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 - SSI Percentage (Provider Specific), Medicaid Eligible Days & Uncompensated Care Distribution Pool Issues***
North Okaloosa Medical Center (Prov. No. 10-0122)
FYE 03/31/2016
Case No. 19-1033

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-1033. Set forth below is the decision of the Board to dismiss the 3 remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific), Medicaid Eligible Days, and Uncompensated Care ("UCC") payments.

Background

A. *Procedural History for Case No. 19-1033*

On **July 20, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end March 31, 2016.

On **January 14, 2019**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **August 23, 2019**, the Provider transferred Issues 2 and 5 to CHS CIRP groups.

[1] On August 23, 2019, this issue was transferred to Case No. 19-1409GC.
[2] On August 23, 2019, this issue was transferred to Case No. 19-1410GC.

As a result of the case transfers, there are three (3) remaining issues in this appeal: Issue 1 (the DSH – SSI Percentage Provider Specific), Issue 3 (the DSH – Medicaid Eligible Days), and Issue 4 (UCC Distribution Pool).

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

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[3]

On **May 6, 2019**, the Medicare Contractor timely filed a Jurisdictional Challenge[4] with the Board over Issues 1, 4 and 5, 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's response was received on **June 7, 2019**, which was 2 days after the due date.

On **September 6, 2019**, the Provider timely filed its preliminary position paper. With respect to Issue 3, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days." As a result, the Provider included, as an Exhibit, the original "estimated impact" for this issue of $72,000 based on an *estimated* 100 days.

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[3] (Emphasis added.)

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

On **January 3, 2020**, the Medicare Contractor filed its preliminary position paper. With regard to Issue 3, the Medicare Contractor's position paper noted that: (1) the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position; and (2) the Provider had failed to respond to any of the Medicare Contractor's requests for that Medicaid eligible days listing.

On **November 14, 2022**, the Medicare Contractor timely filed an additional Jurisdictional Challenge with the Board over Issue 3, requesting that the Board dismiss this issue. The Provider timely filed a response on **December 14, 2022**.

On **December 15, 2022**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

As no response was received from the Provider, on **December 28, 2022**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to furnish documentation in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); (2) the Provider failed to furnish the Medicaid eligible days listing with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2; and (3) the Provider has effectively abandoned Issue 3. Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** timely respond to that Motion.

On **April 5, 2024**, the Board issued the Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

> Provider's Final Position Paper – *For each remaining issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *also include* ***any exhibits*** *the Provider will use to support to support its position*. *See* Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.[5]

On **August 19, 2024**, the Provider timely filed its final position paper. With respect to Issue 3, for the first time in the appeal, the Provider addresses section 1115 waiver days.

On **September 3, 2024**, Medicare Contractor timely filed a superseding Jurisdictional Challenge with the Board over Issues 1, 3 and 4, requesting that the Board dismiss these issues. The

[5] (Emphasis added.)

Medicare Contractor asked the Board to disregard the May 6, 2019 and November 14, 2022 Jurisdictional Challenges, as it argues that several facts of the case had changed since those filings. Additionally, the Medicare Contractor asked that the Board rule on the outstanding December 28, 2022 Motion to dismiss Issue No. 3. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider's response was received on **October 8, 2024**, which was 5 days after the due date.

On **September 11, 2024**, the Medicare Contractor timely filed its final position paper.

On **October 22, 2024**, almost 21 months after the deadline for responding to the Motion to Dismiss Issue 3, QRS filed a "Redacted Medicaid Eligible Days Listing Submission." The Listing was 6 pages with roughly 799 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 799 days) was being submitted at this late date, ***more than 8 years after the fiscal year at issue had closed***. NOTE—the roughly 799 included in this belated listing is much larger than the original *estimated* impact of 100 days included with the appeal request.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-1409GC - CHS CY 2016 DSH SSI Percentage CIRP Group

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

> The Provider contends that its' 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

[6] Issue Statement at 1 (Jan. 14, 2019).

> Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[7]

On September 6, 2019, the Board received the Provider's preliminary position paper in 19-1033. 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 (March 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.

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

> 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).[8]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $32,000.

C. Description of Issue 3 in the Appeal Request

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

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

[8] Provider's Preliminary Position Paper at 8-9 (Sept. 6, 2019).

Audit Adjustment Number(s): 5,6,23,S-D

Estimated Reimbursement Amount: $72,000[9]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the Jewish Hospital case[10] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[11]

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2. The portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[12] The MAC also argues that Issue 1 should be dismissed because the Provider failed to file a complete preliminary or final position paper.[13]

Issue 3 – DSH Payment – Medicaid Eligible Days

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

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

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)."[14]

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[9] Appeal Request at Issue 3.
[10] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[11] Provider's Preliminary Position Paper at 7.
[12] Medicare Contractor's Jurisdictional Challenge at 2 (Sept. 3, 2024)
[13] *Id*.
[14] *Id.* at 20.

The MAC also contends that this issue is a duplicate of PRRB Case Nos. 15-1334GC and 16-0769GC and should therefore be dismissed.[15]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[16] The Provider filed a response to the Jurisdictional Challenge, but the time for doing so had elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

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

Decision of the Board

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

As set forth below, the Board hereby ***dismisses*** the Provider's three (3) remaining issues.

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider 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. 19-1409GC.

[15] *Id*. at 21.
[16] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[17] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[18] The Provider argues in its issue statement, which was included in the appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[19]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 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. 19-1033 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[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" but fails to explain how it can, explain how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2.[22] Moreover, the Board

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

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

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

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[23]

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

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

group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

[23] (Italics and underline emphasis added.)

[24] Last accessed Oct. 15, 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."[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. 19-1409GC.

Accordingly, *based on the record before it*,[26] the Board finds that the SSI Provider Specific issue in Case No. 19-1033 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. DSH Payment – Medicaid Eligible Days

1. *Section 1115 Waiver Days*

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

The appeal was filed with the Board in January of 2019 and the regulations required the

[25] (Emphasis added).
[26] Again, the Board notes that the Provider failed to ***timely*** respond to the Jurisdictional Challenges and the Board must make its determination based on the record before it.

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…[27]

Board Rule 7.2.1[28] elaborated on this regulatory requirement instructing providers:

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

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

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include:

[27] 42 C.F.R. § 405.1835(b).
[28] v. 2.0 (Aug. 2018).

…

- ***Section 1115 waiver days (program/waiver specific)***[29]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[30]
42 C.F.R. § 405.1835(e) provides in relevant part:

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

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

In this regard, the Board notes that section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[31] Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program ***and*** not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction.[20] In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

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

computation, the following requirements apply:

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

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

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

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

2. *Medicaid Eligible Days*

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

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

No Access to Data

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

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

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[32]

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

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

> **Rule 25 Preliminary Position Papers**[33]
>
> **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.

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

25.1.1 The Provider's Position Paper

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

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

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

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

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

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[34]

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

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

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

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

- if it has reasonable basis to believe that the issues have been

[34] (Emphasis added.)

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

On September 6, 2019, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[35] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $72,063 based on an estimated 100 days). The Provider's complete briefing of this issue in its position paper is as follows:

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

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

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

In its Motion to Dismiss, the Medicare Contractor asserts that the Provider has failed to submit a 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.

Due to the non-responsiveness of the Provider, on **December 28, 2022**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish the list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2. The Medicare Contractor thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the regulations and the Board Rules.[36]

Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** to timely respond to that Motion by the January 27, 2023 filing deadline (*i.e.*, 30 days after December 28, 2022).

However, on October 22, 2024 (21 months after the deadline to respond to the Motion), QRS filed a "Redacted Medicaid Eligible Days Listing Submission". The Listing was 6 pages with roughly 3000 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 3000 days) was being submitted at this late date or why it was not final (*i.e.*, why it was "pending finalization") at this late date, ***more than 6 years after the fiscal year at issue had closed***. NOTE—the roughly 799 included in this belated listing is *exponentially* larger than the original estimate of 100 days included with the appeal request. Regardless, this filing was nearly 21 months past the deadline for responding to the Motion to Dismiss *and, more importantly,* ***was roughly 5 years past the deadline for including it with its preliminary position paper*** since the position paper deadline was September 11, 2019.

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

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 change in the designated representative to QRS does not excuse the Provider for its failure to include the information with its preliminary position paper or its failure to timely respond to the Motion to Dismiss. Board Rule 5.2 makes clear that "the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings." Moreover, the Board rejects the October 22, 2024 filing because:

1. The listing was filed ***more than 5 years*** *after the deadline* for that exhibit to be included with its preliminary position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)). Indeed, the Provider failed to timely reply to the Medicare Contractor's Motion to Dismiss Issue 3 and the listing was filed ***nearly 21 months*** *after the deadline* for filing a response to the Motion to Dismiss Issue 3.

2. The listing fails to explain the following critical information: (a) *why* it was being filed so late (*i.e.*, upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the roughly 799 days was not previously available, *in whole or in part* (*i.e.*, it is not clear why the Provider failed to identify a single day at issue until more than 5 years after this appeal was filed and more than 8 years after the fiscal year at issue had closed).

