov't Servs., Inc*., PRRB Dec. 2017-D04 (Jan. 27, 2017), *rev'd* CMS Adm'r Dec. (Mar. 21, 2017), *vacated & remanded sub nom. HealthAlliance Hosps., Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. Oct. 26, 2018); *Florida Section 1115 LIP Rehab DSH Waiver Days Grps. v. First Coast Serv. Options*, PRRB Decs. 2018-D21, 2018-D22 (Feb. 8, 2018), *vacated by* Adm'r Dec. (Mar. 30, 2018), *rev'd by Bethesda Health Inc. v. Azar*, 389 F. Supp. 3d 32 (DDC 2019), *aff'd by* 980 F.3d 121 (D.C. Cir. 2020).

[30] Here, the NPR at issue was issued on October 2, 2017 and the Provider had until Thursday, April 5, 2018 to file the appeal (where receipt is presumed to be 5 days later and the Provider had 180 from that date to file an appeal request). Accordingly, the deadline to add issues is 60 days beyond that date, *i.e.*, Tuesday, June 4, 2018.

> paragraphs (b)(1) through (b)(4) of this section. **If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (b)(2), or (b)(3) of this section, the Board <u>may dismiss</u>** with prejudice the appeal or take any other remedial action it considers appropriate.
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the final contractor or Secretary determination under appeal.
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final contractor or Secretary determination under appeal, including an account of all of the following:
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
>
> (iii) If the provider self-disallows a specific item (as specified in §413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.
>
> (3) A copy of the final contractor or Secretary determination under appeal and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section.[31]

Board Rule 7.1 (Jul 1, 2015) elaborated on these regulatory "contents" requirements instructing providers:

> **Rule 7 – Issue Statement and Claim of Dissatisfaction**
>
> For <u>each</u> issue under appeal, give a brief summary of the determination being appealed and the basis for dissatisfaction. (*See* Rule 8 *for special instructions regarding multi-component disputes*.)

[31] (Italics and bold and underline emphases added).

7.1 NPR or Revised NPR Adjustments

A. Identification of Issue

Give a concise issue statement describing:

- the adjustment, including the adjustment number,
- why the adjustment is incorrect, and
- how the payment should be determined differently.

B. No Access to Data

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

7.2 – Self-Disallowed Items

A. Authority Requires Disallowance

If the Provider claims that the item being appealed was not claimed on the cost report because a regulation, manual, ruling, or some other legal authority predetermined that the item would not be allowed, the following information must be submitted:

- a concise issue statement describing the self-disallowed item
- the reimbursement or payment sought for the item, and
- the authority that predetermined that the claim would be disallowed. [*March 2013*]

B. 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.

C. Protest

Effective for cost reporting periods ending on or after December 31, 2008, items not being claimed under subsection A above must be adjusted through the protested cost report process. The Provider must follow the applicable procedures for filing a cost report under

> protest as contained in CMS Pub. 15-2, Section 115. *See* 42 C.F.R. § 405.1835(a)(1)(ii). [*March 2013*][32]

As explained above in Board Rule 7, Board Rule 8 (Jul. 1, 2015) provides "*special instructions*" for issue statements *involving* ***multi-component disputes***. In particular, 8.1 explains that, when framing issues for adjustments *involving multiple components*, that providers must "***specifically*** identify" each cost item in dispute, and "…each contested component must be appealed as a *separate* issue and described as ***narrowly as possible***…".[33] Board Rule 8. 2 (Jul. 1, 2015) gives common *examples* of different components of the Disproportionate Share Hospital payment calculation that may be in dispute. Specifically, Board Rule 8 states:

> **Rule 8 – Framing Issues for Adjustments Involving Multiple Components**
>
> **8.1 – General**
>
> Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7. See common examples below.
>
> **8.2 – Disproportionate Share Cases** (e.g., dual eligible, general assistance, charity care, HMO days, etc.)
>
> **8.3 – Bad Debts Cases** (e.g., crossover, use of collection agency, 120-day presumption, indigence determination, etc.)
>
> **8.4 – Graduate Medical Education/Indirect Medical Education** (e.g., managed care days, resident count, outside entity rotations, etc.)
>
> **8.5 – Wage Index** (e.g., wage vs. wage-related, rural floor, data corrections, etc.) [34]

Pursuant to the May 23, 2008 final rule, new Board regulations went into effect on August 21, 2008 *that limited the* ***addition*** *of issues to appeals*.[35] As a result of this final rule, 42 C.F.R. § 405.1835(e) (Sept. 2015) 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

[32] (Italics emphasis in initial paragraph for Rule 7 added.)
[33] (Emphasis added.)
[34] Board Rules are available https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-rules-and-board-orders (last visited April 30, 2024).
[35] *See* 73 Fed. Reg. 30190 (May 23, 2008).

> the original hearing request by submitting a written request to the Board, only if –
>
> ****
>
> 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 establish that the Provider timely and properly added the § 1115 Waiver Days to the case. In this regard, the first discussion of § 1115 waiver days in this case occurred in the Provider's October 30, 2023 preliminary position paper, well after the deadline for adding issues had passed.

In this regard, the Board notes that § 1115 Waiver days are *not* traditional Medicaid eligible days. Indeed, it was only effective January 20, 2000 that the Secretary incorporated, ***at her discretion*** *by regulation*, only ***certain*** types of § 1115 waiver days into the DSH calculation (*i.e.,* the Secretary maintains that no statute requires that days associated with § 1115 waiver/expansion programs be included in the DSH calculation and that she exercised her discretion to include only certain such days).[36] Rather, § 1115 waiver days relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to § 1115 waiver days. 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)**

[36] 65 Fed. Reg. 47054, 47087 (Aug. 1, 2000). *See also* 68 Fed. Reg. 45346, 45420 (Aug. 1, 2003) (stating: "On January 20, 2000, we issued an interim final rule with comment period (65 FR 3136), followed by a final rule issued on August 1, 2000 (65 FR 47086 through 47087), to allow hospitals to include the patient days of all populations that receive benefits under a section 1115 demonstration project in calculating the Medicare DSH adjustment. Previously, hospitals were to include only those days for populations under the section 1115 demonstration project who were, or could have been made, eligible under a State plan. Patient days of those expansion waiver groups who could not be made eligible for medical assistance under the State plan were not to be included for determining Medicaid patient days in calculating the Medicare DSH patient percentage. Under the January 20, 2000 interim final rule with comment period (65 FR 3137), hospitals could include in the numerator of the Medicaid fraction those patient days for individuals who receive benefits under a section 1115 expansion waiver demonstration project (effective with discharges occurring on or after January 20, 2000).").

> **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.[37]

*Significantly, **§ 1115 waiver programs can pertain** to not just Medicaid (Title XIX), but also **to other programs under Titles I, X, XIV, XIV or part A or D of Title IV of the Social Security Act***.[38] Hence, an important limitation is that the § 1115 waiver program receive Title XIX matching payments. Moreover, not every state Medicaid program has a qualifying § 1115 expansion program receiving Title XIX matching payments[39] and not every inpatient day associated with a beneficiary enrolled in such a § 1115 waiver program qualifies to be included in the numerator of the DSH Medicaid fraction.[40] In contrast, every state has a Medicaid state

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[37] (Bold emphasis added.)

[38] Section 1115 of the Social Security Act (42 U.S.C. § 1315] pertains to "experimental, pilot, or demonstration project[s] which, in the judgment of the Secretary, is likely to assist in promoting the objectives of ***title I, X, XIV, XVI, or XIX, or part A or D of title IV***, in a State or States." 1115(a) of the Social Security Act (emphasis added). As such, § 1115 waiver programs are not just limited to Title XIX Medicaid programs but may also relate to programs under Titles I, X, XIV, XVI, or part A or D of Title IV.

[39] Further, a specific approved state § 1115 waiver day program is not necessarily static and may vary from one year to the next.

[40] Unlike traditional Medicaid eligible days under a State Plan, the following discussion from the FY 2004 IPPS Final Rule, 68 Fed. Reg.at 45420-21 highlights that not all § 1115 waiver days can be included in the numerator of the Medicaid fraction and that factual determinations must be made regarding any § 1115 waiver day program to determine if 42 C.F.R. § 412.106(b)(4) is applicable to that program:

> Since that revision, we have become aware that there are certain section 1115 demonstration projects that serve expansion populations with benefit packages so limited that the benefits are not similar to the medical assistance available under a Medicaid State plan. These section 1115 demonstration projects extend coverage only for specific services and do not include inpatient care in the hospital. Because of the limited nature of the coverage offered, the population involved may have a significantly higher income than traditional Medicaid beneficiaries.
>
> In allowing hospitals to include patient days related to section 1115 expansion waiver populations, our intention was to include patient days of section 1115 expansion waiver populations who receive benefits under the demonstration project that are similar to those available to traditional Medicaid beneficiaries, including inpatient benefits. Because of the differences between expansion populations in these limited benefit demonstrations and traditional Medicaid beneficiaries, in the May 19, 2003 proposed rule, we proposed that the Medicare DSH calculation should exclude from treatment as Medicaid patient days those

plan; every state Medicaid plan includes inpatient hospital benefits; and by statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), the numerator of the DSH Medicaid fraction must include inpatient days of patients "who . . . were eligible for medical assistance ***under a State plan*** approved under subchapter XIX" but who were not entitled to Medicare Part A.[41]

In this regard, documentation needed to verify eligibility for a § 1115 waiver day is materially different than that for a traditional Medicaid eligible day[42] and, similarly, it is not a given that *all* § 1115 waiver days (even those under a program receiving Title XIX matching payments) necessarily would qualify under § 412.106(b)(4) as demonstrated by Board decisions and case law.[43] Here, 42 C.F.R. § 405.1835(b) and Board Rules 7 and 8 required each separate issue to be identified in the appeal request. Here, the Provider failed to do so, notwithstanding including a ***detailed*** description of "The Process That The Provider Used To Identify And Accumulate The Actual Medicaid Paid And Unpaid Days That Were Reported And Filed On The Medicare Cost Report At Issue" to support its assertion that the Medicaid eligible days at issue in the appeal were ones that could not have been identified through that process.[44]

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patient days attributable to limited benefit section 1115 expansion waiver populations (proposed § 412.106(b)(4)(i)).

For example, a State may extend a family planning benefit to an individual for 2 years after she has received the 60- day postpartum benefit under Medicaid, or a State may choose to provide a family planning benefit to all individuals below a certain income level, regardless of having previously received the Medicaid postpartum benefit. This is a limited, temporary benefit that is generally administered in a clinic setting (see section 1905(a)(4)(C) of the Act). Also, a number of States are developing demonstrations that are limited to providing beneficiaries an outpatient prescription drug benefit. Generally, these limited benefits under a demonstration project do not include inpatient benefits. If a hospital were to include the days attributable to patients receiving benefits under such a limited benefit, the hospital would be able to receive higher DSH payments, perhaps substantially, for patients who may otherwise be insured for inpatient care. For example, these limited demonstrations provide benefits that may be needed to supplement private insurance coverage for individuals who do not have incomes low enough to qualify for Medicaid under the State plan. We do not believe such patients should be counted in the DSH patient percentage as eligible for title XIX.

****

Therefore, we proposed to revise § 412.106(b)(4)(i) to clarify that patients must be eligible for medical assistance inpatient hospital benefits under an approved State Medicaid plan (or similar benefits, including inpatient hospital benefits, under a section 1115 demonstration project) in order for their hospital inpatient days to be counted as Medicaid days in the calculation of a hospital's DSH patient percentage. Under the proposed clarification, hospital inpatient days attributed to patients who do not receive coverage for inpatient hospital benefits either under the approved State plan or through a section 1115 demonstration would not be counted in the calculation of Medicaid days for purposes of determining a hospital's DSH patient percentage.

Under this reading, in the examples given above, the days associated with a hospital inpatient who receives coverage of prescription drugs or family planning services on an outpatient basis, but no inpatient hospital coverage, through either a Medicaid State plan or a section 1115 demonstration, would not be counted as Medicaid days for purposes of determining the DSH patient percentage.

[41] (Emphasis added.)

[42] In addition to providing proof that the patient at issue was eligible for the § 1115 waiver program for each day claimed, the Provider must also establish that the particular § 1115 waiver program at issue relates to Title XIX and qualified under 42 C.F.R. § 412.106(b)(4) as demonstrated by the preamble discussion in *supra* note 40 and litigation in *infra* note 48.

[43] *See* litigation in *infra* note 48.

[44] The Board recognizes that the appeal request states that "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

Regardless of whether the Provider *properly* included the § 1115 waiver days issue in its appeal request (which it did not), the Provider failed to properly develop the merits of § 1115 waiver day issue in its preliminary position papers. Specifically, the Provider's preliminary position paper does not mention, much less identify, the **specific state** § 1115 waiver program(s) at issue[45] or how any days under such program(s) would qualify under 42 C.F.R. § 412.106(b) to be included in the numerator of the DSH Medicaid fraction, notwithstanding its obligation to do so, consistent with the position paper content requirements at 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules 25 and 27.[46] This is an independent basis for dismissal of the § 1115 waiver day issue. Specifically, the material facts and legal arguments needed to establish the merits of the Provider's claims regarding the § 1115 waiver days issue along with the relevant supporting documentation were not properly briefed and included in the position paper filing.

Finally, even if the Board were to find that Issue 3 encompassed § 1115 waiver days, there is no indication that any § 1115 waiver days were included with the as-filed cost report and, if they were not, that would make them an *unclaimed* cost and provide an independent basis for dismissal (*see* Board Alert 10). In raising this issue, the Board notes that it has found that when a class of days (*e.g.*, § 1115 waiver days) is excluded due to choice, error, and/or inadvertence from the as-filed cost report,[47] then that class of days is an unclaimed cost for which the Board would lack jurisdiction under 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835(a)(1)(i)-(ii) (2012) as clarified by CMS Ruling 1727-R.[48] The Provider's briefings generally address this jurisdictional issue by generically asserting that its process did not identify certain Medicaid eligible days. However, this discussion did not identify or discuss the class of days involving § 1115 waiver days and whether

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adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation." However, the "including but not limited to" phrase only pertained to traditional Medicaid eligible days and reasons why they may not have been included in the fraction. It did not expand to include other classes of days such as general assistance, State-only days or § 1115 waiver days. A generic catchall phrase cannot be used to essentially shoehorn in the later addition of an issue on an ***untimely*** basis in contravention of Board Rules and regulations. Indeed, preliminary position paper did not include any description (much less identification of) § 1115 waiver days as being an issue, notwithstanding the obligation to do so under the requirements for the content of position papers at 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules 25 and 27.