3. Neither the Board Rules nor the February 8, 2019 Case Acknowledgment and Critical Due Dates permit the Provider to file a supplement to its preliminary position paper (nor did the Provider allege in the listing filing that they do).

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

> (indeed the 799 days listed is, without explanation, *exponentially* larger than the original estimated 100 days included with the appeal request).[37]

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[38] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provider the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[39]

C. UCC Distribution Pool

Last, the Board finds that it does not have jurisdiction over the DSH UCC payment issue in the above-referenced appeal because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).

1. Bar on Administrative Review

The Board does not generally have jurisdiction over Uncompensated Care DSH payment issues because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation. Based on these provisions, judicial and administrative review is precluded under 42 U.S.C. §§ 1395ff and 1395oo for:

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[37] *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."

[38] (Emphasis added.)

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

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

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[40]

(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*"),[41] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[42] 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."[43] 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.[44]

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.[45]

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[40] 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.
[41] 830 F.3d 515 (D.C. Cir. 2016).
[42] 89 F. Supp. 3d 121 (D.D.C. 2015).
[43] 830 F.3d 515, 517.
[44] *Id.* at 519.
[45] *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*").

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*").[46] 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."[47] 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.[48]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[49] 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.[50] 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.[51] 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.[52] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[53]

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

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[46] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[47] *Id.* at 506.
[48] *Id.* at 507.
[49] 514 F. Supp. 249 (D.D.C. 2021).
[50] *Id.* at 255-56.
[51] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[52] *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.
[53] *Id.*

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.[54]

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."[55] 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.[56] 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.[57]

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.[58] 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*").[59] 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.[60] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3)

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[54] *Id.* at 262-64.
[55] *Id.* at 265.
[56] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[57] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[58] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[59] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[60] *Id*. at *4.

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."[61] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[62] 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***."[63]

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 has dismissed the three (3) remaining issues in this case – (Issues 1, 3 and 4). As no issues remain, the Board hereby closes Case No. 19-1033 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

11/4/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

[61] *Id.* at *9.
[62] 139 S. Ct. 1804 (2019).
[63] *Ascension* at *8 (bold italics emphasis added).

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Tampa General Hospital (Provider Number 10-0128)
FYE: 9/30/2009
Case Number: 24-0491

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request of Tampa General Hospital ("Tampa" or "Provider") filed by Tampa's designated representative, Stephanie Webster of Ropes & Gray, LLP ("Ropes & Gray") on December 14, 2023 to establish the above-referenced individual appeal pertaining to Tampa's fiscal year ("FY") 2009. Set forth below is the decision of the Board to dismiss Tampa's appeal.

Issue in Dispute

On **December 14, 2023**, Ropes & Gray filed Tampa's appeal request and identified the determination being appealed as the publication of "CMS 1739-F SSI Ratios" on CMS' website. These ratios were published pursuant to CMS-1739-F,[1] which officially established the retroactive policy concerning the treatment of Part C Days for calculating a hospital's disproportionate share percentage for cost reporting periods starting before fiscal year 2014 in response to the Supreme Court's ruling in *Azar v. Allina Health Services*.[2] SSI Ratios are published annually and available on CMS' website.[3]

The issue in this appeal, per the Provider, "is the proper treatment in the Medicare disproportionate share hospital ("DSH") calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Allina* litigation. The Provider contends that part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction for patients eligible for Medicaid."[4]

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[1] *Available at* https://public-inspection.federalregister.gov/2023-12308.pdf (last visited Nov. 7, 2024).
[2] 139 S. Ct. 1804 (2019).
[3] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/disproportionate-share-hospital-dsh (last visited Nov. 7, 2024).
[4] Issue Statement at 1 (Dec. 14, 2023).

The Provider has appealed the publication of SSI ratios on CMS' website but makes clear that it is seeking to challenge the CMS policy adopted in the June 2023 Final Rule[5] to be applied *retroactively* for periods prior to October 1, 2013[6] and estimates the amount in controversy as $1,230,772 for its FY 2009.[7]

Statutory and Regulatory Background

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[8] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[9]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[10] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[11]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[12] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[13] The DPP is defined as the sum of two fractions expressed as percentages.[14] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both of these fractions consider whether a patient was "entitled to benefits under part A."

The statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) defines the Medicare/SSI fraction as:

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

[5] 88 Fed. Reg. 37772 (June 9, 2023).
[6] Issue Statement at 1. ("The Provider challenges as invalid CMS's final determination on remand of this issue in the DSH SSI fraction for this cost year published on or about August 11, 2023, reflecting the payment standard adopted in the June 9, 2023, Federal Register publication ("CMS-1739-F"), 88 Fed. Reg. 37,772 (June 9, 2023).")
[7] Appeal Request (Dec. 14, 2023).
[8] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[9] *Id.*
[10] *See* 42 U.S.C. § 1395ww(d)(5).
[11] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[12] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[13] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[14] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).

> supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[15]

The Medicare/SSI fraction is computed annually by the Centers for Medicare and Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[16]

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[17]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[18]

B. Establishment of Medicare Part C and Treatment of Part C Days in the DSH Calculation

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations ("HMOs") and competitive medical plans ("CMPs") is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to an eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A and enrolled under part B . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In the September 4, 1990 Federal Register, the Secretary[19] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it

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

> is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[20]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[21]

With the creation of Medicare Part C in 1997,[22] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C and, following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[23] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[24] The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[25]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.[26] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare

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[20] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[21] *Id.*
[22] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[23] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[24] *Id.*
[25] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[26] 69 Fed. Reg. 28196, 28286 (May 18, 2004).

fraction of the DSH calculation."[27] In response to a comment regarding this change, the Secretary explained that:

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[28]

This statement would require inclusion of Medicare Part C inpatient days in the Medicare fraction of the DSH calculation.

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[29] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[30] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[31]

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[27] 69 Fed. Reg. at 48916, 49099 (Aug. 11, 2004).
[28] *Id.* (emphasis added).
[29] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[30] *Id*. at 47411.
[31] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

There has been substantial litigation over whether enrollees in Part C plans are "entitled to benefits" under Medicare Part A when determining their placement in either the DSH Medicare or Medicaid fraction.

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[32] In 2014, the U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[33] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[34] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[35] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[36] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.[37] A number of hospitals appealed this action.[38] In *Azar v. Allina Health Services* ("*Allina II*"),[39] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[40] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[41] The Supreme Court did not reach the question of

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[32] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[33] 746 F. 3d 1102 (D.C. Cir. 2014).
[34] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[35] *Id.* at 2011.
[36] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[37] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[38] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(ii). Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo**(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell,* No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result*, the [9] plaintiff Hospitals timely filed appeals to the Board, **pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B),*** to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[39] 139 S. Ct. 1804 (2019).
[40] *Id.* at 1817.
[41] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.

whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[42]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[43] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in *Allina [II]*":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[44]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[45] The June 2023 Final Rule provides the following guidance on the extent to which it is to be applied *retroactively*:

> [T]he Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals whose DSH payments ***for those periods are still open or have not yet been finally settled***, encompassing thousands of cost reports.[46]

Further, the June 2023 Final Rule provided the following clarification on the intent and purpose

[42] 139 S. Ct. at 1814.
[43] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[44] CMS Ruling 1739-R at 1-2.
[45] 88 Fed. Reg. 37772 (June 9, 2023).
[46] *Id.* at 37774 (emphasis added).

of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[47]

Finally, the following excerpts from the June 9, 2023 Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule or subsequent publication of SSI ratios to be an appealable "final determination":

1. Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports***. *In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days.[48]

2. We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation**

[47] 88 Fed. Reg. at 37788.
[48] 88 Fed. Reg. at 37774-75 (emphasis added).

adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action.[49]

3. Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically.[50]

4. *When the Secretary's treatment of Part C days in this final action is reflected* ***in NPRs and revised NPRs****, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation* ***by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings.[51]

The above discussion in the preamble to the June 9, 2023 Final Rule makes clear that hospitals covered by that Final Rule would have appeal rights maturing with the yet-to-be-issued NPRs (original or revised) that would both apply the finalized policy and be used to determine DSH eligibility for a hospital's prior period that is still open for resolution (whether through issuance of an original or revised NPR)[52] and, if so, the amount of the DSH payment.

Tampa's Appeal Request

The Provider's appeal request included a "Statement of Jurisdiction" asserting that the Provider had met the applicable statutory conditions for appeal because: (1) it is "dissatisfied with the Secretary's newly issued SSI fractions that include part C days." and (2) "the estimated $1,230,772 amount in controversy for this appeal reflected in the accompanying worksheet exceeds $10,000."[53] The Provider noted its appeal is being taken under 42 U.S.C.

[49] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[50] *Id.* at 37788 (emphasis added).
[51] *Id.* (emphasis added).
[52] Just because a hospital was eligible for a DSH payment in the original NPR, does not mean that the hospital would *continue* to be eligible for a DSH payment following the issuance of a revised NPR pursuant to the June 9, 2023 Final Rule. Similarly, the converse may be true. As such, a hospital's eligibility status may change following the issuance of a revised NPR pursuant to the June 9, 2023 Final Rule. Moreover, there could be other DSH variables at play in the NPR/revised NPR such as consideration of Medicaid eligible days (removal or addition of such days) depending on what other issues may remain open in the relevant fiscal year.
[53] Appeal Request, Statement of Jurisdiction at 1-2 (citations omitted) (Dec. 14, 2023).

§ 1395oo(a)(1)(A)(ii) from the publication of its SSI fraction.[54]

The Statement of Issue included with the appeal request states that the issue concerns the proper treatment in the Medicare DSH calculation of days for Medicare Part C patients "in the aftermath of the *Allina II* litigation."[55] The Provider contends that part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.[56] Pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(ii) and *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 149 (D.C. Cir. 1986), the Provider insists it "need not wait until an NPR has been issued" to appeal this final determination.[57] It also cites *Battle Creek Health Sys. v. Becerra*,[58] which held (in direct contrast to precedent in the same judicial circuit) that the publication of SSI ratios *is* an appealable final determination.[59]

The Provider maintains that the SSI fraction is "substantively and procedurally invalid . . . arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[60] It argues that CMS "has misconstrued the legal effect of the vacatur of the 2004 Rule in *Allina Health Servs. v. Sebelius"*[61] and "violated the prohibition against retroactivity in 42 U.S.C. § 1395hh(e)."[62] It also takes issue with the promulgation of the policy, arguing it is arbitrary and capricious due to the alleged failure to adequately explain or acknowledge the impacts of this policy.[63]

Decision of the Board

The Provider has appealed the publication of its SSI fraction pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(ii), which allows an appeal from a Secretary determination. Specifically, this statutory provision allows an appeal if a provider:

> (ii) is dissatisfied with a final determination of the Secretary **as to the amount of the payment** under subsection (b) or (d) of section 1395ww of this title

Pursuant to 42 C.F.R. § 405.1835(a)(1), an individual provider generally has a right to a hearing before the Board "with respect to a final contractor or Secretary determination ***for the provider's cost reporting period***"[64] if:

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[54] *Id.*
[55] Appeal Request, Statement of Issue at 1 (Dec. 14, 2023).
[56] *Id.*
[57] Appeal Request, Statement of Jurisdiction at 1.
[58] No. 17-cv-545 (CKK), 2023 WL 7156125, at *4 (D.D.C. Oct. 31, 2023).
[59] Appeal Request, Statement of Jurisdiction at 1-2.
[60] Appeal Request, Statement of Issue at 1.
[61] 746 F.3d 1102, 1105 (D.C. Cir. 2014).
[62] Appeal Request, Statement of Issue at 2.
[63] *Id.*
[64] 42 C.F.R. § 405.1835(a) (emphasis added).

- It "is dissatisfied *with the contractor's final determination of the total amount of reimbursement* ***due the provider***, as set forth in the contractor's written notice specified under § 405.1803."[65] In other words, providers must appeal from a "final determination" that impacts payment for the period under appeal.[66]

- The request for a hearing is filed within 180 days of the date of receipt of the final determination.

- The amount in controversy is $10,000 or more.[67]

Satisfying the criteria set out in 42 C.F.R. § 405.1835(a) is required before the Board can exercise jurisdiction over an appeal.[68]

42 C.F.R. § 405.1835(b) specifically requires that a provider's request for a hearing must meet the requirements of paragraph (b), subsections (1-4), and paragraph (b)(1) specifically notes that the hearing request must include "[a] demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a)." Specifically, subsection (b) states in pertinent part:

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

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[65] 42 C.F.R. § 405.1835(a)(1) (emphasis added).
[66] *See also* 42 U.S.C. § 1395oo(a)(1)(A); *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-146 (D.C. Cir. 1986) (stating: "Viewing the amendments as a whole, we are inescapably drawn to the same conclusion as the District Court: § 1395oo (a) 'clearly contemplates two different kinds of appeal. One begins when the intermediary issues an NPR; the other, when the intermediary issues a notice of ***what will be paid*** *under the PPS system*.' . . . . Under PPS, in contrast, ***payment amounts*** are independent of current costs and *can be determined with finality* prior to the beginning of the cost year. Id. § 412.71(d). Thus a year-end cost report is not a report which is necessary ***in order for the Secretary to make PPS payments***, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal." (emphasis added and citations omitted)).
[67] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[68] 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 claim filing requirements such as timelines or filing deadlines. However, whether an appeal was timely is not a jurisdictional requirement but rather is a claim filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013). *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*. Similarly, the Board notes that 42 C.F.R. § 405.1835(b) addresses claim filing requirements.

> **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 . . . 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.
>
> ****
>
> (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**.[69]

42 C.F.R. § 405.1801(a) defines the term "contractor determination" as including:

> (2) With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (part 412 of this chapter), the term means a final determination of the total amount of payment due the hospital, pursuant to § 405.1803 following the close of the hospital's cost reporting period, under that system for the period covered by the final determination.
>
> (3) For purposes of appeal to the Provider Reimbursement Review Board, the term is synonymous with the phrases "intermediary's final determination," "final determination of the organization serving as its fiscal intermediary," "Secretary's final determination" and "final determination of the Secretary," as those phrases are used in section 1878(a) of the Act, and with the phrases "final contractor determination" and "final Secretary determination" as those phrases are used in this subpart.

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

A. Appealability of Published SSI Fractions

Unlike DRG rates and other adjustments such as the wage index,[70] a hospital's eligibility for a DSH payment (and, if eligible, the amount of that payment) during a particular fiscal year is not ***prospectively*** set or determined as part of the relevant IPPS final rule. In this regard, 42 U.S.C. § 1395ww(d)(5)(F) refers to the DSH adjustment being calculated "with respect to a [hospital's] cost reporting period" and uses days associated with inpatient stays *occurring during that cost reporting period*.[71] To this end, DSH eligibility ***and*** payment, if any, is determined, calculated, and finalized *annually* through the cost report audit/settlement process as made clear in 42 C.F.R. § 412.106(i) which sets forth the following instructions regarding the determination of a hospital's eligibility for a DSH payment for each fiscal year and, if so, how much:

> (i) *Manner and timing of [DSH] payments*. (1) **Interim** [DSH] **payments** are made **during the payment year to each hospital that is estimated to be eligible** for payments under this section at the time of the annual final rule for the hospital inpatient prospective payment system, **subject to the final determination of eligibility at the time of cost report settlement for each hospital**.
>
> (2) **Final payment determinations are made at the time of cost report settlement**, based on the **final** determination of each hospital's eligibility for payment under this section.[72]

The Secretary makes clear that this regulation is based on "our ***longstanding*** *process* of making ***interim*** *eligibility* determinations for Medicare DSH payments *with* ***final*** *determination* ***at cost report settlement***."[73] Examples of other adjustments to IPPS payment rates that are based, in

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[70] Another example is the Two-Midnight Rule which impacted *prospectively* set payment rates.

[71] The Board notes that the Medicare DSH adjustment provision under 42 U.S.C. § 1395ww(d)(5)(F) was enacted by § 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and became effective for discharges occurring on or after May 1, 1986. Pub. L. 99-272, § 9105, 100 Stat. 82, 158-60. As such, it was enacted several years after the initial legislation that established the IPPS.

[72] (Italics emphasis in original and bold and underline emphasis added.) This section was added as part of the FY 2014 IPPS Final Rule. 78 Fed. Reg. 50496, 50646, (Aug. 19, 2013). It was initially codified at § 412.106(h) (*id.*) but was later redesignated as § 412.106(i) (87 Fed. Reg. 48780, 49049 (Aug. 10, 2022)).