[45] In failing to identify the specific state § waiver program(s) at issue, the Provider fails to address whether such § 1115 waiver program(s) are under Titles I, X, XIV, XVI, XIX, or IV and whether such § 1115 waiver program(s) received Title XIX matching funds and would otherwise qualify under 42 C.F.R. § 412.106(b) to be counted in the numerator of the DSH Medicaid fraction.

[46] 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25 (Aug. 2018) require a fully-developed preliminary position paper that includes the legal merits and material facts of the Provider's position as well as all available supporting documents as required in Board Rule 25.2 (Aug. 2018).

[47] CMS Transmittal 11912 (Mar. 16, 2023) makes clear that hospitals must maintain records on § 1115 waiver days:

> Each provider with an approved [§] 1115 waiver program ***has a method for identifying the days*** that are applicable to such waiver for reimbursement from the Medicaid program. As such, ***the provider is responsible for maintaining the appropriate supporting documentation*** *for the accrual of the days associated with [§] 1115 waiver reimbursements*. Providers *typically keep this information in the form of a listing* of specific patient accounts for each individual acute hospital stay ([§] 1115 log) that is subject to [§] 1115 reimbursement. This [§] 1115 log is similar to a provider's DSH Medicaid eligible days listing. (Emphasis added.)

[48] *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 06-1852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days 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* decisions under PRRB Dec. Nos. 2012-D14 and 2014-D03 is not applicable (available at: https://www.cms.gov/regulations-and-guidance/review-boards/prrbreview/downloads/jd-2017-11.pdf (last accessed July 3, 2024)).

that class of days were included on the cost report. In this regard, if the Provider purposefully excluded § 1115 waiver days from the as-filed cost report, then CMS Ruling 1727-R confirms that the Provider only had a right to appeal those days if it "***had a good faith belief*** *that claiming reimbursement for [the § 1115 waiver days at issue] in the cost report would be futile because [the § 1115 waiver days at issue] was subject to a regulation or other payment policy* ***that bound the Medicare contractor and left the contractor with no authority or discretion to make payment in the manner sought by the provider***."[49] Here, the Provider has failed to specifically address or discuss the Board's jurisdiction over this unique class of days. This is an independent basis which leads the Board to dismiss the § 1115 waiver days issue (*i.e.*, in addition to and independent from dismissal for failure to properly include the issue in its appeal request or properly brief and develop the issue).

In summary, as the DSH Medicaid Eligible Days issue as stated in the original appeal request did not include the § 1115 waiver days and that specific issue was not timely added to the appeal, the Board dismisses it from this appeal. Because the Provider did not raise the § 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. Indeed, even if the Provider had properly included the issue as part of its appeal request, there are multiple independent bases upon which the Board would dismiss the issue, namely the failure to establish the Board's jurisdiction over the issue (added late) and the failure to properly develop the merits of the issue in its position paper filings.

2. *Medicaid Eligible Days*

According to its Appeal Request, as quoted above, the Provider asserts that all Medicaid Eligible Days were not included in the calculations of the DSH calculation.

However, the Provider failed to include a list of the additional Medicaid eligible days they expected to be included in their Medicaid percentage and DSH computations with their appeal request.

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[50]

Board Rule 7.3.1.2 states:

> **No Access to Data**
>
> If the provider elects not to 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.

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[49] CMS Ruling 1727-R (emphasis added).
[50] Provider's Preliminary Position Paper at 10.

In this case, 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.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[51]

42 C.F.R. § 405.1853 addresses position papers and specifies in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[52]

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

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

Similarly, with regard to position papers,[53] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[54] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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[51] *See also* Board's 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.
[52] (Emphasis added).
[53] The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[54] (Emphasis added).

Similarly, 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.[55]

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.

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 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.

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[55] (Emphasis added).

The Board finds that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled, consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, 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"[56] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. Indeed, without any days identified in the position paper filing, the Board assumes that there are no days or amount in dispute for this issue.

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 Board Rules 25.2.1 and 25.2.2 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.[57] Accordingly, the DSH Payment – Medicaid Eligible Days issue is dismissed in its entirety.

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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. 22-1031GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the late added 1115 waiver day issue which the Provider attempted to add in its preliminary position paper, long after the deadline to add issues had passed. The Board also dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue, 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. 23-1077 and removes it from the Board's docket.

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

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[56] (Emphasis added).
[57] Board Rule 25, of which 25.2 (A) and 25.2 (B) are a part, is applicable to final position papers via Board Rule 27.2.

<u>Board Members Participating</u>:

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

For the Board:

7/10/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., 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

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

RE: ***Notice of Dismissal***
Merit Health River Region (Provider Number 25-0031)
FYE: 06/30/2016
Case Number: 19-0673

Dear Mr. Summar:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-0673. 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 Uncompensated Care ("UCC") payments.

Background

A. *Procedural History for Case No. 19-0673*

On **June 12, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2016. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **December 6, 2018**, 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[2]
4. Uncompensated Care ("UCC") Distribution Pool
5. 2 Midnight Census IPPS Payment Reduction[3]

[1] On July 17, 2019, this issue was transferred to Case No. 19-1409GC.
[2] On June 10, 2024, the Provider withdrew Issue 3 from the appeal.
[3] On July 17, 2019, this issue was transferred to Case No. 19-1410GC.

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **July 17, 2019**, the Provider transferred Issues 2 and 5 to CHS CIRP groups. On **June 10, 2024,** the Provider withdrew Issue 3, Medicaid Eligible Days, from the appeal.

As a result of the case transfers and withdrawal, there are two (2) remaining issues in this appeal: Issue 1 (the DSH – SSI Percentage Provider Specific), and Issue 4 (UCC Distribution Pool).

On **January 15, 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 **July 31, 2019**, the Provider timely filed its preliminary position paper.

On **August 19, 2019**, the Medicare Contractor timely filed a Jurisdictional Challenge[5] 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. On **September 16, 2019**, the Provider timely filed a response to the Medicare Contractor's Jurisdictional Challenge.

On **November 29, 2019**, the Medicare Contractor filed its preliminary position paper.

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[4] (Emphasis added.)

[5] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timeliness 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).

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 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 [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. 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?

[6] Provider's Initial Appeal Request (Dec. 6, 2018).

> **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 31, 2019, the Board received the Provider's preliminary position paper in 19-0673. 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 (June 30).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services,* No. CV-94-0055 (C.D. Cal June 2, 1995), the SSI entitlement of individuals can be ascertained from [s]tate records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the

[7] Group Appeal Issue Statement in Case No. 19-1409GC.

> 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 $40,000.

<u>MAC's Contentions</u>

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

The MAC argues that the Board should dismiss the DSH – SSI Percentage (Provider Specific) issue for two reasons. First, the MAC argues that the appeal is duplicative:

> The MAC contends that Issue 1 has 3 sub-issues. Sub-issues 1 (SSI data accuracy) and sub-issue 3(individuals who are eligible for SSI but did not receive SSI payment) are duplicates of Issue 2 and should be dismissed. In sub-issue[s] 1 and 3, the Provider states:
>
> 1. 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 [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.
>
> 3. The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the

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[8] Provider's Preliminary Position Paper at 8-9 (Jul. 31, 2019).

> statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.

The MAC contends that the Provider makes the same arguments in Issue 2. The Provider states in Issue 2:

> The Provider contends that the Lead 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). The Provider contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.

…

The Provider further argues in Issue 2:

> > The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> Rule 4.6 of the August 29, 2018 Rules states:
>
> > A Provider may not appeal an issue from a single final determination in more than one appeal.
>
> The MAC contends that the SSI data accuracy portion and the individuals that were eligible for SSI but did not receive payment portions of Issue 1 should be dismissed in accordance with this rule. Both portions are a duplicate of Issue 2, which has been transferred to PRRB case number 19-1409GC.[9]

The MAC also argues that the appeal is premature because the Provider has not requested realignment in accordance with 42 C.F.R. § 412.106(b)(3):

> Issue 1 includes the Provider's subsidiary appeal over SSI realignment. In its appeal request, the Provider states:
>
> > The Provider is seeking 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).
>
> SSI realignment is still active in this appeal. Within its preliminary position paper, the Provider states:

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[9] Jurisdictional Challenge at 3-5 (Aug. 19, 2019).

> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (June 30). (Emphasis Added)[.]

The decision to realign a hospital's SSI percentage with its fiscal year end is a Provider election. It is not a final MAC determination. A Provider must make a formal request to the MAC and 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 the reimbursement impact.

The regulations at 42 C.F.R. § 405.1835 set forth the criteria for a Provider's right to a [Board] hearing:

> A provider . . . has a right to a Board hearing, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination (emphasis added)[.]

* * *

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 PRRB dismiss this issue consistent with recent jurisdictional decisions.[10]

Issue 4 – UCC Distribution Pool

The MAC argues that "[t]he 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)."[11] The MAC also contends that this issue is a duplicate of PRRB Case No. 15-1134GC and should therefore be dismissed.[12]

[10] *Id.* at 5-6.
[11] *Id.* at 7.
[12] *Id*. at 8.

Provider's Jurisdictional Response

The Provider timely filed a jurisdictional response on September 16, 2019, and asserted the following arguments:

Duplicate SSI Issues:

The MAC argues issue 1 & 2 – SSI Provider Specific/Realignment are duplicate issues to issue 3 – SSI Systemic issue that the Provider transferred to group appeal 19-1409GC. Provider contends each of the appealed SSI issues are separate and distinct issues, and that the Board should find jurisdiction over PRRB Case Number 19-0673.

Board Rule 8.1 states "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…" Appeal issues # 1 and 2 represent different components of the SSI issue, which was specifically adjusted during the audit. Since these specific appeal issues represent different aspects/components of the SSI issue, Provider contends the Board should find jurisdiction over both the SSI Systemic and SSI Provider Specific/Realignment issues.

Discussion

SSI Systemic Issue:

The SSI Systemic issue addresses the various errors discussed in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) in CMS' calculation of the disproportionate payment percentage, which result in the MedPAR not reflecting all individuals who are eligible for SSI, including such errors as: not accounting for retroactive SSI eligibility determinations by the Social Security Administration (SSA); omitting days of individuals who were eligible for SSI at the time of their stay due to their records being considered inactive by SSA due to their death following their stay; omitting SSI eligibility records of individuals who received a forced or manual payment on a temporary basis in lieu of the automated payments that are typically used for SSI payments, and the exclusion of days from the numerator of the Medicare Fraction belonging to patients who are not eligible to receive SSI payments at the time of their stay, but who have a special status under Section 1619(b) of the Social Security Act, 42

U.S.C. § 1382h(b), which enables them to receive Medicaid assistance based on a past entitlement to SSI payments. These systemic errors are the results of CMS's improper policies and data matching process. The SSI Systemic Issue also covers CMS Ruling 1498-R.

SSI Provider Specific Issue:

FSS, on behalf of the Medicare Administrative Contractor ("MAC") Novitas Solutions, Inc., challenges the Board's jurisdiction, stating that the Provider does not have a right to a hearing before the Board on the DSH/SSI realignment issue because it is duplicative of the SSI Systemic issue. However, Provider contends that FSS is incorrect. Provider is not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category. In Baystate, the Board also considered whether, independent of these systemic errors, whether Baystate's SSI fractions were understated due to the number of days included in the SSI ratio. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008). The Provider has analyzed Medicare Part A records and has been able to identify patients believed to be entitled to both Medicare Part A and SSI. The Provider has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio. Therefore, the Board should find jurisdiction over the SSI provider specific issue in the instant appeal.

Accordingly, this is an appealable item because the MAC specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2016, resulting from its understated SSI percentage due to errors of omission and commission.

The Provider is entitled to appeal an item with which it is dissatisfied. Further, the Centers for Medicare & Medicaid Services ("CMS") in *Northeast Hospital Corporation v. Sebelius*, 657 F.3d 1 (D.C. Cir. 2011) specifically abandoned the CMS Administrator's December 1, 2008 decision that the SSI ratio cannot be revised based upon updated data after it has been calculated by CMS. Accordingly, the Provider has specifically identified patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS, due to errors that are or may be specific to the Provider, but in any case, are not the systemic errors that have been

> previously identified in the *Baystate* litigation. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008). Once these patients are identified, the Provider contends that it will be entitled to a correction of these errors of omission to its SSI percentage. The DSH/SSI percentage was adjusted on the Provider's cost report. Accordingly, Provider requests that the Board find that it has jurisdiction over the DSH/SSI provider specific issue.
>
> **Uncompensated Care ("UCC") Distribution Pool Duplicate Issues:**
>
> The MAC states that it "appears" Providers are violating PRRB Rule 4.6.2 which states "appeals of the same issue from distinct determinations must be pursued in a single appeal". Providers have appealed from the Federal Register dated August 22, 2014, August 17, 2015 and from the NPR. In this instance, Provider's appeals in PRRB CN 15-1134GC, CN 16-0769GC and 19-0673 are from separate and distinct determinations, and appeal rights associated with Federal Register Publications vary from those of appeal rights based upon NPRs. Therefore, Provider contends there is no conflict with PRRB Rule 4.6.2, and Providers wish to preserve their appeal rights for both types of appeals.[13]

The Providers argue that the Secretary is not authorized to estimate the uninsured patient population percentage. Specifically, the Provider states:

> The MAC argues that the Secretary's "*estimates*" are shielded from judicial review. However, this ignores the central point that the Secretary is not authorized to "*estimate*" the uninsured patient percentage.
>
> The DSH statute does not use the word "*estimate*" in connection with the computation of the second prong of Factor 2, i.e., the FY 2014-2017 nationwide uninsured patient percentage. 42 U.S.C. § 1395ww(r)(2)(B)(i)(II). The omission of the term "*estimate*" from the second prong of Factor 2 was evidently deliberate, given that the word was employed elsewhere in numerous instances in the same section of the statute. *See Georgetown University Hosp. v. Bowen*, 862 F.2d. 323, 327 (D.C. Cir. 1988). *"Indeed, the Secretary acknowledged that elsewhere in the same section of the statute Congress expressly indicated when the Secretary's estimates would constitute key components of the PPS rates….. In these passages*

[13] Provider's Jurisdictional Challenge Response at 1-3 (Sept. 16, 2019).