[73] 78 Fed. Reg. at 50627. *See also* Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2807.2(B)(5) (last revised Aug. 1993, Transmittal 371) (stating: "*At* ***final*** ***settlement*** *of the cost report*, the intermediary determines the final disproportionate share adjustment based on the actual bed size and disproportionate share patient percentage for the cost reporting period." (emphasis added)). In the preamble to the FY 2014 IPPS Final Rule, the Secretary discussed the DSH eligibility and payment process and the following are excerpts from that discussion:

> *Comment*: Several commenters requested that CMS undertake additional audits to verify the data used to compute the 25-percent empirically justified Medicare DSH payment adjustments. Other commenters requested that CMS grant additional time for hospitals to verify the data and adjust their cost reports to ensure that the data used to compute the adjustment are accurate and up to date. Some commenters requested that CMS establish procedures to allow a hospital initially determined not to be

whole or in part, on certain data/costs claimed on the as-filed cost report and then determined and reimbursed through the cost report audit and settlement process include bad debts,[74] direct graduate medical education ("GME"),[75] and indirect GME.[76]

The Provider is not appealing the published SSI Fractions pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(i), but rather pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(ii), which allows an appeal from a Secretary determination. This was the same provision relied upon for the

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> eligible for Medicare DSH payments to begin receiving empirically justified Medicare DSH payments if data become available that indicate that the hospital would be eligible.
> *Response*: As we have emphasized, we are maintaining the well-established methodology and payment processes used under the current Medicare DSH payment adjustment methodology for purposes of making the empirically justified Medicare DSH payment adjustments. Hospitals are quite familiar with the cost reporting requirements and auditing procedures employed under the current Medicare DSH payment adjustment methodology. Hospitals are also familiar with the current process of determining **interim eligibility** for Medicare DSH payments **with <u>final determination</u> at cost report settlement**. Therefore, we do not believe that it would be warranted to add additional complexity to these procedures by adopting any of these recommendations.
>
> ****
>
> For the reasons discussed above regarding the empirically justified Medicare DSH payments [*i.e.*, the DSH payment calculation made under 42 U.S.C. § 1395ww(d)(5)(F)], we do not believe that it is necessary or advisable to depart from our longstanding process of making <u>interim eligibility</u> determinations for Medicare DSH payments with <u>final determination</u> at cost report settlement. As we discuss in greater detail in section V.E.3.f. of the preamble to this final rule, we will make interim eligibility determinations based on data from the most recently available SSI ratios and Medicaid fractions prior to the beginning of the payment year. We will then make final determinations of eligibility at the time of settlement of each hospital's cost report.
>
> ****
>
> Therefore, we proposed that, at cost report settlement, the fiscal intermediary/MAC will issue a notice of program reimbursement that includes a determination concerning whether each hospital is eligible for empirically justified Medicare DSH payments and, therefore, eligible for uncompensated care payments in FY 2014 and each subsequent year. In the case where a hospital received interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year on the basis of estimates prior to the payment year, but is determined to be ineligible for the empirically justified Medicare DSH payment at cost report settlement, the hospital would no longer be eligible for either payment and CMS would recoup those monies. For a hospital that did not receive interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year, but at cost report settlement is determined to be eligible for DSH payments, the uncompensated care payment for such a hospital is calculated based on the Factor 3 value determined prospectively for that fiscal year.

Id. at 50626-27, 50646 (emphasis added).

[74] 42 C.F.R. §§ 412.2(f)(4), 412.115(a) (stating: "An additional payment is made to each hospital in accordance with § 413.89 of this chapter for bad debts attributable to deductible and coinsurance amounts related to covered services received by beneficiaries.).

[75] 42 C.F.R. § 412.2(f)(7) (stating that hospitals receive an additional payment for "[t]he direct graduate medical education costs for approved residency programs in medicine, osteopathy, dentistry, and podiatry as described in §§413.75–413.83 of this chapter.").

[76] 42 C.F.R. §§ 412.2(f)(2), 412.105. *See also* PRM 15-1 § 2807.2(B)(6) (stating: "*At **<u>final</u> settlement** of the cost report*, the intermediary determines the indirect teaching adjustment based on the actual number of full time equivalent residents and average daily census for the cost reporting period." (emphasis added)).

providers appealing the publication of SSI ratios in *Memorial Hospital*.[77] The statute allows an appeal if a Provider:

> (ii) is dissatisfied with a final determination of the Secretary **as to the amount of the payment** under subsection (b) or (d) of section 1395ww of this title

In *Memorial Hospital*, certain providers appealed the publication of SSI ratios. The D.C. District Court ultimately agreed with the Board that this was not an appealable final determination. In its discussion, the court noted that the SSI ratios, even if final, could not be a final determination "as to the amount of payment" because they are just one component of the DSH adjustment.[78] It explained that challenging the SSI ratios was a challenge to one element that eventually flows into the amount of payment for a final determination. Appealing such an element prior to payment is only appropriate if it was the only variable element as to the amount of payment due.[79]

The providers in *Memorial Hospital* also argued that there are certain instances where a provider can appeal prior to receiving an NPR and gave citations to certain D.C. Circuit cases in support. However, the D.C. District Court distinguished these cases because "the secretarial determination at issue was either the only determination on which payment depended or clearly promulgated as a final rule."[80] The D.C. District Court ultimately agreed with the Board that a published SSI Fraction was not an appealable final determination. In its discussion, the D.C. District Court agreed with the Secretary that the publication of the SSI ratios, *even if the publication of the SSI fractions had been issued as "final,"* could and would not be a final determination "as to the amount of payment" because the SSI fractions are "just one of the variables that determines whether hospitals receive a DSH payment ***and***, ***if so***, *for how much*."[81] The D.C. District Court concluded:

> A challenge to *an* ***element*** *of payment* under 42 U.S.C. § 1395oo(a)(1)(A)(ii) is ***only*** *appropriate* ***if***, as the D.C. Circuit has explained, "*the Secretary ha[s] firmly established '****the only variable factor*** in the final determination as to the amount of payment under § 1395ww(d).'" *Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807, 811 (D.C. Cir. 2001) (quoting *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 147 (D.C. Cir. 1986)) (emphasis added); *see also Samaritan Health Serv. v. Sullivan*, 1990 WL 33141 at *3 (9th Cir. 1990) (unpublished table decision) ("We have held that if the Secretary's classification of a hospital effectively fixes the hospital's reimbursement rate, then that

[77] 2022 WL 888190.
[78] *Id.* at *7.
[79] *Id.* at *8.
[80] *Id.*
[81] *Id.* at *9 (emphasis added).

> decision is a 'final determination' as referred to 42 U.S.C. § 1395oo(a)(1)(A)(ii).").[82]

Accordingly, the Court upheld the Board's decision to dismiss because the DSH SSI fraction was only one of the variables that determine whether a hospital receives a DSH payment (and, if so, for how much) and the publication of a hospital's SSI fraction is "not a determination as to the amount of payment received."[83] The Board declines to follow D.C. District Court's decision in *Battle Creek*[84] and finds the D.C. District Court's 2022 decision in *Memorial Hospital* to be instructive.

This is what makes this case distinguishable from the facts presented in the D.C. Circuit's decisions in *Washington Hospital* where the determination that was appealed finalized the only hospital-specific variable used in setting the per-patient payment amount. Specifically, the hospitals in *Washington Hospital* appealed their "Final Notice of Base Period Cost and Target Amount Per Discharge"[85] and the D.C. Circuit found: (a) "the ***only variable*** *factor* in the final determination as to the amount of payment under § 1395ww(d) is the hospital's target amount . . . ";[86] and (b) "The amount is the per-patient amount calculated under § 1395ww(d) and is final once the Secretary has published the DRG amounts (and he has) and finally determined the hospital's target amount. Here each of the hospitals has received a 'Final Notice of Base Period Cost and Target Amount per Discharge.' The statute requires no more to trigger the hospital's right to appeal PPS Payments to the PRRB."[87]

Similar to the D.C. District Court's decision in *Memorial Hospital*, the SSI Ratios published pursuant to CMS-1739-F are ***not*** a "final determination" as to the amount of the DSH payment to be received by the Provider for FY 2009. Rather, this publication reflects "just one of the variables that determines whether hospitals receive a DSH payment [for the relevant fiscal year] ***and***, ***if so***, *for how much*"; and any "***final*** *payment* determination"[88] on whether a hospital receives a DSH payment for a particular fiscal year and, if so, for how much *is made during the cost report audit/settlement process as explained at 42 C.F.R. § 412.106(i)*.[89] In this regard, the Board again notes that the publication of the SSI Fractions did not make a determination on any specific hospital's DSH eligibility and, if so, the amount of DSH payment. Rather, as it relates to this appeal, the Final Rule adopts a policy that is to be applied retroactively but only to certain hospitals and makes clear that, following the publication of new SSI percentages, those affected

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[82] *Id.* at *8.
[83] *Id.* at *9.
[84] In *Battle Creek*, the D.C. District Court addressed a jurisdictional issue involving DSH SSI fractions ***similar to*** the jurisdictional issue that the *same* Court (different judge) issued in *Memorial Hospital* but reached a different conclusion. However, the Board disagrees with the *Battle Creek* decision and maintains that *Memorial Hospital* is a better-reasoned decision and, in particular, provides a more thoughtful analysis and application of the D.C. Circuit's decision in *Washington Hospital*. Indeed, the *Battle Creek* decision does not even discuss (much less reference) the *Memorial Hospital* decision that was issued 19 months earlier by a different judge in the ***same*** Court.
[85] 795 F.2d at 143.
[86] 795 F.2d at 147 (emphasis added).
[87] *Id.* at 148 (footnote omitted).
[88] 42 C.F.R. § 412.106(i)(2) (emphasis added).
[89] 2022 WL 888190 at *9 (emphasis added).

hospitals who had open cost reporting periods for this issue would be issued an NPR (original or revised) that both would apply the finalized policy and would determine: (a) DSH eligibility for a hospital's prior period that is still open for resolution (whether through issuance of an original or revised NPR); and (b) if so, the amount of the DSH payment.

B. Conclusion

The Board finds that the publication of SSI Ratios on CMS' website appealed by Tampa is not an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835. Satisfying the criteria set out in 42 C.F.R. § 405.1835(a) is required before the Board can exercise jurisdiction over an appeal,[90] and since Tampa has failed to demonstrate in its hearing request that those criteria have been met for the year under appeal (*i.e.*, FY 2009)[91] the Board hereby dismisses Case 24-0491 for Provider's FY 2009 taken from the publication of SSI Ratios on CMS' website ***with prejudice.***

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

Board Members Participating:

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

For the Board:

11/7/2024

X Kevin D. Smith, CPA

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

cc: Geoff Pike, First Coast Service Options, Inc. (J-N)
Wilson Leong, FSS

[90] 42 C.F.R. § 405.1840(a), (b).
[91] 42 C.F.R. § 405.1835(b).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Mr. Russell Kramer
Director
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

Ms. Lorraine Frewert
Appeals Coordinator, JE Provider Audit
Noridian Healthcare Solutions c/o
Cahaba Safeguard Administrators
P.O. Box 6782
Fargo, ND 58108-6782

RE: ***Notice of Dismissal*: Appeal Not Timely Filed**
Garfield Medical Center (05-0737)
FYE 6/30/2008
PRRB Case Number: 25-0435

Dear Mr. Kramer and Ms. Frewert:

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

Background:

On October 25, 2024, the above-captioned Provider filed an appeal for its Fiscal Year End ("FYE") 6/30/2008. The appeal's support documentation states that the subject appeal is based on the Revised Notice of Program Reimbursement ("Revised NPR") dated April 22, 2024. The Confirmation of Correspondence generated by the Office of Hearings Case and Document Management System ("OH CDMS") verifies that the appeal was filed on October 25, 2024.

Board Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the contractor's final determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of receipt of the final determination. 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***.[1]

[1] Emphasis added.

Board Rule 4.4.3, **Due Date Exceptions,** states:

> If the due date falls on a Saturday, a Sunday, a federal legal holiday, (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the Board is unable to conduct business in the usual manner. . . then the deadline becomes the next day that is not one of the aforementioned days. *See* 42 C.F.R.§ 405.1801(d)(3).

Board Rule 4.5, **Date of Receipt by the Board**, explains:

> The timeliness of a filing is determined based on the date of receipt by the Board. The date of receipt is presumed to be:
>
> A. The date of filing in OH CDMS as evidenced by the Confirmation of Correspondence generated by the system…

After its review, the Board has determined that Quality Reimbursement Service's appeal request filed on behalf of Garfield Medical Center under case number 25-0435 was not timely filed in accordance with the regulations at 42 C.F.R. § 405.1835(a)(3) and Board Rules.

As noted above, the final determination support documentation states that the subject appeal is based on a Revised NPR dated April 22, 2024. Allowing for the 180-day appeal period and a five-day presumption for mailing, the 185th day fell on Thursday, October 24, 2024. The appeal was received on Friday, October 25, 2024, one day beyond the deadline. Since the appeal was not timely filed, the Board hereby dismisses case number 25-0435 in its entirety and removes it from the Board's docket.

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

Board Members:

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

FOR THE BOARD:

11/8/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Mr. Russell Kramer
Director
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

Ms. Lorraine Frewert
Appeals Coordinator, JE Provider Audit
Noridian Healthcare Solutions c/o
Cahaba Safeguard Administrators
P.O. Box 6782
Fargo, ND 58108-6782

RE: ***Notice of Dismissal:*** **Appeal Not Timely Filed**
Garfield Medical Center (05-0737)
FYE 6/30/2009
PRRB Case Number: 25-0436

Dear Mr. Kramer and Ms. Frewert:

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

Background:

On October 25, 2024, the above-captioned Provider filed an appeal for its Fiscal Year End ("FYE") 6/30/2008. The appeal's support documentation states that the subject appeal is based on the Revised Notice of Program Reimbursement ("Revised NPR") dated April 22, 2024. The Confirmation of Correspondence generated by the Office of Hearings Case and Document Management System ("OH CDMS") verifies that the appeal was filed on October 25, 2024.

Board Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the contractor's final determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of receipt of the final determination. 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***.[1]

[1] Emphasis added.

Board Rule 4.4.3, **Due Date Exceptions,** states:

> If the due date falls on a Saturday, a Sunday, a federal legal holiday, (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the Board is unable to conduct business in the usual manner. . . then the deadline becomes the next day that is not one of the aforementioned days. *See* 42 C.F.R.§ 405.1801(d)(3).

Board Rule 4.5, **Date of Receipt by the Board**, explains:

> The timeliness of a filing is determined based on the date of receipt by the Board. The date of receipt is presumed to be:
>
> A. The date of filing in OH CDMS as evidenced by the Confirmation of Correspondence generated by the system…

After its review, the Board has determined that Quality Reimbursement Service's appeal request filed on behalf of Garfield Medical Center under case number 25-0436 was not timely filed in accordance with the regulations at 42 C.FR. §§ 405.1835(a)(3).

As noted in the facts above, the final determination support documentation states that the subject appeal is based on a Revised NPR dated April 22, 2024. Allowing for the 180-day appeal period and a five-day presumption for mailing, the 185th day fell on Thursday, October 24, 2024. The appeal was received on Friday, October 25, 2024, one day beyond the deadline. Since the appeal was untimely filed, the Board hereby dismisses case number 25-0436 in its entirety and removes it from the Board's docket.

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

Board Members:

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

FOR THE BOARD:

11/8/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

November 13, 2024

Sharon Jones
Reimbursement Manager
University of Miami Health System
9675 NW 117th Avenue, Suite 310
Medley, FL 33178

Geoff Pike
Senior Auditor (Provider Appeals)
First Coast Service Options, Inc. c/o GuideWell Source (J-N)
Provider Audit and Reimbursement Dept.
532 Riverside Avenue
Jacksonville, FL 32202

RE: Dismissal for Failure to Respond
UMHC - Bascom Palmer Eye Institute
Provider Number: 10-0240
Appealed Period: FYE 05/31/2017
PRRB Case Number: 19-2182

Dear Ms. Jones and Mr. Pike:

Pursuant to 42 C.F.R. § 405.1868, the Provider Reimbursement Review Board ("Board") has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provision of section 1878 of the Act and of the regulations. The Board's powers include the authority to take appropriate actions in response to the failure of a party to comply with Board rules and orders. Specifically, if a Provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may dismiss the appeal with prejudice.

On April 5, 2024, a Notice of Hearing was issued and established critical due dates and set forth a live hearing date for November 22, 2024. Emails to the Provider representative inquiring about a status on this case have been returned as undeliverable.

Board Rule 41.2 states:

The Board may dismiss a case or an issue on its own motion:
• if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
• upon failure of the provider or group to comply with Board procedures or filing deadlines (see 42 C.F.R. § 405.1868);
• if the Board is unable to contact the provider or representative at the last known address; or
• upon failure to appear for a scheduled hearing.

As the Board has been unable to contact the Provider Representative regarding the November 22, 2024 hearing, the Board hereby dismisses this case.

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

FOR THE BOARD:

Ratina Kelly, CPA
Board Member

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Ms. Lorraine Frewert
Appeals Coordinator, JE Provider Audit
Noridian Healthcare Solutions c/o
Cahaba Safeguard Administrators
P.O. Box 6782
Fargo, ND 58108-6782

RE: **DETERMINATION RE: TIMELY FILING OF APPEAL**
Via Christi Hospital Pittsburgh
Provider Number: 17-0006
Appealed Period: FYE 9/30/2011
PRRB Case Number: 25-0439

Dear Mr. Ravindran and Ms. Frewert:

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

BACKGROUND:

On October 25, 2024, the above-captioned Provider filed an appeal for its Fiscal Year End ("FYE") 9/30/2011. The appeal's support documentation states that the subject appeal is based on the Revised Notice of Program Reimbursement ("Revised NPR") dated April 22, 2024. The Confirmation of Correspondence generated by the Office of Hearings Case and Document Management System ("OH CDMS") verifies that the appeal was filed on October 25, 2024.

RULES/REGULATIONS:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the contractor's final determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of receipt of the final determination. 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.***[1]

Board Rule 4.4.3, Due Date Exceptions, provides that if the due date falls on a Saturday, a Sunday, a federal legal holiday, (as enumerated in Rule 6(a) of the Federal Rules of Civil

[1] Emphasis added.

Procedure), or a day on which the Board is unable to conduct business in the usual manner, then the deadline becomes the next day that is not one of the aforementioned days. See 42 C.F.R. § 405.1801(d)(3).

Board Rule 4.5, Date of Receipt by the Board, states that the timeliness of a filing is determined based on the date of receipt by the Board, and the date of receipt is presumed to be the date of filing in OH CDMS as evidenced by the Confirmation of Correspondence generated by the system. See 42 C.F.R. § 405.1801(a)(2)(iii).

BOARD DETERMINATION:

After its review, the Board has determined that Quality Reimbursement Service's appeal request filed on behalf of Via Christi Hospital Pittsburgh under case number 25-0439 was not timely filed in accordance with the regulations at 42 C.FR. §§ 405.1835(a)(3).