> *and others, Congress showed that it knew how to enshrine estimates into the rate calculations when it so desired."*
>
> Notwithstanding CMS position to the contrary, the Secretary should be required to reconcile her initial estimate of the uninsured patient percentage with actual data when it becomes available after the close of the year. Only "*estimates*" are subject to the ban on administrative or judicial review. 42 U.S.C. § 1395ww(r)(3). Therefore, the PRRB has jurisdiction over provider challenges to the uninsured patient percentage computed by the Secretary on the basis that such computation is not supposed to be an "*estimate.*"[14]

The Provider also argues that the Board is not barred from administrative review of the Secretary's estimates. Providers contend:

> The provisions of 42 U.S.C. § 1395ww(r)(3) bar administrative or judicial review over certain "*estimates*" used by the Secretary. This suggests that Congress intended that administrative review and judicial review should be treated similarly. Thus, administrative review should be available if judicial review is also available.
>
> For the following reasons, judicial review of the Secretary's estimates is available. Accordingly, administrative review by the Board is also available. Moreover, even if such review by the Board is precluded, the providers desire to channel their claims to this tribunal prior to proceeding to the federal courts.
>
> …
>
> … [A]n agency that acts outside of the scope of its lawful authority or in an ultra vires manner may not be shielded from judicial review, notwithstanding the existence of a statutory ban on judicial review. For example, an agency's promulgation of a regulation without undertaking the required notice and comment procedures may be grounds for circumventing the preclusion of judicial review on the basis that the agency acted outside of the scope of its authority in issuing the regulation. In such a case, a provider may well be entitled to a writ of mandamus directing the agency to comply with notice and comment procedures, or to injunctive relief prohibiting the application of regulations which are issued by the agency outside of the scope of its lawful authority.
>
> …

[14] *Id.* at 3.

> The present case before the PRRB involves a challenge not only to the amount of an estimate used by the Secretary in computing Factors 1-3, but also to the regulations or instructions relied upon by the Secretary in computing those estimates. Specifically, the providers are challenging the annual IPPS rule which incorporate the defective estimates used by the Secretary. As such, the statutory preclusion clause contained in 42 U.S.C. § 1395ww(r)(3) does not bar administrative or judicial review.[15]

Providers further contend that if they are denied the mandamus relief, serious constitutional issues will arise, and state the following arguments:

> As noted in *Michigan Academy* and *Ill. Council on Long Term Care,* a total preclusion of judicial review of the estimates used in computing Factors 1-3 could give rise to serious constitutional issues. There is little doubt that serious due process concerns would arise if the federal government attempts to preclude all possible administrative and judicial remedies, especially if the Secretary were to commit blatant or otherwise clear errors in computing the estimates in DSH Factors 1-3.
>
> We also note that there is little legal authority supporting the right of Congress to ban judicial review of constitutional challenges. Indeed, it is beyond the power of the Congress to preclude such challenges because any requirements mandated by the U.S. Constitution supersede any statutory provisions in violation thereof. See e.g. Sokolov v. Gonzales, 442 F.3d 566, 569 (7th Cir. 2006); Brumley v. United States Dep't of Labor, 28 F.3d 746, 747 (8th Cir. 1994).
>
> In conclusion, review by this Board of the uninsured patient percentage is not barred by 42 U.S.C. § 1395ww(r)(3), because such percentages may not be computed on estimates. Moreover, the provisions of 42 U.S.C. § 1395ww(r)(3) reflect intent by Congress to put administrative review on the same footing as judicial review. The ban on judicial review does not apply in connection with mandamus type claims, challenges to regulations, and constitutional challenges. Accordingly, this Board also has jurisdiction over this appeal.[16]

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[15] *Id.* at 5-6.
[16] *Id.* at 6-7.

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 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 and Third Aspects of Issue 1*

The first and third aspects of Issue No. 1—the Provider's disagreements with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—are duplicative of the DSH – SSI Percentage (Systemic Errors) 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."[17] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[18] The Provider argues in its issue statement, which was included in the original appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[19]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 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. 19-0673 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 19-1409GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by

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[17] Issue Statement at 1.
[18] *Id.*
[19] *Id.*

PRRB Rule 4.6[20], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[21] 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, 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"[22] but fails to explain how it can, to explain how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2.[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:

> **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.

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

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

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

[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. Further, if it was a common systemic issue, it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

> Once the documents become available, promptly forward them to the Board and the opposing party.[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 MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule,

> [b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year.

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh. [25]

This CMS webpage indicates that DSH data is available ***for FY 1998 to 2022,*** and states, "[t]o requests DSH data, send an email to the official DSH mailbox."

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.

[24] (Italics and underline emphasis added.)
[25] Last accessed July 11, 2024.

Accordingly, based on the record before it, the Board finds that the SSI Provider Specific issue in Case No. 19-0673 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 . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board dismisses this aspect of the appeal.

B. UCC Distribution Pool

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).[26]
>
> (B) Any period selected by the Secretary for such purposes.

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[26] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.

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*"),[27] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[28] 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."[29] 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.[30]

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.[31]

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*").[32] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating

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[27] 830 F.3d 515 (D.C. Cir. 2016).
[28] 89 F. Supp. 3d 121 (D.D.C. 2015).
[29] 830 F.3d 515, 517.
[30] *Id.* at 519.
[31] *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*").
[32] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").

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."[33] 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.[34]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[35] 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.[36] 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.[37] 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.[38] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[39]

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.[40]

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[33] *Id.* at 506.
[34] *Id.* at 507.
[35] 514 F. Supp. 249 (D.D.C. 2021).
[36] *Id.* at 255-56.
[37] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[38] *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.
[39] *Id.*
[40] *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."[41] 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.[42] For review to be available in these circumstances, the following criteria must 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.[43]

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.[44] 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*").[45] 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.[46] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the provider's 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."[47] The D.C. Circuit further dismissed the

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[41] *Id.* at 265.
[42] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[43] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[44] *Id.* at 264-65 (quoting *DCH v. Azar*, 925 F.3d at 509).
[45] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[46] *Id*. at *127.
[47] *Id.* at *134.

applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[48] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[49]

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 be 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 two (2) remaining issues in this case – (Issues 1 and 4). As no issues remain, the Board hereby closes Case No. 19-0673 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:
Clayton J. Nix, Esq. Kevin D. Smith, CPA Ratina Kelly, CPA Nicole E. Musgrave, Esq. Shakeba DuBose, Esq.	7/11/2024 X Kevin D. Smith, CPA Kevin D. Smith, CPA Board Member Signed by: Kevin D. Smith -A

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

[48] 139 S. Ct. 1804 (2019).
[49] *Ascension* at *132 (bold italics emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

<u>**Via Electronic Delivery**</u>

Nan Chi
Houston Methodist Hospital System
8100 Greenbriar, GB 240
Houston, TX 77054

Michael Redmond
Novitas Solutions Inc., c/o Guidewell Source
2020 Technology Parkway, Suite 100
Mechanicsburg, PA 17050

RE: ***Board Dismissal of SSI Percentage (Provider Specific)***
Houston Methodist Hospital Sugar Land (Provider Number 45-0820)
FYE: 12/31/2011
Case Number: 17-1830

Dear Ms. Chi and Mr. Redmond,

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

A. *Procedural History for Case No. 17-1830*

On **January 18, 2017**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2011.

On **July 12, 2017**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

1. DSH SSI Percentage (Provider Specific)
2. DSH SSI Percentage Systemic Errors[1]
3. DSH SSI Percentage - Medicare Managed Care Part C Days[2]
4. DSH SSI Percentage -Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days and No -Part A Days)[3]
5. DSH - Medicaid Eligible Days
6. DSH Medicaid Fraction - Medicare Managed Care Part C Days[4]
7. DSH Medicaid Fraction - Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days and No -Part A Days)[5]
8. Whether Capital DSH were calculated correctly

[1] On February 15, 2018, this issue was transferred to PRRB Case No. 15-2932GC.
[2] On February 15, 2018, this issue was transferred to PRRB Case No. 15-2924GC.
[3] On February 15, 2018, this issue was transferred to PRRB Case No. 15-2929GC.
[4] On February 15, 2018, this issue was transferred to PRRB Case No. 15-2928GC.
[5] On February 15, 2018, this issue was transferred to PRRB Case No. 15-2931GC.

9. Whether adjustment to Bad Debts is correct

On **February 28, 2018**, the Provider submitted its preliminary position paper.

On **April 6, 2018**, the Medicare Contractor filed a Jurisdictional Challenge.

On **May 3, 2018**, the Provider filed a response to the Jurisdictional Challenge.

On **June 28, 2018**, the Medicare Contractor submitted its preliminary position paper.

On **August 10, 2022**, the Provider submitted its final position paper.

On **September 19, 2022**, the Medicare Contractor submitted its final position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 15-2932GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[6]

As the Provider is commonly owned by Houston Methodist Hospital System, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 15-2932GC, QRS Houston Methodist 2011 DSH SSI Percentage (Systemic Errors) CIRP Group, on February 15, 2018. The Group Issue Statement in Case No. 15-2932GC reads, in part:

> **<u>Statement of the Issue:</u>**
>
> Whether the Secretary properly calculated the Providers' Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage.

[6] Issue Statement at 1 (July 12, 2017).

Statement of the Legal Basis

The Providers contend that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww (d)(5)(F)(i). The Providers further contend that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.

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

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.[7]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $57,225.

On August 10, 2022, the Provider filed its final position paper. The following is the Provider's ***complete*** position on Issues 1 set forth therein:

Issue 1: Provider Specific

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

[7] Group Issue Statement, Case No. 15-2932GC.

> that were entitled to SSI benefits in their calculation[.]
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> The Provider 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).[8]

C. Filings Concerning the Jurisdictional Challenge

1. MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Provider Specific issue. The MAC argues that the DSH SSI Provider Specific issue is duplicative of the DSH - SSI Systemic Errors issue.

> In Issue 1 the Provider contends that the MAC used the incorrect SSI percentage in processing its DSH payment. In Issue 2 the Provider contends that the Secretary improperly calculated its SSI percentage. The Provider is making the same argument, as the MAC is required to use the SSI ratio provided by CMS. Essentially, the Provider contends that the SSI ratio applied to its cost report was incorrect; the SSI ratio is the underlying dispute in both Issue 1 and Issue 2. Under Board Rules, the Provider is barred from filing a duplicate SSI percentage issue. Therefore, the PRRB should find that the SSI percentage is one issue for appeal purposes and that Issue 1 should be dismissed consistent with recent jurisdictional decisions.[9]

2. Provider's Jurisdictional Response

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

> The MAC argues issue 1, SSI Provider Specific/Realignment, is a duplicate issue to issue 2, SSI Systemic issue. Provider contends

[8] Provider's Final Position Paper at 1-2 (August 10, 2022).
[9] Jurisdictional Challenge at 2 (April 6, 2018).

> each of the appealed SSI issues are separate and distinct issues, and that the Board should find jurisdiction over PRRB Case Number 17-1830.
>
> Board Rule 8.1 states "Some issues may have multiple components. To comply with the regularity requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible..." Appeal issues #1 and #2 represent different components of the SSI issue, which was specifically adjusted during the audit. Since these specific appeal issues represent different aspects/components of the SSI issue, Provider contends the Board should find jurisdiction over both the SSI Systemic and SSI Provider Specific/Realignment issues.[10]

Board Analysis and Decision:

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

A. DSH Payment/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 PRRB Case No. 15-2932GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[11] 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

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[10] Provider Jurisdictional Challenge Response at 1 (May 3, 2018).
[11] Issue Statement at 1.

instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[12] 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."[13]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 15-2932GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 15-2932GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination were also prohibited by PRRB Rule 4.5 at the time of appeal,[14] the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case 15-2932GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). 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] 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 can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 15-2932GC.

To this end, the Board also reviewed the Provider's Final 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. 15-2932GC, but instead reiterates the original issue statement with no further or additional support. Moreover, the Board finds that the Provider's Final Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Final Position Paper and include *all* exhibits.

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[12] *Id.*
[13] *Id.*
[14] Prior PRRB Rules v. 1.3 (July 1, 2015).
[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**
>
> *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.[16]

The Board further notes that 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 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. [17]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data.[18]

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[16] (Emphasis added).
[17] Last accessed July 11, 2024.
[18] Emphasis added.

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 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.

Accordingly, *based on the record before it*, the Board finds that the first aspect of Issue 1 in the instant appeal and the group issue from Group Case 15-2932GC are the same issue.[19] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5, at the time of the appeal, 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.

The Board finds that, under 42 C.F.R. § 412.106(b)(3), 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 . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

****

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. 15-2932GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. Case No. 17-1830 remains open for the remaining issues.

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 upon final disposition of the appeal.

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

<u>Board Members Participating</u>:

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

For the Board:

7/12/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

<u>**Via Electronic Delivery**</u>

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

Geoff Pike
First Coast Service Options c/o GuideWell Source
532 Riverside Avenue
Jacksonville, FL 32202

RE: ***Board Decision*** **– Uncompensated Care Distribution Pool Issue**
Shands Lake Shore Regional Medical Center (Provider Number 10-0102)
FYE: 06/30/2017
Case Number: 19-2702

Dear Messrs. Summar and Pike,

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

Background:

On **March 12, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2017.