As noted in the facts above, the final determination support documentation states that the subject appeal is based on a Revised NPR dated April 22, 2024. Allowing for the 180-day appeal period and a five-day presumption for mailing, the 185th day fell on Thursday, October 24, 2024. The appeal was received on Friday, October 25, 2024, one day beyond the deadline. Since the appeal was untimely filed, the Board hereby dismisses case number 25-0439 in its entirety and removes it from the Board's docket.

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

In closing, the Board notes that the Letter of Representation for the subject appeal was dated July 21, ***2014***, over ten (10) years prior to the late appeal being filed. A letter of representation should be obtained contemporaneously when preparing an appeal to be filed with the Board, and a representative should not be relying on an outdated letter of representation, signed years in advance.

Board Members:

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

FOR THE BOARD:

11/13/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

November 13, 2024

Sharon Jones
Reimbursement Manager
University of Miami Health System
9675 NW 117th Avenue, Suite 310
Medley, FL 33178

Geoff Pike
Senior Auditor (Provider Appeals)
First Coast Service Options, Inc. c/o GuideWell Source (J-N)
Provider Audit and Reimbursement Dept.
532 Riverside Avenue
Jacksonville, FL 32202

RE: Dismissal for Failure to Respond
UMHC - Bascom Palmer Eye Institute
Provider Number: 10-0240
Appealed Period: FYE 05/31/2016
PRRB Case Number: 19-1191

Dear Ms. Jones and Mr. Pike:

Pursuant to 42 C.F.R. § 405.1868, the Provider Reimbursement Review Board ("Board") has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provision of section 1878 of the Act and of the regulations. The Board's powers include the authority to take appropriate actions in response to the failure of a party to comply with Board rules and orders. Specifically, if a Provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may dismiss the appeal with prejudice.

On April 5, 2024, a Notice of Hearing was issued and established critical due dates and set forth a live hearing date for November 22, 2024. Emails to the Provider representative inquiring about a status on this case have been returned as undeliverable.

Board Rule 41.2 states:

The Board may dismiss a case or an issue on its own motion:
• if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
• upon failure of the provider or group to comply with Board procedures or filing deadlines (see 42 C.F.R. § 405.1868);
• if the Board is unable to contact the provider or representative at the last known address; or
• upon failure to appear for a scheduled hearing.

As the Board has been unable to contact the Provider Representative regarding the November 22, 2024 hearing, the Board hereby dismisses this case.

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

FOR THE BOARD:

Ratina Kelly, CPA
Board Member

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

November 13, 2024

Sharon Jones
Reimbursement Manager
University of Miami Health System
9675 NW 117th Avenue, Suite 310
Medley, FL 33178

Geoff Pike
Senior Auditor (Provider Appeals)
First Coast Service Options, Inc. c/o GuideWell Source (J-N)
Provider Audit and Reimbursement Dept.
532 Riverside Avenue
Jacksonville, FL 32202

RE: Dismissal for Failure to Respond
UMHC - Bascom Palmer Eye Institute
Provider Number: 10-0240
Appealed Period: FYE 10/28/2017
PRRB Case Number: 19-2183

Dear Ms. Jones and Mr. Pike:

Pursuant to 42 C.F.R. § 405.1868, the Provider Reimbursement Review Board ("Board") has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provision of section 1878 of the Act and of the regulations. The Board's powers include the authority to take appropriate actions in response to the failure of a party to comply with Board rules and orders.

Specifically, if a Provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may dismiss the appeal with prejudice.

On April 5, 2024, a Notice of Hearing was issued and established critical due dates and set forth a live hearing date for November 22, 2024. Emails to the Provider representative inquiring about a status on this case have been returned as undeliverable.

Board Rule 41.2 states:

The Board may dismiss a case or an issue on its own motion:
• if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
• upon failure of the provider or group to comply with Board procedures or filing deadlines (see 42 C.F.R. § 405.1868);
• if the Board is unable to contact the provider or representative at the last known address; or
• upon failure to appear for a scheduled hearing.

As the Board has been unable to contact the Provider Representative regarding the November 22, 2024 hearing, the Board hereby dismisses this case.

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

FOR THE BOARD:

Ratina Kelly, CPA
Board Member

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Determination - Jurisdiction in Part***

Prime Healthcare CY 2019 Low Wage Index Quartile Adjustment CIRP Group
Case Number: 24-2425GC

Prime Healthcare CY 2019 Redesignated Hospitals Excluding Wage Data Adjustment CIRP Group, Case Number 24-2426GC

Dismissal of Desert Valley Hospital (Provider Number 05-0709) FYE 12/31/2019 as a participant

Dear Ms. Goron:

The Provider Reimbursement Review Board (the "Board") has reviewed the above-captioned common issue related party ("CIRP") groups in response to an October 3, 2024 request for reconsideration filed by Healthcare Reimbursement Services, Inc. ("HRS" or "Representative"). The pertinent facts and the Board's determination are set forth below.

Background:

On **July 22, 2024**, HRS timely filed an individual appeal for Desert Valley Hospital's ("Desert Valley"/"Provider") FYE 12/31/2019 based on a January 26, 2024 Notice of Program Reimbursement ("NPR"). The sole issue in the case, which was assigned Case No. 24-2153, was DSH Medicaid Eligible Days.

On **September 4, 2024**, HRS filed the "Prime Healthcare CY 2019 Low Wage Index Quartile Adjustment CIRP Group" under Case No. 24-2425GC and the "Prime Healthcare CY 2019 Redesignated Hospitals Excluded Wage Data Adjustment CIRP Group" under Case No. 24-2426GC. The groups, were formed in the Office of Hearings Case & Document Management System ("OH CDMS") two minutes apart: Case No. 24-2425GC was formed at 3:54 p.m. and Case No. 24-2426GC at 3:56 p.m. Neither group is designated to be fully-formed and each group currently includes five participants. The originating participant in both groups, Desert

Valley, was directly added to each on **September 4, 2024.**[1] The Notice of Program Reimbursement ("NPR") from which Desert Valley filed was issued by Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators ("Noridian" or "MAC") on **January 26, 2024.** Therefore, the Direct Add to each group was filed **222** days after the issuance of the NPR.

On **September 4, 2024**, at 4:04 p.m., a few minutes after completing the "Add Provider" pages with Desert Valley's information in both Case Nos. 24-2425GC and 24-2426GC,[2] HRS withdrew the DSH Medicaid Eligible Days issue from Desert Valley's individual appeal, Case No. 24-2153, resulting in closure of case.

On **October 1, 2024,** Noridian filed its Rule 15.2 Review letter in both groups, in which it advised the Parties that Desert Valley did not timely file since the Provider was not directly added to either group within 180 days of its final determination.

On **October 3, 2024**, HRS filed requests for reconsideration of the MAC's October 1, 2024 Rule 15.2 letter (in which the MAC observed that Desert Valley (Prov. No. 05-0709) did not file within 180 days of its NPR in Case Nos. 24-2425GC and 24-2426GC). HRS argued that it inadvertently utilized a "Direct Add" to group, rather than an "Add New Issue to Individual Case." HRS indicated that this was an administrative error in that, had it used the correct case action and, instead, added the respective issues to Case 24-2153, those "add issue" requests would have been considered timely since they would have been filed within 245 days of the Provider's NPR.[3] Seemingly, the Low Wage Index Quartile Adjustment issue could then have been transferred to Case No. 24-2425GC and the Redesignated Hospitals Excluded Wage Data Adjustment could have been transferred to Case No. 24-2426GC. Had this occurred, the timeliness of Desert Valley as a participant in the groups would not have been in dispute. HRS concluded by saying that this error was a matter of it inadvertently checking "the wrong box." Therefore, HRS requested that the Board ". . . grant the provider a 'good cause' status and allow this provider to remain in the referenced groups given this administrative error."[4]

Board Determination:

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

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[1] Once the group cases were formed in OH CDMS, HRS transferred two additional providers to the groups on the same date. Since that date, additional providers have been transferred and added to the groups.
[2] *See* Section 3.2.2.2 related to Provider List Page of the OH CDMS -PRRB External User Manual at https://www.cms.gov/regulations-and-guidance/review-boards/prrbreview/downloads/oh-cdms-prrb-external-user-manual-v-10.pdf.
[3] *See* 42 C.F.R. § 405.1835(e) and Board Rule 6.2.1 which indicates the Provider may add an issue to an individual appeal if the request is filed ". . . no later than 60 days after the expiration of the applicable 180-day period for filing the initial hearing request, and the request meets the minimum filing requirements as identified in 42 C.F.R. § 4005.1835(e)."
[4] Request for Reconsideration at 2 (Oct. 3, 2024).

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.

Although in these groups, Case Nos. 24-2425GC and 24-2426GC, the Board had not yet issued a formal jurisdictional determination dismissing Desert Valley, HRS alleges there was 'good cause' for the late filings and has requested a reconsideration of the MAC's notice pointing out the Provider's untimely filing.