On **September 11, 2019**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

1. SSI Percentage (Provider Specific)[1]
2. SSI Percentage (Systemic Errors)[2]
3. SSI Fraction Medicare Managed Care Part C Days[3]
4. SSI Fraction Dual Eligible Days[4]
5. DSH Payment – Medicaid Eligible Days[5]
6. Medicaid Fraction Medicare Managed Care Part C Days[6]
7. Medicaid Fraction Dual Eligible Days[7]
8. UCC Distribution Pool
9. 2 Midnight Census IPPS Payment Reduction[8]

[1] This issue was withdrawn on April 22, 2024.
[2] On April 21, 2020, this issue was transferred to PRRB Case No. 20-1332GC.
[3] On April 21, 2020, this issue was transferred to PRRB Case No. 20-1333GC.
[4] On April 21, 2020, this issue was transferred to PRRB Case No. 20-1334GC.
[5] This issue was withdrawn on April 22, 2024.
[6] On April 21, 2020, this issue was transferred to PRRB Case No. 20-1335GC.
[7] On April 21, 2020, this issue was transferred to PRRB Case No. 20-1336GC.
[8] On April 21, 2020, this issue was transferred to PRRB Case No. 20-1337GC.

As 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 **April 21, 2020**, the Provider transferred Issues 2, 3, 4, 6, 7, and 9 to CHS groups. The Provider withdrew Issues 1 and 5 on April 22, 2024. As a result, there is one (1) remaining issue in this appeal: Issue 8 (UCC Distribution Pool).

MAC's Contentions

Issue 8 – 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)."[9] In support of its position, the Medicare Contractor cites to the D.C. Circuit Court decision in *Fla. Health Sciences Ctr. v. Sec'y of Health & Human Servs.*, 830 F.3d 515 (D.C. Cir. 2016), in which the court agreed with the Board's decision that review of the UCC is precluded.

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. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Analysis and Recommendation:

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 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). In their Individual Appeal Request, Provider summarizes its UCC Distribution Pool issue, in part, as follows:

> The issue in this appeal involves CMS's calculations of the pool of uncompensated care ("UCC") payments available for distribution to [DSH] eligible hospitals (i.e., the UCC Distribution Pool issue)

[9] Medicare Contractor's Jurisdictional Challenge at 9 (June 24, 2020).
[10] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

> as finalized in the 2014 Inpatient Prospective Payment System rulemaking on August 02, 2013.
>
> * * *
>
> Providers contend that CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the UCC payments available for distribution to DSH eligible hospitals, that is, in its calculation of Factors 1 and 2 (the "Distribution Pool"). Because CMS's determination of the Distribution Pool was beyond its authority, i.e., *ultra vires*, in the two respects discussed below, the preclusion of review provision found in Social Security Act § 1886(r)(3) does not apply.

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).[11]
>
> (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*"),[12] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[13] 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

---

[11] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.

[12] 830 F.3d 515 (D.C. Cir. 2016).

[13] 89 F. Supp. 3d 121 (D.D.C. 2015).

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."[14] 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.[15]

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.[16]

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*").[17] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[18] 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.[19]

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[14] 830 F.3d 515, 517.
[15] *Id.* at 519.
[16] *Id.* at 521-22.
[17] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[18] *Id.* at 506.
[19] *Id.* at 507.

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[20] 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.[21] 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.[22] 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.[23] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[24]

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.[25]

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."[26] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such

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[20] 514 F. Supp. 249 (D.D.C. 2021).
[21] *Id.* at 255-56.
[22] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[23] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.
[24] *Id.*
[25] *Id.* at 262-64.
[26] *Id.* at 265.

review is precluded by statute, the criteria in *Scranton* were not met.[27] For review to be available in these circumstances, the following criteria must 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.[28]

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.[29] 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*").[30] 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.[31] 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."[32] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[33] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[34]

The Board finds that the same findings are applicable to the Provider's challenge to their FY 2017 UCC payments. The Provider here is challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FY 2017. The challenge to CMS' notice and comment procedures focuses on a

[27] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[28] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[29] *Id.* at 264-65 (quoting *DCH v. Azar*, 925 F.3d at 509).
[30] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[31] *Id*. at *127.
[32] *Id.* at *134.
[33] 139 S. Ct. 1804 (2019).
[34] *Ascension* at *132 (bold italics emphasis added).

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.

****

In summary, the Board hereby dismisses the UCC Distribution Pool issue as the Board does not have jurisdiction 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. As no issues remain pending, the Board hereby closes Case No. 19-2702 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:

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

For the Board:

7/15/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., 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 University Medical Center (Provider Number 45-0021)
FYE: 06/30/2012
Case Number: 19-0352

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-0352. 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. 19-0352***

On **May 4, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2012.

On **October 31, 2018**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained seven (7) issues:

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

[1] On May 30, 2019, the Provider transferred this issue to PRRB Case No. 15-3173GC.
[2] On May 30, 2019, the Provider transferred this issue to PRRB Case No. 15-3171GC.
[3] On May 30, 2019, the Provider transferred this issue to PRRB Case No. 15-3167GC.
[4] On May 30, 2019, the Provider transferred this issue to PRRB Case No. 15-3172GC.
[5] On May 30, 2019, the Provider transferred this issue to PRRB Case No. 15-3170GC.

The Standardized Payment Amount (Issue 8) was added on December 19, 2018 and transferred to PRRB Case No. 19-1969GC on May 30, 2019.

As a result of the case transfers, the remaining issues in this appeal are Issue 1 (the DSH – SSI Percentage Provider Specific issue) and Issue 5 (the DSH – Medicaid Eligible Days issue).

On **November 20, 2018**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[6]

On **April 9, 2019**, the Medicare Contractor filed a Jurisdictional Challenge[7] over Issue 1: DSH SSI Percentage (Provider Specific). The Provider filed a response on **May 9, 2019**.

On **June 19, 2019**, the Provider 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.[8] However, no such filing was made and no explanation was included to explain 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 were 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' 2011 [sic] cost report does not reflect an accurate number of Medicaid eligible days."[9]

On **October 18, 2019**, the Medicare Contractor filed its preliminary position paper.

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[6] (Emphasis added.)
[7] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).
[8] Provider's Preliminary Position Paper at 8 (June 19, 2019).
[9] *Id.*

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

On **April 26, 2024**, the Provider filed its Final Position Paper. The Medicare Contractor filed its Final Position Paper on **May 20, 2024**.

On **June 10, 2024**, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission". The Listing was 160 pages and included an untotaled amount of 1115 Waiver Days, over 44,000 "Medicaid NPR Days," and 294 Medicaid eligible days. QRS' filing did not explain why the listing of so many days was being submitted at this late date.

On **June 25, 2024**, the Medicare Contractor filed a Jurisdictional Challenge over Issues 1 and Issue 5. The Provider filed a response on **July 2, 2024.**

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 15-3173GC – QRS BSWH 2012 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' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).[10]

The Group issue Statement in Case No. 15-3173GC, to which the Provider transferred Issue No. 2, reads, in part:

> **<u>Statement of the Issue:</u>**
>
> Whether the Secretary properly calculated the Providers' Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage.

[10] Issue Statement at 1 (Oct. 31, 2018).

> **<u>Statement of the Legal Basis</u>**
>
> 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)(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 Report does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20, *as amended,* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[11]

On June 19, 2019, the Board received the Provider's preliminary position paper in 19-0352. 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 (June 30).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services,* No. CV-94-0055 (C.D. Cal June 2, 1995), the SSI entitlement of individuals can be ascertained from [s]tate records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"),

[11] Group Appeal Issue Statement in Case No. 15-3173GC.

> HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the completed MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008).[12]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $288,000.

<u>MAC's Contentions</u>

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)
The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue, stating,

> [i]ssue 1 has three components: 1) SSI data accuracy; 2) realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2. The portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[13]

Issue 5 – DSH – Medicaid Eligible Days

The MAC argues the Provider is attempting to add the Section 1115 Waiver days issue improperly and untimely. The MAC maintains that Section 1115 Wavier days are a separate and distinct issue. There was no mention of Section 1115 waiver days as part of the original appeal request or preliminary position paper.[14]

Additionally, the MAC argues that this issue "should be dismissed because the Provider failed to file a complete preliminary or final position 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."[15]

Accordingly, the Medicare Contractor requests that the Board dismiss Issue 5.

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[12] Provider's Preliminary Position Paper at 8-9 (June 19, 2019).
[13] Medicare Contractor's Jurisdictional Challenge at 3 (April 9, 2019).
[14] Medicare Contractor's Jurisdictional Challenge at 2, 12-13 (June 25, 2024).
[15] *Id.* at 2.

Provider cites 100 days in dispute in appeal request AND preliminary position paper in June of 2019, both citing $47,902. The preliminary position paper states that the listing is being sent under separate cover. No listing was sent or received until 2024. The Provider's final position paper was filed on April 26, 2024, and introduces the issue of 1115 waiver days for the first time. The "listing" attached to the final paper is for 17,885 days, and is labeled "1115 Waiver and Additional [Medicaid Eligible] Days Consolidated"[16] and "Listing pending finalization upon receipt of State eligibility data."[17]

On June 10, 2024, the Provider filed another listing, labeled as a "Supplement" to the final position paper. This listing has an untotaled amount of 1115 waiver days & 44,140 Medicaid NPR days; 129 Medicaid eligible high strata days, and 165 Medicaid eligible low strata days.[18]

<u>Provider's Jurisdictional Response</u>

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

The Provider argues that it is entitled to appeal an item with which it is dissatisfied, stating,

> the Provider has specifically identified patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS, due to errors that are or may be specific to the Provider, but in any case, are not the systemic errors that have been previously identified in the *Baystate* litigation. . . . Once these patients are identified, the Provider contends that it will be entitled to a correction of these errors of omission to its SSI percentage.[19]

The Provider maintains it "is not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systematic errors" category."[20] The Provider cites Board Rule 8.1 which allows issues with multiple components such as Issue 1 and Issue 2, that represent different components of the SSI issue.[21]

Issue 5 – DSH – Medicaid Eligible Days

The Provider argues that it timely appealed all Medicaid eligible days including 1115 waiver days. The Provider's issue statement reads: "The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid

[16] *Id.* at 12-13.
[17] Provider's Final Position Paper at Exhibit P-1.
[18] Supplement to Position Paper/Redacted ME Days Listing 45-0021.
[19] Provider's Jurisdictional Response at 2 (May 9, 2019).
[20] *Id.*
[21] *Id.* at 1.

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."[22]

The Provider maintains that they have not abandoned their claim and has submitted a redacted listing on June 10, 2024. The MAC's argument that the Provider has abandoned the "issue" of section 1115 waiver days is "not a jurisdictional argument and is inappropriate for a jurisdictional challenge."[23]

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 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 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. 15-3173GC.

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."[24] 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)."[25] The Provider argues in its issue statement, which was included in the appeal request, that it "disagrees with the

[22] Provider Jurisdictional Response at 3 (July 2, 2024).
[23] *Id*. at 5.
[24] Issue Statement at 1.
[25] *Id.*

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."[26]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 15-3173GC 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. 19-0352 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 15-3173GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[27], 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.[28] 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, 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. 15-3173GC, 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 [s]tate records" but fails to explain how this can be done, to explain how that information is relevant, and whether or not such a review was done for purposes of the year in question, consistent with its obligations under Board Rule 25.2.[29] Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Aug. 29, 2018), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

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[26] *Id.*
[27] PRRB Rules v. 2.0 (Aug. 2018).
[28] 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).
[29] It is also not clear whether this is a systemic issue for CHS providers in the same state subject to the CIRP rules or something that is provider specific because, if it was a common systemic issue, it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

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

> **25.2.2 Unavailable and Omitted Documents (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.[30]

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. [31]

[30] (Italics and underline emphasis added.)
[31] Last accessed July 18, 2024.

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data.[32]

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. 15-3173GC.

Accordingly, based on the record before it, the Board finds that the SSI Provider Specific issue in Case No. 19-0352 and the group issue from the CIRP group under Case No. 15-3173GC 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 . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board dismisses this aspect of the appeal.

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 2018 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

[32] Emphasis added.

> be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[33]

Board Rule 7[34] elaborated on this regulatory requirement instructing providers:

> **7.2.1 General Information**
>
> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>   - the adjustment, including the adjustment number,
>   - the controlling authority,
>   - why the adjustment is incorrect,
>   - how the payment should be determined differently,
>   - the reimbursement effect, and
>   - the basis for jurisdiction before the PRRB.
> - A copy of the applicable audit adjustment report page(s) or a statement addressing why an adjustment report is not applicable or available.
> - A calculation or other support for the reimbursement effect noted in the issue statement.
> - Support for protested items or claim of dissatisfaction as noted in Rules 7.3 and 7.4

Board Rule 8[35] explains that when framing issues for adjustments involving multiple components, providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

[33] 42 C.F.R. § 405.1835(b).
[34] v. 2 (Aug. 2018).
[35] *Id*.

> 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.[36]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[37]
42 C.F.R. § 405.1835(e) provides in relevant part:

> (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.

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

In this regard, the Board notes that section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[38] Rather, 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. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, 42 C.F.R. § 412.106(b)(4) states in pertinent part:

---

[36] (Emphasis added).
[37] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[38] 65 FR 47054, 47087 (Aug. 1, 2000).

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

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

C. DSH Payment – Medicaid Eligible Days

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

With regard to the filing of an individual appeal, Board Rule 7.3.2 (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.[39]

Thus, 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:

[39] (Bold emphasis added.)

Rule 25 Preliminary Position Papers[40]

COMMENTARY:

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

25.1 Content of Position Paper Narrative

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

25.1.1 Provider's Position Paper

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.

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on November 20, 2018, 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.[41]

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 19, 2019, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent, promising that the listing was being sent under separate cover.[42] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case. The Provider's complete briefing of this issue in its position paper is as follows:

> **<u>Calculation of Medicaid Eligible Days</u>**
>
> 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,

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[41] (Emphasis added.)
[42] Provider's Preliminary Position Paper at 8 (May 4, 2020).