The regulation at 42 C.F.R. § 405.1836(b) addresses good cause extensions of the time limit to file a hearing and states:

> The Board may find good cause to extend the time limit only if the provider demonstrates in writing it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board the circumstances) after the expiration of the applicable 180-day limit specified in § 405.1835(a)(3) or § 405.1835(c)(2).

The Board also points HRS to Board Rules 47.1 and 47.3 which govern motions for reinstatement of an issue or case and Board dismissals:

> **47.1 Motion for Reinstatement**
>
> A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s) (see 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (see Rule 44 governing motions). **The Board will not reinstate an issue(s)/case if the provider was at fault. . . .**
>
> . . . .
>
> **47.3 Dismissals for Failure to Comply with Board Procedures**
>
> **Upon written motion demonstrating good cause**, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, **administrative oversight**, settlement negotiations or a change in representative **will not be considered good cause to reinstate**. . . .[5]

[5] (Bold emphasis added with the exception of the titles which had bold emphasis in original.)

Although Desert Valley was not formally dismissed from the groups at the time of HRS' request for reconsideration, these Rules are pertinent because they detail what the Board **does not consider to be good cause**, specifically, *administrative oversight*. Board Rule 47.1 makes clear that the Board will not reinstate a case or issue **if the provider was at fault** and Board Rule 47. 3, explains that administrative oversight is not considered good cause.

After a review of the facts, the Board finds that Desert Valley's Direct Additions to Case Nos. 24-2425GC and 24-2426GC were, in fact, untimely. 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. In this instance, the MAC issued the NPR for Desert Valley on January 26, 2024. The 185th day fell on Monday, July 29, 2024. The Direct Additions for Desert Valley to Case Nos. 24-2425GC and 24-2426GC were not filed until Wednesday, September 4, 2024, which was 222 days after the issuance of the final determination.[6]

The Board has considered HRS' argument that the untimeliness of the Provider's Direct Additions was simply a matter of having "checked the wrong box." In short, the Representative has admitted fault for filing its request to pursue the Low Wage Index Quartile Adjustment and Redesignated Hospitals Excluded Wage Data Adjustment issues in the wrong appeals, by filing ***late*** Direct Adds into the group cases instead of ***timely*** adding the issues to the Provider's individual case where they could have then been transferred to the groups. The Board rejects this line of reasoning as the "Add Participant" and "Add Issue" functions are completely separate case actions that must be effectuated in different cases (*i.e.,* one in a group case and the other in an individual appeal as discussed in sections 3.3.2 and 3.3.3.2 of the External User Manual.)[7]

Therefore, the Board finds that the circumstances described by HRS for Desert Valley's late Direct Addition to Case Nos. 24-2425GC and 24-2426GC do not meet the standards for good cause as described in 42 C.F.R. § 405.1836(b). HRS has admitted the untimely filings were due to an administrative error, which is not considered to be a matter outside of the Provider's control. As such, the Board denies HRS' October 3, 2024 request to allow the Provider to remain in Case Nos. 24-2425GC and 24-2426GC. Because **Desert Valley does not meet the regulatory filing requirements, the Board hereby dismisses the Provider from both groups**.

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 group cases.

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[6] There was no allegation of good cause filed with Desert Valley's direct add filing.
[7] https://www.cms.gov/regulations-and-guidance/review-boards/prrbreview/downloads/oh-cdms-prrb-external-user-manual-v-10.pdf

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

For the Board:

11/14/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Request for Reconsideration of Board's Dismissal of Appeal***
University Medical Center (Provider Number 45-0686)
FYE: 12/31/2013
Case Number: 19-0078

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the Request for Reconsideration of Board's Dismissal of Appeal submitted by University Medical Center ("Provider") on August 23, 2024. The decision of the Board is set forth below.

Pertinent Facts:

On **June 21, 2024**, the Board dismissed the remaining issue in the appeal, Issue No. 5: DSH Payment – Medicaid Eligible Days and closed the instant appeal. In the dismissal, the Board found the Provider noncompliant with 42 C.F.R. §§ 405.1835(a)-(b), 405.1853(b)(2)-(3), and 412.106(b)(4)(iv) and Board Rules 7, 8, 25, and 27.[1]

On **August 23, 2024**, the Provider requested reinstatement of the DSH Payment – Medicaid Eligible Days issue.

Provider's Position:

The Provider "asserts that there is no section 1115 waiver days issue, and as such it was not added timely, or untimely to the Provider's appeal."[2]

The Provider's argument is that 1115 waiver days are a component or sub issue of the Medicaid Eligible Days issue, and regulations and Board rules do not place a time limit on adding those.[3] They go on to argue:

[1] The Board also noted a failure to comply with the instructions included in the Board's Notices setting the Board's deadlines).
[2] Request for Reconsideration and Reinstatement of Dismissal of Medicaid Eligible Days & 1115 Medicaid Waiver Days at 1 (Aug. 23, 2024).
[3] *Id*. at 2.

> [T]he Provider timely appealed the non-inclusion of Medicaid eligible days, saying "[t]he MAC, contrary to the regulation, *failed to include all Medicaid eligible days, including but not limited to* Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation." Emphasis added. The italicized language above makes clear that the Provider claimed that the MAC needed to include *all* Medicaid eligible days, and that this in fact was the single issue being appealed. By definition, section 1115 waiver days are Medicaid eligible days. Therefore, by definition, section 1115 waiver days were within the scope of the appeal.
>
> . . .
>
> Rule 8 is internally inconsistent with Rule 7. Whereas Rule 8 refers to "components" of an issue, and gives section 1115 waiver days as an example, Rule 7.2.1 provides that, for purposes of identifying the "issue" under appeal, the provider needs to give "an issue title and concise issue statement" that describes the cost report adjustment, including the cost report adjustment number, the controlling authority, why the cost report adjustment is incorrect, how the payment should be determined differently, the reimbursement effect, and the basis for jurisdiction before the PPRB. Thus, Rule 8 is both inconsistent with the regulations and Rule 7.[4]

Board's Analysis and Decision:

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

The Board disagrees with the Provider's argument that "there is no section 1115 waiver issue." As the Board indicated in its initial decision, although the Provider appealed Medicaid eligible days, that issue ***is separate and distinct*** from the § 1115 waiver days as recognized by numerous Board, Administrator and Court decisions[5] as well as the Board's Rules in effect when the appeal

[4] *Id*. at 1-2.

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

for this case was filed. At the time of the filing of this appeal, PRRB Rules v. 2.0, effective August 29, 2018, were in effect. In contrast to the Provider's argument that there is no Section 1115 waiver days issue, the plain wording of Rule 8 proves otherwise:

> **Rule 8 Framing Issues for Adjustments Involving Multiple Components**
>
> **8.1 General**
>
> Some issues may have multiple components. *To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7*. Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: dual eligible Medicare Part A/Medicaid, dual eligible Medicare Part C/Medicaid, SSI data matching, state/program specific general assistance days, ***Section 1115 waiver days (program/waiver specific)***, and observation bed days.[6]

Therefore, had the Provider intended to appeal the 1115 waiver days issue, it was required to do so in accordance with regulations and Board rules, which the Provider failed to do. Further, the Provider's argument that there is only one issue is belied by its original appeal which included four different issues [Provider Specific, Systemic Errors, Part C Days, and Dual Eligible Days] related to the SSI Percentage (not one, since it was only one adjustment), and similarly, three separate issues [Medicaid Eligible Days, Dual Eligible Days, and Part C Days] related to the Medicaid Fraction (again, not just one). Clearly, the Provider saw the need for multiple issues for the individual components of the two fractions at the time the appeal was filed.

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).

[6] (Emphasis added).

Further, the Board finds the Provider's request for reinstatement fails to establish good cause. Board Rule 47 reads, in relevant part:

> **Rule 47 Reinstatement**
>
> **47.1 Motion for Reinstatement**
>
> [T]he Board will not reinstate an issue(s)/case if the provider was at fault.
>
> . . .
>
> **47.3 Dismissal for Failure to Comply with Board Procedures**
>
> Upon written motion demonstrating good cause, the Board may reinstate a cause dismissed for failure to comply with Board procedures. Generally, administrative oversight, settlement negotiations or a change in representative will not be considered good cause to reinstate. . .

As such, the Board ***denies*** the request for reconsideration. Accordingly, Case No. 19-0078 remains closed.

Board Members Participating:

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

For the Board:

11/14/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Request for Reconsideration of Board's Dismissal of Appeal***
St. Cloud Regional Medical Center (Provider Number 10-0302)
FYE: 12/31/2015
Case Number: 19-0152

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the Request for Reconsideration of Board's Dismissal of Appeal submitted by St. Cloud Regional Medical Center ("Provider") on August 23, 2024. The decision of the Board is set forth below.