> 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' 2011 [sic] 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.[43]

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.[44]

On June 10, 2024, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission". The Listing was 160 pages with an untotaled number of 1115 waiver days, 44,140 Medicaid NPR Days, and 294 Medicaid eligible days. QRS' filing did not explain why the listing of so many days was being submitted at this late date and was roughly 4 years past the deadline for including it with its preliminary position paper since the position paper deadline was June 28, 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

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[43] Provider references 2011 incorrectly in its Preliminary Position Paper, as the appeal is for FYE 6/30/2012.
[44] Medicare Contractor's Jurisdictional Challenge at 18.

identify and prove the specific additional Medicaid Eligible days at issue which it may be entitled to include in its DSH calculations, 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 June 10, 2024 filing as a "Supplement to Position Paper" and does not accept that filing because:

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

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); and (b) *why* the listing of the an untotaled number of 1115 waiver days, 44,100 1115 Medicaid NPR days and 294 Medicaid eligible days days was not previously available, *in whole or in part*;

3. Neither the Board Rules, the November 20, 2018 Case Acknowledgment and Critical Due Dates, nor the Notice of Hearing permit the Provider to file a "Supplement" to its position papers (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* number of over 44,000 days listed in the alleged "Supplement" is, without explanation, *exponentially* larger than the original estimated 100 days included with the appeal request).[45]

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"[46] 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

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[45] *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."
[46] (Emphasis added.)

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

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable.[47]

* * * *

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. 19-0352 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:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

7/22/2024

X Kevin D. Smith, CPA

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

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

[47] *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***
Baylor University Medical Center (Provider Number 45-0021)
FYE: 06/30/2011
Case Number: 19-0353

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-0353. 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. 19-0353*

On **May 3, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2011.

On **October 31, 2018**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained seven (7) issues:

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

[1] On May 30, 2019, the Provider transferred this issue to PRRB Case No. 15-0733GC.
[2] On May 30, 2019, the Provider transferred this issue to PRRB Case No. 15-0731GC.
[3] On May 30, 2019, the Provider transferred this issue to PRRB Case No. 15-0734GC.
[4] On May 30, 2019, the Provider transferred this issue to PRRB Case No. 15-0732GC.
[5] On May 30, 2019, the Provider transferred this issue to PRRB Case No. 15-0735GC.

On **December 19, 2018**, the Provider added the Standardized Payment Amount Issue.[6]

As a result of case transfers, the remaining issues in this appeal are Issue 1 (the DSH – SSI Percentage Provider Specific issue) and Issue 5 (the DSH – Medicaid Eligible Days issue).

On **November 20, 2018**, 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 9, 2019**, the Medicare Contractor filed a Jurisdictional Challenge[8] over Issue 1: DSH SSI Percentage (Provider Specific). The Provider file a response on **May 3, 2019**.

On **June 19, 2019**, the Provider 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 Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2011 cost report does not reflect an accurate number of Medicaid eligible days."[9]

On **October 7, 2019**, the Medicare Contractor filed its preliminary position paper.

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[6] On May 30, 2019, the Provider transferred this issue to PRRB Case No. 19-1967GC.
[7] (Emphasis added.)
[8] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).
[9] Provider's Preliminary Position Paper at 8 (June 19, 2019).

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

On **April 26, 2024**, the Provider filed its Final Position Paper. The Medicare Contractor filed its Final Position Paper on **May 21, 2024**.

On **June 10, 2024**, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission.". The Listing was 89 pages with over 46,000 Medicaid eligible days. QRS' filing did not explain why the listing of so many days was being submitted at this late date.

On **June 24, 2024**, the Medicare Contractor filed a Jurisdictional Challenge over Issue 1 and Issue 5. The Provider filed a response on **July 2, 2024.**

On **July 2, 2024**, the Provider withdrew the 1115 waiver days portion from its appeal and requested that the MAC withdraw its Jurisdictional Challenge on the 1115 Waiver Days issue.

Only **July 5, 2024**, the Provider requested a 180-day postponement for the MAC to sample the listing provided.

A. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 15-0733GC – QRS BHCS 2011 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' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).[10]

The Group issue Statement in Case No. 15-0733GC, to which the Provider transferred Issue No. 2, reads, in part:

[10] Issue Statement at 1 (Oct. 31, 2018).

<u>Statement of the Issue:</u>

Whether the Secretary properly calculated the Providers' Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage.

<u>Statement of the Legal Basis</u>

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)(i). The Providers further contend that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20, *as amended,* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.

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

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.[11]

On June 19, 2019, the Board received the Provider's preliminary position paper in 19-0353. 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 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.

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[11] Group Appeal Issue Statement in Case No. 15-0733GC.

> 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"), 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).[12]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $282,000.

<u>MAC's Contentions</u>

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)
The Medicare Contractor argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. In its June 19, 2019 Jurisdictional Challenge, it states:

> Issue 1 has three components: 1) SSI data accuracy; 2) realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2. The portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[13]

Issue 5 – DSH – Medicaid Eligible Days

The MAC argues in its June 24, 2024 Jurisdictional Challenge that the Provider is attempting to add the Section 1115 Waiver days issue improperly and untimely. The MAC maintains that Section 1115 Wavier days are a separate and distinct issue. There was no mention of Section 1115 waiver days as part of the original appeal request or preliminary position paper.

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[12] Provider's Preliminary Position Paper at 8-9 (June 19, 2019).
[13] Medicare Contractor's Jurisdictional Challenge at 3 (April 9, 2019)

Additionally, this issue should be dismissed because the Provider failed to file a complete position paper 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.[14]

Accordingly, the Medicare Contractor requests that the Board dismiss Issue 5.

Provider's Jurisdictional Response

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

The Provider argues that it is entitled to appeal an item with which it is dissatisfied, stating, "[t]he Provider has specifically identified patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS, due to errors that are or may be specific to the Provider, but in any case, are not the systemic errors that have been previously identified in the Baystate litigation. Once these patients are identified, the Provider contends that it will be entitled to a correction of these errors of omission to its SSI percentage."[15]

The Provider maintains it is not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systematic errors" category. The Provider cites Board Rule 8.1 which allows issues with multiple components such as Issue 1 and Issue 2, that represents different components of the SSI issue.[16]

Issue 5 – DSH – Medicaid Eligible Days

The Provider states "[a] redacted listing of the Additional Medicaid Eligible days was uploaded to the CMS Portal and an unredacted listing was sent to the MAC on June 10, 2024. Patients with Sec 1115 Days are not in this listing."[17]

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.

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[14] Medicare Contractor's Jurisdictional Challenge at 3, 15-17 (June 25, 2024)
[15] Provider's Jurisdictional Response at 2 (May 3, 2019)
[16] *Id.* at 1.
[17] Provider Jurisdictional Response at 3 (July 2, 2024)

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 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. 15-0733GC.

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]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 15-0733GC 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. 19-0353 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 15-0733GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[21], 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

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[18] Issue Statement at 1.
[19] *Id.*
[20] *Id.*
[21] PRRB Rules v. 2.0 (Aug. 2018).

impact the SSI percentage for each provider differently.[22] 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, 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. 15-0733GC, 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"[23] but fails to explain how it can be done, to explain how that information is relevant, and whether or not 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 (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, <u>*and*</u> *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 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

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[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] Provider's Preliminary Position Paper at 8.
[24] (Italics and underline emphasis added.)

> request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year.

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from 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. 15-0733GC.

Accordingly, *based on the record before it*, the Board finds that the SSI Provider Specific issue in Case No. 19-0353 and the group issue from the CIRP group under Case No. 15-0733GC 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.

[25] Last accessed July 16, 2024.
[26] Emphasis added.

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 . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, 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 the initial appeal request or in either of the position papers. In both the appeal request and the Preliminary Position Paper, filed in June 2019, the Provider cited 100 days in dispute for an amount in controversy of $45,837. The position paper indicated that it would submit a listing under separate cover.

The Provider's Final Position Paper was filed on April 26, 2024, and that paper *still* cites 100 days in dispute for an amount in controversy of $45,837. However, the "listing" of days that was attached to the final position paper cites 18,872 days, and it is not clear what kind of days this listing includes. The listing also states "[l]isting pending finalization upon receipt of State eligibility data"[27] on every page. Subsequently, on June 10, 2024, the Provider filed *another* listing, which now lists 46,783 "Medicaid NPR days," and claims 234 days are additional Medicaid days. The Medicare Contractor affirmed that it received an unredacted listing of days on June 11, 2024.

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] Provider's Final Position Paper, Exhibit 1.

> **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]

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

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

> **Rule 25 Preliminary Position Papers**[29]
>
> | **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,

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

agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.

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

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on November 20, 2018, 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.[30]

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

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

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

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

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

[30] (Emphasis added.)

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

On June 19, 2019, the Provider filed its preliminary position paper in which it suggested 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. 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

[31] Provider's Preliminary Position Paper at 11 (May 4, 2020).

> reflected in its' 2011 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

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

On June 10, 2024, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission". The Listing was 89 pages with over 46,000 Medicaid eligible days. QRS' filing did not explain why the listing of ***so many*** days was being submitted at this late date and was roughly 4 years past the deadline for including it with its preliminary position paper since the position paper deadline was June 28, 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).

The Board rejects the Provider's attempt to label the June 10, 2024 filing as a "Supplement to Position Paper" and does not accept that filing because:

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

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); and (b) *why* the listing of the over 46,000 days was not previously available, *in whole or in part*;

3. Neither the Board Rules nor the November 20, 2018 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* 46,000 days listed in the alleged "Supplement" is, without explanation, *exponentially* larger than the original estimated days included with the appeal request, and still awaiting State verification).[32]

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[33] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provider the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable.[34]

* * * *

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. 19-0353 and removes it

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

[33] (Emphasis added.)

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

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

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.

<u>Board Members Participating</u>:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

7/22/2024

X Kevin D. Smith, CPA

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

cc: Michael Redmond, Novitas Solutions c/o GuideWell Source
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Byron Lamprecht
WPS Government Health Administrators
1000 N 90th Street, Suite 302
Omaha, NE 68114-2708

RE: ***Board Decision* – Medicaid Eligible Days Issue**
Detar Healthcare System (Provider Number 45-0147)
FYE: 09/30/2015
Case Number: 19-1445

Dear Mr. Ravindran and Mr. Lamprecht,

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

Background:

A. *Procedural History for Case No. 19-1445*

On **August 30, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2015.

On **February 25, 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)[1]
2. DSH/SSI Percentage (Systemic Errors)[2]
3. DSH Payment – Medicaid Eligible Days
4. UCC Distribution Pool[3]
5. 2 Midnight Census IPPS Payment Reduction[4]

There is one remaining issue in the appeal: Issue 3 (DSH Payment – Medicaid Eligible Days).

On **March 20, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

[1] This issue was withdrawn by the Provider on Oct. 24, 2023.
[2] On Sep. 24, 2019, this issue was transferred to PRRB Case No. 18-0552GC.
[3] On Sep. 24, 2019, this issue was transferred to PRRB Case No. 18-0555GC.
[4] On Sep. 24, 2019, this issue was transferred to PRRB Case No. 18-0554GC.

> 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 **October 15, 2019**, the Provider timely filed its preliminary position paper.

On **February 19, 2020**, the Medicare Contractor timely filed its preliminary position paper. With respect to Issue 3, the Medicare contractor requested from the Provider all documentation necessary to resolve the issue in dispute.[6]

On **January 6, 2023**, the Medicare Contractor filed a "Final Request for Medicaid Eligible Days Support", which cited a prior attempt on August 9, 2019, and advised of additional items required by the Medicare Contractor to attempt to resolve the dispute.

On **April 6, 2023**, the Board issued a corrected Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

> Provider's Final Position Paper – *For each remaining issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *also include* ***any exhibits*** *the Provider will use to support to support its position*. *See* Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.[7]

On **August 23, 2023**, the Provider changed its designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **October 24, 2023**, the Provider timely filed its final position paper and withdrew Issue 1.

On **November 13, 2023**, the Medicare Contractor filed a Jurisdictional Challenge requesting the dismissal of Issue No. 3. A responsive brief was filed by the Provider on **December 8, 2023**.

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[5] (Emphasis added).
[6] Medicare Contractor's Preliminary Position Paper at 5 (Feb. 19, 2020).
[7] (Emphasis added).

On **November 16, 2023**, the Medicare Contractor timely filed its final position paper.

B. Description of Issue 3 in the Appeal Request

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

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 9,10,36,44,45,S-D
> Estimated Reimbursement Amount: $26,000[8]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the Jewish Hospital case[9] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[10] In their Final Position Paper, this argument is repeated verbatim and then, for the first time in this appeal, the Provider states it is seeking reimbursement for section 1115 waiver days as a part of the Medicaid eligible day issue. Specifically, the Provider states:

> Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days) are to be included in the numerator of the Provider's

[8] Appeal Request at Issue 3.
[9] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[10] Provider's Preliminary Position Paper at 7 (Oct. 15, 2019).

> 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).[11]

MAC's Contentions

The MAC contends that the Provider is attempting to untimely and improperly add the issue of Section 1115 waiver days as a sub-issue via its final position paper, filed on October 24, 2023.[12] The MAC asserts that prior to the final position paper, the Provider had not formally added the dispute to the appeal, nor had it otherwise raised the issue of section 1115 waiver days.[13] The MAC contends that the Provider's attempt to add the issue within its final position paper is improper and untimely, citing 42 C.F.R. § 405.1835(e), which governs when specific Medicare payment issues may be added to the original hearing request, including a timeframe of no later than 60 days after the expiration of the applicable 180-day deadline to file an appeal.[14]

The MAC contends that the section 1115 waiver days issue is one component of the DSH issue. The MAC contends that section 1115 waiver days issue is a separate and distinct issue from Medicaid eligible days issue and must be identified and appealed separately.[15]

Further, the MAC argues the Provider attempted to untimely and improperly add the Low Income Pool 1115 Waiver Days via the final position paper.[16]

Finally, 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 regardless of whether additional support was submitted at the time of the final paper.[17]

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[11] Provider's Final Position Paper at 8-9 (Oct. 24, 2023).
[12] Jurisdictional Challenge at 6 (Nov. 13, 2023).
[13] *Id*. at 7.
[14] *Id*. at 6-7.
[15] *Id*. at 8.
[16] *Id*. at 8-9.
[17] *Id*. at 6.

Provider's Jurisdictional Response

The Provider argues that in their initial appeal request, they appealed all Medicaid eligible days, including section 1115 waiver days.[18] The Provider points out that the appeal issue statement reads, in pertinent part:

> all Medicaid eligible days, *including but not limited to* Medicaid paid days . . .[19]

The Provider also argues that it has not abandoned the Medicaid eligible days issue because Board rules in place at the time of the initial appeal[20] require "the final position paper…to identify the issue and its reimbursement impact."[21]

Analysis and Recommendation

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

1. *Section 1115 Waiver Days*

The Board finds that the § 1115 Waiver Days issue is *not* properly part of this appeal because it was not properly included in the original appeal request and it was not properly or timely added to the appeal. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the § 1115 Waiver Days as recognized by multiple Board, Administrator and Court

[18] Jurisdictional Response at 1 (Dec. 8, 2023).
[19] *Id*. (Emphasis included).
[20] Importantly, the Provider references the July 1, 2015 version of Board rules. However, the Board rules effective as of the time of this filing were, in fact, the Aug. 29, 2018 version, as this appeal was filed on Feb. 25, 2019.
[21] Jurisdictional Response at 2.

decisions[22] (many of which were issued prior to the Provider's May 3, 2019 deadline for adding issues to this appeal).[23]

The appeal was filed with the Board in April of 2018 and 42 C.F.R. § 405.1835(b) (effective Jan. 1, 2016) gives the following "contents" requirements for an initial appeal request for a Board hearing:

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing to the Board, and the request **must include** the elements described in paragraphs (b)(1) through (b)(4) of this section. **If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (b)(2), or (b)(3) of this section, the Board <u>may dismiss</u>** with prejudice the appeal or take any other remedial action it considers appropriate.
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the final contractor or Secretary determination under appeal.
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final contractor or Secretary determination under appeal, including an account of all of the following:
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the

[22] *See, e.g.*, *QRS 1993-2007 DSH/Iowa Indigent Patient /Charity Care (GA) Group v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Jan. 15, 2013), *affirming* PRRB Dec. No. 2013-D02 (Nov. 21, 2012)*; St. Dominic-Jackson Mem'l Hosp. v. Sebelius*, No. 3:12-cv-832, 2014 WL 8515280 (S.D. Miss. 2014); *Singing River Health Sys. v. Novitas Solutions, Inc.*, PRRB Dec. 2016-D19 (Sept. 20, 2016), *rev'd* CMS Adm'r Dec. (Nov. 18, 2016); *CCT&B 2005-2006 Hurricane Katrina § 1115 Waiver UCP Days Grp. v. Novitas Solutions, Inc*., PRRB Dec. 2016-D18 (Sep. 16, 2016), *rev'd* CMS Adm'r Dec. (Nov. 18, 2016), *aff'd sub nom. Forrest Gen. Hosp. v. Hargan*, No. 2:17-CV-8, 2018 WL 11434575 (S.D. Miss. Feb. 22, 2018), *rev'd & remanded Forrest Gen. Hosp. v. Azar*, 926 F.3d 221 (5th Cir. 2019); *Southwest Consulting UMass Mem'l Health Care & Steward Health 2009 DSH CCHIP Section 1115 Waiver Days Grps. v. Nat'l Gov't Servs., Inc*., PRRB Dec. 2017-D04 (Jan. 27, 2017), *rev'd* CMS Adm'r Dec. (Mar. 21, 2017), *vacated & remanded sub nom. HealthAlliance Hosps., Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. Oct. 26, 2018); *Florida Section 1115 LIP Rehab DSH Waiver Days Grps. v. First Coast Serv. Options*, PRRB Decs. 2018-D21, 2018-D22 (Feb. 8, 2018), *vacated by* Adm'r Dec. (Mar. 30, 2018), *rev'd by Bethesda Health Inc. v. Azar*, 389 F. Supp. 3d 32 (DDC 2019), *aff'd by* 980 F.3d 121 (D.C. Cir. 2020).

[23] Here, the NPR at issue was issued on August 30, 2018 and the Provider had until Monday, March 4, 2019 to file the appeal (where receipt is presumed to be 5 days later and the Provider had 180 from that date to file an appeal request, and the 185th day falls on a weekend or holiday). Accordingly, the deadline to add issues is 60 days beyond that date, *i.e.*, Friday, May 3, 2019.

calculation of its payment).

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

(iii) If the provider self-disallows a specific item (as specified in §413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.

(3) A copy of the final contractor or Secretary determination under appeal and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section.[24]

Board Rule 7.1 (Jul 1, 2015) elaborated on these regulatory "contents" requirements instructing providers:

Rule 7 – Issue Statement and Claim of Dissatisfaction

For each issue under appeal, give a brief summary of the determination being appealed and the basis for dissatisfaction. (*See* Rule 8 *for special instructions regarding multi-component disputes*.)

7.1 NPR or Revised NPR Adjustments

A. Identification of Issue

Give a concise issue statement describing:

- the adjustment, including the adjustment number,
- why the adjustment is incorrect, and
- how the payment should be determined differently.

B. No Access to Data

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

7.2 – Self-Disallowed Items

A. Authority Requires Disallowance

[24] (Italics emphasis in original and bold and underline emphasis added).

> If the Provider claims that the item being appealed was not claimed on the cost report because a regulation, manual, ruling, or some other legal authority predetermined that the item would not be allowed, the following information must be submitted:
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> - a concise issue statement describing the self-disallowed item
> - the reimbursement or payment sought for the item, and
> - the authority that predetermined that the claim would be disallowed. [*March 2013*]
>
> **B. 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.
>
> **C. Protest**
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> Effective for cost reporting periods ending on or after December 31, 2008, items not being claimed under subsection A above must be adjusted through the protested cost report process. The Provider must follow the applicable procedures for filing a cost report under protest as contained in CMS Pub. 15-2, Section 115. *See* 42 C.F.R. § 405.1835(a)(1)(ii). [*March 2013*][25]

As explained above in Board Rule 7, Board Rule 8 (Jul. 1, 2015) provides "*special instructions*" for issue statements *involving* ***multi-component disputes***. In particular, 8.1 explains that, when framing issues for adjustments *involving multiple components*, that providers must "***specifically*** identify" each cost item in dispute, and "…each contested component must be appealed as a *separate* issue and described as ***narrowly as possible***…".[26] Board Rule 8. 2 (Jul. 1, 2015) gives common *examples* of different components of the Disproportionate Share Hospital payment calculation that may be in dispute. Specifically, Board Rule 8, in its entirety, states:

> **Rule 8 – Framing Issues for Adjustments Involving Multiple Components**
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> **8.1 – General**
>
> Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute,

[25] (Italics emphasis in initial paragraph for Rule 7 added.)
[26] (Emphasis added.)

> each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7. See common examples below.
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> **8.2 – Disproportionate Share Cases** (e.g., dual eligible, general assistance, charity care, HMO days, etc.)
>
> **8.3 – Bad Debts Cases** (e.g., crossover, use of collection agency, 120-day presumption, indigence determination, etc.)
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> **8.4 – Graduate Medical Education/Indirect Medical Education** (e.g., managed care days, resident count, outside entity rotations, etc.)
>
> **8.5 – Wage Index** (e.g., wage vs. wage-related, rural floor, data corrections, etc.) [27]

Pursuant to the May 23, 2008 final rule, new Board regulations went into effect on August 21, 2008 *that limited the **addition** of issues to appeals*.[28] As a result of this final rule, 42 C.F.R. § 405.1835(e) (Sept. 2015) 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 –
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> ****
>
> 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 establish that the Provider timely and properly added the § 1115 Waiver Days to the case. In this regard, the first discussion of § 1115 waiver days in this case occurred in the Provider's October 24, 2023 preliminary position paper, well after the deadline for adding issues had passed.

In this regard, the Board notes that § 1115 Waiver days are *not* traditional Medicaid eligible days. Indeed, it was only effective January 20, 2000 that the Secretary incorporated, ***at her discretion** by regulation*, only ***<u>certain</u>*** types of § 1115 waiver days into the DSH calculation (*i.e.,* the Secretary maintains that no statute requires that days associated with § 1115 waiver/expansion programs be included in the DSH calculation and that she exercised her discretion to include only certain such

[27] Board Rules are available https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-rules-and-board-orders (last visited April 30, 2024).
[28] *See* 73 Fed. Reg. 30190 (May 23, 2008).

days).[29] Rather, § 1115 waiver days relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to § 1115 waiver days. 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:
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> (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.[30]

*Significantly, **§ 1115 waiver programs can pertain** to not just Medicaid (Title XIX), but also **to other programs under Titles I, X, XIV, XIV or part A or D of Title IV of the Social Security***

[29] 65 Fed. Reg. 47054, 47087 (Aug. 1, 2000). *See also* 68 Fed. Reg. 45346, 45420 (Aug. 1, 2003) (stating: "On January 20, 2000, we issued an interim final rule with comment period (65 FR 3136), followed by a final rule issued on August 1, 2000 (65 FR 47086 through 47087), to allow hospitals to include the patient days of all populations that receive benefits under a section 1115 demonstration project in calculating the Medicare DSH adjustment. Previously, hospitals were to include only those days for populations under the section 1115 demonstration project who were, or could have been made, eligible under a State plan. Patient days of those expansion waiver groups who could not be made eligible for medical assistance under the State plan were not to be included for determining Medicaid patient days in calculating the Medicare DSH patient percentage. Under the January 20, 2000 interim final rule with comment period (65 FR 3137), hospitals could include in the numerator of the Medicaid fraction those patient days for individuals who receive benefits under a section 1115 expansion waiver demonstration project (effective with discharges occurring on or after January 20, 2000).").

[30] (Bold emphasis added.)

Act.[31] Hence, an important limitation is that the § 1115 waiver program receive Title XIX matching payments. Moreover, not every state Medicaid program has a qualifying § 1115 expansion program receiving Title XIX matching payments[32] and not every inpatient day associated with a beneficiary enrolled in such a § 1115 waiver program qualifies to be included in the numerator of the DSH Medicaid fraction.[33] In contrast, every state has a Medicaid state

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[31] Section 1115 of the Social Security Act (42 U.S.C. § 1315] pertains to "experimental, pilot, or demonstration project[s] which, in the judgment of the Secretary, is likely to assist in promoting the objectives of ***title I, X, XIV, XVI, or XIX, or part A or D of title IV***, in a State or States." 1115(a) of the Social Security Act (emphasis added). As such, § 1115 waiver programs are not just limited to Title XIX Medicaid programs but may also relate to programs under Titles I, X, XIV, XVI, or part A or D of Title IV.

[32] Further, a specific approved state § 1115 waiver day program is not necessarily static and may vary from one year to the next.

[33] Unlike traditional Medicaid eligible days under a State Plan, the following discussion from the FY 2004 IPPS Final Rule, 68 Fed. Reg.at 45420-21 highlights that not all § 1115 waiver days can be included in the numerator of the Medicaid fraction and that factual determinations must be made regarding any § 1115 waiver day program to determine if 42 C.F.R. § 412.106(b)(4) is applicable to that program:

> Since that revision, we have become aware that there are certain section 1115 demonstration projects that serve expansion populations with benefit packages so limited that the benefits are not similar to the medical assistance available under a Medicaid State plan. These section 1115 demonstration projects extend coverage only for specific services and do not include inpatient care in the hospital. Because of the limited nature of the coverage offered, the population involved may have a significantly higher income than traditional Medicaid beneficiaries.
>
> In allowing hospitals to include patient days related to section 1115 expansion waiver populations, our intention was to include patient days of section 1115 expansion waiver populations who receive benefits under the demonstration project that are similar to those available to traditional Medicaid beneficiaries, including inpatient benefits. Because of the differences between expansion populations in these limited benefit demonstrations and traditional Medicaid beneficiaries, in the May 19, 2003 proposed rule, we proposed that the Medicare DSH calculation should exclude from treatment as Medicaid patient days those patient days attributable to limited benefit section 1115 expansion waiver populations (proposed § 412.106(b)(4)(i)).
>
> For example, a State may extend a family planning benefit to an individual for 2 years after she has received the 60- day postpartum benefit under Medicaid, or a State may choose to provide a family planning benefit to all individuals below a certain income level, regardless of having previously received the Medicaid postpartum benefit. This is a limited, temporary benefit that is generally administered in a clinic setting (see section 1905(a)(4)(C) of the Act). Also, a number of States are developing demonstrations that are limited to providing beneficiaries an outpatient prescription drug benefit. Generally, these limited benefits under a demonstration project do not include inpatient benefits. If a hospital were to include the days attributable to patients receiving benefits under such a limited benefit, the hospital would be able to receive higher DSH payments, perhaps substantially, for patients who may otherwise be insured for inpatient care. For example, these limited demonstrations provide benefits that may be needed to supplement private insurance coverage for individuals who do not have incomes low enough to qualify for Medicaid under the State plan. We do not believe such patients should be counted in the DSH patient percentage as eligible for title XIX.
>
> ****
>
> Therefore, we proposed to revise § 412.106(b)(4)(i) to clarify that patients must be eligible for medical assistance inpatient hospital benefits under an approved State Medicaid plan (or similar benefits, including inpatient hospital benefits, under a section 1115 demonstration project) in order for their hospital inpatient days to be counted as Medicaid days in the calculation of a hospital's DSH patient percentage. Under the proposed clarification, hospital inpatient days attributed to patients who do not receive coverage for inpatient hospital benefits either under the approved State plan or through a section 1115 demonstration would not be counted in the calculation of Medicaid days for purposes of determining a hospital's DSH patient percentage.

plan; every state Medicaid plan includes inpatient hospital benefits; and by statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), the numerator of the DSH Medicaid fraction must include inpatient days of patients "who . . . were eligible for medical assistance ***under a State plan*** approved under subchapter XIX" but who were not entitled to Medicare Part A.[34]

In this regard, documentation needed to verify eligibility for a § 1115 waiver day is materially different than that for a traditional Medicaid eligible day[35] and, similarly, it is not a given that *all* § 1115 waiver days (even those under a program receiving Title XIX matching payments) necessarily would qualify under § 412.106(b)(4) as demonstrated by Board decisions and case law.[36] Here, 42 C.F.R. § 405.1835(b) and Board Rules 7 and 8 required each separate issue to be identified in the appeal request. Here, the Provider failed to do so, notwithstanding including a ***detailed*** description of "The Process That The Provider Used To Identify And Accumulate The Actual Medicaid Paid And Unpaid Days That Were Reported And Filed On The Medicare Cost Report At Issue" to support its assertion that the Medicaid eligible days at issue in the appeal were ones that could not have been identified through that process.[37] Significantly, at the time of the appeal the Provider sought only 50 additional Medicaid eligible days. The listing of days attached to the final position paper were for 1,806 days in a listing specifically identified as "1115 Waiver Days"[38] and it is unclear why that amount increased more than thirty-six times over or whether the listing contains ONLY Section 1115 Waiver Days or any other days.

Regardless, of whether the Provider *properly* included the § 1115 waiver days issue in its appeal request (which it did not), the Provider failed to properly develop the merits of the § 1115 waiver day issue in any of the Provider's position papers. Specifically, the Provider's preliminary position paper nor the final position paper mention, much less identify, the **specific state** § 1115 waiver program(s) at issue[39] or how any days under such program(s) would qualify under 42

> Under this reading, in the examples given above, the days associated with a hospital inpatient who receives coverage of prescription drugs or family planning services on an outpatient basis, but no inpatient hospital coverage, through either a Medicaid State plan or a section 1115 demonstration, would not be counted as Medicaid days for purposes of determining the DSH patient percentage.

[34] (Emphasis added.)

[35] In addition to providing proof that the patient at issue was eligible for the § 1115 waiver program for each day claimed, the Provider must also establish that the particular § 1115 waiver program at issue relates to Title XIX and qualified under 42 C.F.R. § 412.106(b)(4) as demonstrated by the preamble discussion in *supra* note 33 and litigation in *supra* note 22.

[36] *See* litigation in *supra* note 22.

[37] The Board recognizes that the appeal request states that "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." However, the "including but not limited to" phrase only pertained to traditional Medicaid eligible days and reasons why they may not have been included in the fraction. It did not expand to include other classes of days such as general assistance, State-only days or § 1115 waiver days. A generic catchall phrase cannot be used to essentially shoehorn in the later addition of an issue on an ***untimely*** basis in contravention of Board Rules and regulations. Indeed, neither the original appeal request nor the preliminary position paper include any description (much less identification of) § 1115 waiver days as being an issue, notwithstanding the obligation to do so under the requirements for the content of position papers at 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules 25 and 27.

[38] Provider's Final Position Paper at Exhibit P-1.

[39] In failing to identify the specific state § waiver program(s) at issue, the Provider fails to address whether such § 1115 waiver program(s) are under Titles I, X, XIV, XVI, XIX, or IV and whether such § 1115 waiver program(s)

C.F.R. § 412.106(b) to be included in the numerator of the DSH Medicaid fraction, notwithstanding its obligation to do so consistent with the position paper content requirements at 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules 25 and 27.[40] This is an independent basis for dismissal of the § 1115 waiver day issue. Specifically, the material facts and legal arguments needed to establish the merits of the Provider's claims regarding the § 1115 waiver days issue along with the relevant supporting documentation were not properly briefed and included in the position paper filings.

Finally, even if the Board were to find that Issue 3 encompassed § 1115 waiver days, there is no indication that any of the § 1115 waiver days included in the listing attached to the final position paper were included with the as-filed cost report and, if they were found to have not been included, that would make them an *unclaimed* cost and provide an independent basis for dismissal (*see* Board Alert 10). In raising this issue, the Board notes that it has found that when a class of days (*e.g.*, § 1115 waiver days) is excluded due to choice, error, and/or inadvertence from the as-filed cost report,[41] then that class of days is an unclaimed cost for which the Board would lack jurisdiction under 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835(a)(1)(i)-(ii) (2012) as clarified by CMS Ruling 1727-R.[42] The Provider's briefings generally address this jurisdictional issue by generically asserting that its process did not identify certain Medicaid eligible days. However, this discussion did not identify or discuss the class of days involving § 1115 waiver days and whether that class of days were included on the cost report. In this regard, if the Provider purposefully excluded § 1115 waiver days from the as-filed cost report, then CMS Ruling 1727-R confirms that the Provider only had a right to appeal those days if it "***had a good faith belief*** *that claiming reimbursement for [the § 1115 waiver days at issue] in the cost report would be futile because [the § 1115 waiver days at issue] was subject to a regulation or other payment policy* ***that bound the Medicare contractor and left the contractor with no authority or discretion to make payment in the manner sought by the provider***."[43] Here the Provider has failed to specifically address or discuss the Board's jurisdiction over this unique class of days. This is an independent basis for the Board to dismiss the § 1115 waiver days issue (*i.e.*, in addition to and independent from dismissal for failure to properly include the issue in its appeal request or properly brief and develop the issue).

---

received Title XIX matching funds and would otherwise qualify under 42 C.F.R. § 412.106(b) to counted in the numerator of the DSH Medicaid fraction.

[40] 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25 (Aug. 2018) required a fully-developed preliminary position paper that includes the legal merits and material facts of the Provider's position as well as all available supporting documents as required Board Rule 25.2 (Aug. 2018).

[41] CMS Transmittal 11912 (Mar. 16, 2023) makes clear that hospitals must maintain records on § 1115 waiver days:

> Each provider with an approved [§] 1115 waiver program ***has a method for identifying the days*** that are applicable to such waiver for reimbursement from the Medicaid program. As such, ***the provider is responsible for maintaining the appropriate supporting documentation*** *for the accrual of the days associated with [§] 1115 waiver reimbursements*. Providers *typically keep this information in the form of a listing* of specific patient accounts for each individual acute hospital stay ([§] 1115 log) that is subject to [§] 1115 reimbursement. This [§] 1115 log is similar to a provider's DSH Medicaid eligible days listing. (Emphasis added.)

[42] *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 06-1852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days 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* decisions under PRRB Dec. Nos. 2012-D14 and 2014-D03 is not applicable (available at: https://www.cms.gov/regulations-and-guidance/review-boards/prrbreview/downloads/jd-2017-11.pdf (last accessed July 3, 2024)).

[43] CMS Ruling 1727-R (emphasis added).

In summary, as the DSH Medicaid Eligible Days issue as stated in the original appeal request did not include the § 1115 waiver days and was not timely added to the appeal, the Board dismisses it from this appeal. Because the Provider did not raise the § 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. Indeed, even if the Provider had properly included the issue as part of its appeal request, there are multiple independent bases upon which the Board would dismiss the issue, namely the failure to establish the Board's jurisdiction over the issue (added late) and the failure to properly develop the merits of the issue in its position paper filings.

2. *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, as stated *supra*.

The Provider failed to include a list of additional Medicaid eligible days they expect to be included in their Medicaid percentage and DSH computations with their appeal request.

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[44] No listing was received, even after repeated requests by the Medicare Contractor, until the Provider's final position paper was filed, four years later.

Board Rule 7.3.2[45] 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.

In this case, 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.[46]

The Provider did not submit a listing of Medicaid Eligible Days until October 24, 2023. The listing included no explanations for the delay in the submission and was labeled "1115 Waiver Days," calling into question whether there were any non-1115 Medicaid Eligible Days on the listing at all. The Board finds the Provider has essentially abandoned the issue by failing to

[44] Provider's Preliminary Position Paper at 8.
[45] v. 2 (Aug. 2018).
[46] *Id*.

properly develop its arguments and to provide supporting documents or to explain why it could not timely produce those documents, as required by the regulations and the Board Rules.[47]

42 C.F.R. § 405.1853 addresses position papers and specifies in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[48]

Similarly, with regard to position papers,[49] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[50] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

Similarly, 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.[51]

[47] *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.
[48] (Emphasis added).
[49] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[50] (Emphasis added).
[51] (Emphasis added).

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.

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 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.

The Board concurs with the Medicare Contractor that the Provider is required to timely identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, 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"[52] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to timely provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what caused the delay with Board Rule 25.2.2. Indeed, based on these facts plus the Provider's failure to timely respond to either the Medicare Contractor's request for the listing and the Medicare Contractor's Jurisdictional Challenge on this issue, the Board must assume that the Provider has abandoned this issue.

[52] (Emphasis added).

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. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25 related to timely identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.[53]

Accordingly, the Board dismisses the DSH Payment – Medicaid Eligible Days issue.

****

In summary, the Board hereby dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 19-1445 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:

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

For the Board:

7/22/2024

X Kevin D. Smith, CPA

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

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

[53] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.

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

Stephanie A. Webster, Esq.
Ropes & Gray LLP
2099 Pennsylvania Ave., NW
Washington, DC 20006-6807

RE: ***Request for Reconsideration of Board's Dismissal of Appeal***
Infirmary LTAC Hospital (Prov. No. 01-2006)
FYE 03/31/2010
Case No. 15-2650

Dear Ms. Webster,

The Provider Reimbursement Review Board ("Board") has reviewed the Request for Reconsideration of Board's Dismissal of Appeal submitted by Infirmary LTAC Hospital ("Provider") on July 1, 2024. The decision of the Board is set forth below.

Pertinent Facts:

On **March 14, 2023**, the Provider filed its individual hearing request, appealing Notices of Program Reimbursement ("NPR") dated November 21, 2014. The request included only the following issue:

- Issue: Outlier Reconciliation – Cost-to-Charge Ratio

On **June 1, 2015**, the Provider was first notified of its initial critical due dates. Since December 11, 2015, due to the ongoing litigation of *Clarian Health West, LLC v. Burwell*, the Provider has been granted multiple extensions and postponements for their Preliminary Position Paper. The Board has recognized that *Clarian*, which addressed similar reconciliation issues, could significantly impact the outcome of the Provider's appeal.

Additionally, on **July 29, 2021**, the PPP deadline was suspended because of PRRB Alert 19 until May 23, 2023. Then, on **May 5, 2023**, the Provider requested another 1-year postponement due to *Clarian*. On **May 8, 2023**, the Board notified the Provider that it was postponing the Provider's preliminary position paper due date to May 24, 2024. Consistent with prior postponements, the Board warned that, absent a Board-approved extension, failure to meet the deadline would result in dismissal:

> Upon review, the Board grants the request and extends the Provider's PPP deadline to May 24, 2024. . . . An updated Critical Due Dates Notice will be issued under separate cover. Absent a

> Board-approved extension, failure of the Provider to file its PPP in compliance with the Updated Notice will result in dismissal.

On **May 9, 2023**, the Board issued a critical due dates notice confirming the May 24, 2024 due date for the Provider's preliminary position paper and again warned that failure to comply would result in dismissal:

> The parties are responsible for pursuing the appeal in accordance with the Board's Rules. The parties must meet the following due dates regardless of any outstanding jurisdictional challenges, motions, or subpoena requests. *If the Provider misses any of its due dates, the Board will dismiss the appeal*.[1]

However, the Provider failed to either: (1) timely request another postponement request; or (2) submit its Preliminary Position Paper by that deadline. Accordingly, on **May 29, 2024**, the Board dismissed the case for untimely filing of its preliminary position paper.

On **July 1, 2024**, the Provider filed its reconsideration request in which its requests the Board to reconsider the dismissal of this appeal and accept the preliminary position paper.

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

On July 1, 2024, the Provider's Representative filed its request that the Board to reinstate their appeal because "a programming glitch in our firm's appeals database" caused them to miss the critical due date and there would be no prejudice to the MAC or the Board due to the numerous extensions already given. The Provider explains that their mistake in missing the deadline was because of a one-off programming glitch in their firm's appeals database. The deadline was inputted and verified in their database but, this case had been postponed various times which triggered a programming glitch, leading to the deadline not being included in their "Critical Due Dates Report." This is the only deadline in their database omitted from their deadlines tracking.

Although the Provider's Representative late-filed their Preliminary Position Paper they assert there would be no prejudice due to *Clarian's* ongoing litigation. This case had been postponed numerous times in the past due to *Clarian's* current litigation which would be determinative in the Provider's Outlier Reconciliation issue. Lastly, the Provider asks the Board to be understanding of how glitches can sometimes occur, like in the Board's own electronic appeals system.

<u>Board's Analysis and Decision:</u>

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

Failure to comply with the Board's deadline for submission of a required filing can be found at 42 C.F.R. § 405.1868:

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[1] (Emphasis added and footnote omitted.)

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

Board Rule 47.1 (Dec. 2023) governs motions to reinstate an issue:

> A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s) (*see* 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (*see* Rule 44 governing motions). *The Board will **not** reinstate an issue(s)/case if the provider was **at fault.*** If an issue(s)/case was remanded pursuant to a CMS ruling (*e.g.*, CMS Ruling 1498-R), the provider must address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board reinstates an issue(s) or case, the provider will have the same rights (no greater and no less) that it had in its initial appeal. These requirements also apply to Rule 47.2 below.[2]

More specifically, Board Rule 47.3 governs Dismissals for Failure to Comply with Board Procedures:

> Upon written motion demonstrating good cause, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, ***administrative oversight***, settlement negotiations or a change in representative will not be considered good cause to reinstate. If the dismissal was for failure to file with

[2] (Emphasis added.)

> the Board a required position paper, Schedule of Providers, or other filing, then the motion for reinstatement must, as a prerequisite, include the required filing before the Board will consider the motion.[3]

The Board will not generally reinstate an appeal that was closed due to untimely filing when the provider is at fault (*e.g*., administrative oversight) but may reinstate if good cause is established. Here, the Provider did not establish "good cause" for its failure to comply with the preliminary paper deadline. Notably, the Provider's preliminary paper had been delayed already for ***ten years***, with ***seven*** extensions for *Clarian Health* litigation, as well as a deadline suspension from 2021 to 2023 pursuant to Alert 19. The failure of the Provider's Representative to file or request an eighth extension, especially because *Clarian Health* was also on its docket, is the fault of the Provider's Representative. The alleged error in the Provider's Representative's "appeals database" system,[4] as admitted by the Provider's Representative, is administrative error/oversight.[5] Board Rule 47.1 and 47.3 state the Board will not reinstate an issue if the Provider was at fault, as here, and administrative oversight is not "good cause" to reinstate. As such, the Board declines to exercise its discretion and denies the request for reconsideration. Accordingly, Case No. 15-2650 remains closed.

Board Members Participating:	For the Board:
Clayton J. Nix, Esq.	7/23/2024
Kevin D. Smith, CPA	
Ratina Kelly, CPA	X Clayton J. Nix
Nicole E. Musgrave, Esq.	Clayton J. Nix, Esq.
Shakeba DuBose, Esq.	Chair
	Signed by: PIV

cc: Wilson C. Leong, Esq., Federal Specialized Services
Cecile Huggins, Palmetto GBA (J-J)

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[3] (Emphasis added.)
[4] The Representative's system appears to be proprietary and within its control as it is "a large, sophisticated database developed over the last two decades that we use to track appeal deadlines and to manage a large amount of other information associated with thousands of cases." Provider's Reinstatement Request at 2.
[5] In this regard, the Board notes that, if this case has been postponed (similar to other cases) multiple times and included in their database multiple times, it is unclear why the alleged system "glitch" only occurred in this one instance and not in other similar situations (whether for this case or other cases). An example is Case No. 21-0392 for this same provider but for a different year which is referenced in the letter but for which an appropriate extension request was timely filed on May 1, 2024.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Baylor Scott & White Medical Center McKinney (Provider Number 67-0082)
FYE: 06/30/2015
Case Number: 19-0172

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-0172. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") SSI Percentage (Provider Specific) payments.

Background

A. *Procedural History for Case No. 19-0172*

On **April 17, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2015. The Provider is commonly owned by Baylor Scott & White Health ("BS&W Health").

On **October 19, 2018**, the Provider filed their individual appeal request. The initial Individual Appeal Request contained ten (10) issues:

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

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[1] On May 30, 2019, this issue was transferred to Case No. 18-1276GC.
[2] On May 30, 2019, this issue was transferred to Case No. 18-1279GC.
[3] On May 30, 2019, this issue was transferred to Case No. 18-1281GC.

5. DSH – Medicaid Eligible Days[4]
6. DSH Medicaid Fraction / Medicare Managed Care Part C Days[5]
7. DSH Medicaid Fraction / Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[6]
8. Uncompensated Care ("UCC") Distribution Pool[7]
9. 2 Midnight Census IPPS Payment Reduction[8]
10. Standardized Payment Amount[9]

As the Provider is commonly owned/controlled by Baylor Scott & White ("BS&W") Health, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **May 30, 2019**, the Provider transferred Issues 2, 3, 4, 6, 7, 8, 9 and 10 to BS&W Health CIRP groups.

On **October 31, 2018**, 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 26, 2019**, the Medicare Contractor timely filed a Jurisdictional Challenge[11] with the Board over Issue 1 requesting that the Board dismiss this issue. Pursuant to Board Rule 44.4.3,

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[4] On July 23, 2024, the Provider withdrew this issue.
[5] On May 30, 2019, this issue was transferred to Case No. 18-1277GC.
[6] On May 30, 2019, this issue was transferred to Case No. 18-1280GC.
[7] On May 30, 2019, this issue was transferred to Case No. 18-1282GC.
[8] On May 30, 2019, this issue was transferred to Case No. 18-1275GC.
[9] On May 30, 2019, this issue was transferred to Case No. 19-1717GC.
[10] (Emphasis added.)
[11] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to timely file a response.

On **June 13, 2019**, the Provider timely filed its preliminary position paper.

On **October 7, 2019**, the Medicare Contractor filed its preliminary position paper.

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

On **May 17, 2024**, the Provider filed its Final Position Paper.

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

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-1276GC – QRS BSWH 2015 DSH SSI Percentage CIRP Group

In their Individual Appeal Request, the Provider summarizes its DSH Payment/SSI Percentage (Provider Specific) issue 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 [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).[12]

The Group issue Statement in Case No. 18-1276GC, to which the Provider transferred Issue No. 2, reads, in part:

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[12] Issue Statement at 1 (Oct. 19, 2018).

> **<u>Statement of the Issue:</u>**
>
> 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?
>
> **<u>Statement of the Legal Basis</u>**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[13]

On June 13, 2019, the Board received the Provider's preliminary position paper in 19-0172. 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 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

[13] Group Appeal Issue Statement in Case No. 18-1276GC.

> 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"), 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).[14]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $28,000.

<u>Provider's Jurisdictional Response</u>

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 did not ***timely*** file a response to the Medicare Contractor's first Jurisdictional Challenge over the SSI Provider Specific issue. 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."

On July 18, 2024, the Provider timely filed a response to the Medicare Contractor's second jurisdictional challenge.[16] In its Response, the Provider did address the SSI Provider Specific challenge, however, as that Response was filed ***more than 5 years*** after the initial Jurisdictional Challenge, the Board will not consider it in its decision.

<u>Decision of the Board</u>

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

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[14] Provider's Preliminary Position Paper at 8-9 (Jun. 13, 2019).
[15] Board Rule 44.4.3, v. 2.0 (Aug. 2018).
[16] The Provider subsequently withdrew the Medicaid Eligible Days issue, therefore it is not addressed in this decision.

within 180 days of the date of receipt of the final determination.

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

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. 18-1276GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[17] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[18] The Provider argues in its issue statement, which was included in the appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[19]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 18-1276GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 19-0172 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 18-1276GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[20], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged

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

"systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[21] 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, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 18-1276GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records"[22] but fails to explain how it can be done, to explain how that information is relevant, and whether or not 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 (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, <u>*and*</u> *explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[23]

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule,

> [b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's

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[21] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[22] Provider's Preliminary Position Paper at 8.
[23] (Italics and underline emphasis added.)

> request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period****.* Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year.

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from CMS as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh. [24]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DHS data."[25]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 18-1276GC.

Accordingly, *based on the record before it*, the Board finds that the SSI Provider Specific issue in Case No. 19-0172 and the group issue from the CHS CIRP group under Case No. 18-1276GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

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 . . . ." Without this

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[24] Last accessed July 23, 2024.
[25] Emphasis added.

written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board dismisses this aspect of the appeal.

* * * * *

Based on the foregoing, the Board has dismissed the remaining issue in this case. As no issues remain, the Board hereby closes Case No. 19-0172 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:

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

For the Board:

7/24/2024

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Member
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***
Novant Health Rowan Medical Center (Provider Number 34-0015)
FYE: 12/31/2015
Case Number: 19-2397

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-2397. Set forth below is the decision of the Board to dismiss the two 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. 19-2397*

On **August 12, 2019**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained two (2) issues:

1. DSH Medicaid Eligible Days
2. DSH Payment/SSI Percentage (Provider Specific)

On **August 14, 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 **April 2, 2020**, the Provider filed its Preliminary Position Paper. With respect to Issue 1, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover.[2] 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' 2015 cost report does not reflect an accurate number of Medicaid eligible days."[3]

On **July 31, 2020**, the Medicare Contractor filed its Preliminary Position Paper.

On **May 1, 2024**, the Provider filed its Final Position Paper. The Medicare Contractor filed its Final Position Paper on **May 29, 2024.**

On **June 3, 2024**, the Medicare Contractor filed a Jurisdictional Challenge over Issue 1: Medicaid Eligible Days and Issue 2: DSH SSI Percentage (Provider Specific). The Provider did not file a response.

On **June 13, 2024**, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission". The Listing was a single page with roughly 60 Medicaid eligible days. QRS' filing did not explain why the listing of eligible days was being submitted at this late date.

Only **July 5, 2024**, the Provider requested a 180-day postponement for the MAC to sample the listing provided.

A. Description of Issue 2 in the Appeal Request and the Provider's Participation in Case No. 19-1519GC – Novant Health CY 2015 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' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]

[1] (Emphasis added.)
[2] Provider's Preliminary Position Paper at 8 (April 2, 2020).
[3] *Id.*

> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> The Provider 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).[4]

The Group Issue Statement in Case No. 19-1519GC, to which the Provider was directly added, 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

[4] Issue Statement (Aug. 12, 2019).

> procedures.[5]

On April 2, 2020, the Board received the Provider's preliminary position paper in 19-2397. The following is the Provider's ***complete*** position on Issue 2 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 their calculation based on the Provider's Fiscal Year End (December 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services,* No. CV-94-0055 (C.D. Cal June 2, 1995), the SSI entitlement of individuals can be ascertained from [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"), 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]

<u>MAC's Contentions</u>

Issue 1 – DSH – Medicaid Eligible Days

The MAC argues the Provider is attempting to add the Section 1115 Waiver days issue improperly and untimely. The MAC maintains that Section 1115 Wavier days are a separate and distinct issue. There was no mention of Section 1115 waiver days as part of the original appeal request or preliminary position paper.

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[5] Group Appeal Issue Statement in Case No. 19-1519GC.
[6] Provider's Preliminary Position Paper at 8-9 (April 2, 2020).

Additionally, this issue should be dismissed because the Provider failed to file a complete position paper 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.[7]

Accordingly, the Medicare Contractor requests that the Board dismiss Issue 1.

Issue 2 – DSH Payment/SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. The MAC states that "[i]ssue 2 has two sub-components: 1) SSI data accuracy; 2) SSI realignment. The MAC contends that the portion of Issue 2 concerning data accuracy should be dismissed, as it is duplicative of the issue in Group Case No. 19-1519GC."[8] 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]

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. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Similarly, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Decision of the Board

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

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

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[7] Medicare Contractor's Jurisdictional Challenge at 1 (June 3, 2024)
[8] *Id.* at 12.
[9] *Id.* at 14-15.
[10] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

A. 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…[11]

Board Rule 7[12] elaborated on this regulatory requirement instructing providers:

> **7.2.1 General Information**
>
> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>   - the adjustment, including the adjustment number,
>   - the controlling authority,
>   - why the adjustment is incorrect,
>   - how the payment should be determined differently,
>   - the reimbursement effect, and
>   - the basis for jurisdiction before the PRRB.
> - A copy of the applicable audit adjustment report page(s) or

[11] 42 C.F.R. § 405.1835(b).
[12] v. 2 (Aug. 2018).

a statement addressing why an adjustment report is not applicable or available.

- A calculation or other support for the reimbursement effect noted in the issue statement.
- Support for protested items or claim of dissatisfaction as noted in Rules 7.3 and 7.4.

Board Rule 8[13] 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: 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.[14]

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.[15] 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 in a proper or timely fashion.

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[13] *Id*.
[14] (Emphasis added).
[15] *See* 73 Fed. Reg. 30190 (May 23, 2008).

In this regard, the Board notes that section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[16] 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. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, 42 C.F.R. § 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 **<u>or</u> 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

[16] 65 FR 47054, 47087 (Aug. 1, 2000).

be construed to include section 1115 Waiver days. Additionally, there is no indication that any 1115 waiver days were included with the as-filed cost report and, if they were not included, they would be considered an unclaimed cost and, thus, provide an independent basis for dismissal.

B. DSH Payment – Medicaid Eligible Days

The Provider did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal in either the initial appeal or the 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.[17]

The regulations require the parties to fully brief the merits of each issue in their position papers (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.

[17] (Bold emphasis added.)

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

Rule 25 Preliminary Position Papers[18]

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

25.1 Content of Position Paper Narrative

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

25.1.1 Provider's Position Paper

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

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

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to 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 August 14, 2019, included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 1, 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.[19]

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 2, 2020, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent, promising that the listing was being sent under separate cover.[20] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case. The Provider's complete briefing of this issue in its position paper is as follows:

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[19] (Emphasis added.)
[20] Provider's Preliminary Position Paper at 8 (April 2, 2020).

Calculation of Medicaid Eligible Days

> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
>> [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2015 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[21]

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.[22]

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[21] Provider's Preliminary Position Paper at 7-8.
[22] Medicare Contractor's Jurisdictional Challenge at 1 (June 3, 2024).

On June 13, 2024, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission". The Listing was one page in length with roughly 60 Medicaid eligible days. QRS' filing did not explain why the listing of eligible days was being submitted at this late date and was over 4 years past the deadline for including it with its preliminary position paper, since the position paper deadline was April 8, 2020.

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

The fact that the Listing was filed one month after the Provider changed its designated representative to QRS does not excuse the Provider for its failure to include the information, as required, with its preliminary position paper 4 years earlier or its failure to timely respond to the Jurisdictional Challenge. Board Rule 5.2 makes clear that "the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings." Moreover, the Board rejects the Provider's attempt to label the June 13, 2024 filing as a "Supplement to Position Paper" and does not accept that filing because:

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

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); and (b) *why* the listing of days was not previously available, *in whole or in part*;

3. Neither the Board Rules nor the August 14, 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.[23]

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

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

C. DSH Payment/SSI Percentage (Provider Specific)

The analysis for Issue No. 2 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 2*

The first aspect of Issue No. 2—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 issue that was appealed in Case No. 19-1519GC.

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

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

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[26] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[27] 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."[28]

The Provider's DSH/SSI Percentage issue in group Case No. 19-1519GC 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. 19-2397 is duplicative of the DSH/SSI Percentage issue in Case No. 19-1519GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[29], 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.[30] 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, 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. 19-1519GC, 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"[31] but fails to explain how this can be done, to explain how that information is relevant, and whether or not 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

[26] Issue Statement at 1.
[27] *Id.*
[28] *Id.*
[29] PRRB Rules v. 2.0 (Aug. 2018).
[30] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[31] Provider's Preliminary Position Paper at 8.

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 2 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.[32]

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 CMS as explained on the following webpage:

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[32] (Italics and underline emphasis added.)

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[33]

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."[34]

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. 19-1519GC.

Accordingly, *based on the record before it*,[35] the Board finds that the SSI Provider Specific issue in Case No. 19-2397 and the group issue from the CIRP group under Case No. 19-1519GC 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 . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board dismisses this aspect of the appeal.

* * * *

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. 19-2397 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

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[33] Last accessed July 23, 2024.
[34] Emphasis added.
[35] 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 Members Participating:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

7/26/2024

X Kevin D. Smith, CPA

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

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