Pertinent Facts:

On **May 14, 2024**, the Board dismissed the remaining issue in the appeal, Issue No. 5: DSH Payment – Medicaid Eligible Days and closed the instant appeal. In the dismissal, the Board found the Provider noncompliant with 42 C.F.R. §§ 405.1835(a)-(b), 405.1853(b)(2)-(3), and 412.106(b)(4)(iv) and Board Rules 7, 8, 25, and 27.[1]

On **August 23, 2024**, the Provider requested reinstatement of the DSH Payment – Medicaid Eligible Days issue.

Provider's Position:

The Provider "asserts that there is no section 1115 waiver days issue, and as such it was not added timely, or untimely to the Provider's appeal."[2]

The Provider's argument is that 1115 waiver days are a component or sub issue of the Medicaid Eligible Days issue, and regulations and Board rules do not place a time limit on adding those.[3] They go on to argue:

[1] The Board also noted a failure to comply with the instructions included in the Board's Notices setting the Board's deadlines).
[2] Request for Reconsideration and Reinstatement of Dismissal of Medicaid Eligible Days & 1115 Medicaid Waiver Days at 1 (Aug. 23, 2024).
[3] *Id*. at 2.

> [T]he Provider timely appealed the non-inclusion of Medicaid eligible days, saying "[t]he MAC, contrary to the regulation, *failed to include all Medicaid eligible days, including but not limited to* Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation." Emphasis added. The italicized language above makes clear that the Provider claimed that the MAC needed to include *all* Medicaid eligible days, and that this in fact was the single issue being appealed. By definition, section 1115 waiver days are Medicaid eligible days. Therefore, by definition, section 1115 waiver days were within the scope of the appeal.
>
> . . .
>
> Rule 8 is internally inconsistent with Rule 7. Whereas Rule 8 refers to "components" of an issue, and gives section 1115 waiver days as an example, Rule 7.2.1 provides that, for purposes of identifying the "issue" under appeal, the provider needs to give "an issue title and concise issue statement" that describes the cost report adjustment, including the cost report adjustment number, the controlling authority, why the cost report adjustment is incorrect, how the payment should be determined differently, the reimbursement effect, and the basis for jurisdiction before the PPRB. Thus, Rule 8 is both inconsistent with the regulations and Rule 7.[4]

Board's Analysis and Decision:

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

The Board disagrees with the Provider's argument that "there is no section 1115 waiver issue." As the Board indicated in its initial decision, although the Provider appealed Medicaid eligible days, that issue ***is separate and distinct*** from the § 1115 waiver days as recognized by numerous Board, Administrator and Court decisions[5] as well as the Board's Rules in effect when the appeal

[4] *Id*. at 1-2.

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

for this case was filed. At the time of the filing of this appeal, PRRB Rules v. 2.0, effective August 29, 2018, were in effect. In contrast to the Provider's argument that there is no Section 1115 waiver days issue, the plain wording of Rule 8 proves otherwise:

> **Rule 8 Framing Issues for Adjustments Involving Multiple Components**
>
> **8.1 General**
>
> Some issues may have multiple components. *To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7*. Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: dual eligible Medicare Part A/Medicaid, dual eligible Medicare Part C/Medicaid, SSI data matching, state/program specific general assistance days, ***Section 1115 waiver days (program/waiver specific)***, and observation bed days.[6]

Therefore, had the Provider intended to appeal the 1115 waiver days issue, it was required to do so in accordance with regulations and Board rules, which the Provider failed to do. Further, the Provider's argument that there is only one issue is belied by its original appeal which included four different issues [Provider Specific, Systemic Errors, Part C Days, and Dual Eligible Days] related to the SSI Percentage (not one, since it was only one adjustment), and similarly, three separate issues [Medicaid Eligible Days, Dual Eligible Days, and Part C Days] related to the Medicaid Fraction (again, not just one). Clearly, the Provider saw the need for multiple issues for the individual components of the two fractions at the time the appeal was filed.

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).

[6] (Emphasis added).

Further, the Board finds the Provider's request for reinstatement fails to establish good cause. Board Rule 47 reads, in relevant part:

> **Rule 47 Reinstatement**
>
> **47.1 Motion for Reinstatement**
>
> [T]he Board will not reinstate an issue(s)/case if the provider was at fault.
>
> . . .
>
> **47.3 Dismissal for Failure to Comply with Board Procedures**
>
> Upon written motion demonstrating good cause, the Board may reinstate a cause dismissed for failure to comply with Board procedures. Generally, administrative oversight, settlement negotiations or a change in representative will not be considered good cause to reinstate. . .

As such, the Board ***denies*** the request for reconsideration. Accordingly, Case No. 19-0152 remains closed.

Board Members Participating:

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

For the Board:

11/14/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Request for Reconsideration of Board's Dismissal of Appeal***
University Medical Center (Provider Number 45-0686)
FYE: 12/31/2014
Case Number: 19-0315

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the Request for Reconsideration of Board's Dismissal of Appeal submitted by University Medical Center ("Provider") on August 23, 2024. The decision of the Board is set forth below.

Pertinent Facts:

On **June 21, 2024**, the Board dismissed the remaining issue in the appeal, Issue No. 5: DSH Payment – Medicaid Eligible Days and closed the instant appeal. In the dismissal, the Board found the Provider noncompliant with 42 C.F.R. §§ 405.1835(a)-(b), 405.1853(b)(2)-(3), and 412.106(b)(4)(iv) and Board Rules 7, 8, 25, and 27.[1]

On **August 23, 2024**, the Provider requested reinstatement of the DSH Payment – Medicaid Eligible Days issue.

Provider's Position:

The Provider "asserts that there is no section 1115 waiver days issue, and as such it was not added timely, or untimely to the Provider's appeal."[2]

The Provider's argument is that 1115 waiver days are a component or sub issue of the Medicaid Eligible Days issue, and regulations and Board rules do not place a time limit on adding those.[3] They go on to argue:

[1] The Board also noted a failure to comply with the instructions included in the Board's Notices setting the Board's deadlines).
[2] Request for Reconsideration and Reinstatement of Dismissal of Medicaid Eligible Days & 1115 Medicaid Waiver Days at 1 (Aug. 23, 2024).
[3] *Id*. at 2.

> [T]he Provider timely appealed the non-inclusion of Medicaid eligible days, saying "[t]he MAC, contrary to the regulation, *failed to include all Medicaid eligible days, including but not limited to* Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation." Emphasis added. The italicized language above makes clear that the Provider claimed that the MAC needed to include *all* Medicaid eligible days, and that this in fact was the single issue being appealed. By definition, section 1115 waiver days are Medicaid eligible days. Therefore, by definition, section 1115 waiver days were within the scope of the appeal.
>
> . . .
>
> Rule 8 is internally inconsistent with Rule 7. Whereas Rule 8 refers to "components" of an issue, and gives section 1115 waiver days as an example, Rule 7.2.1 provides that, for purposes of identifying the "issue" under appeal, the provider needs to give "an issue title and concise issue statement" that describes the cost report adjustment, including the cost report adjustment number, the controlling authority, why the cost report adjustment is incorrect, how the payment should be determined differently, the reimbursement effect, and the basis for jurisdiction before the PPRB. Thus, Rule 8 is both inconsistent with the regulations and Rule 7.[4]

Board's Analysis and Decision:

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

The Board disagrees with the Provider's argument that "there is no section 1115 waiver issue." As the Board indicated in its initial decision, although the Provider appealed Medicaid eligible days, that issue ***is separate and distinct*** from the § 1115 waiver days as recognized by numerous Board, Administrator and Court decisions[5] as well as the Board's Rules in effect when the appeal

[4] *Id*. at 1-2.

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

for this case was filed. At the time of the filing of this appeal, PRRB Rules v. 2.0, effective August 29, 2018, were in effect. In contrast to the Provider's argument that there is no Section 1115 waiver days issue, the plain wording of Rule 8 proves otherwise:

> **Rule 8 Framing Issues for Adjustments Involving Multiple Components**
>
> **8.1 General**
>
> Some issues may have multiple components. *To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7*. Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: dual eligible Medicare Part A/Medicaid, dual eligible Medicare Part C/Medicaid, SSI data matching, state/program specific general assistance days, ***Section 1115 waiver days (program/waiver specific)***, and observation bed days.[6]

Therefore, had the Provider intended to appeal the 1115 waiver days issue, it was required to do so in accordance with regulations and Board rules, which the Provider failed to do. Further, the Provider's argument that there is only one issue is belied by its original appeal which included four different issues [Provider Specific, Systemic Errors, Part C Days, and Dual Eligible Days] related to the SSI Percentage (not one, since it was only one adjustment), and similarly, three separate issues [Medicaid Eligible Days, Dual Eligible Days, and Part C Days] related to the Medicaid Fraction (again, not just one). Clearly, the Provider saw the need for multiple issues for the individual components of the two fractions at the time the appeal was filed.

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).

[6] (Emphasis added).

Further, the Board finds the Provider's request for reinstatement fails to establish good cause. Board Rule 47 reads, in relevant part:

> **Rule 47 Reinstatement**
>
> **47.1 Motion for Reinstatement**
>
> [T]he Board will not reinstate an issue(s)/case if the provider was at fault.
>
> . . .
>
> **47.3 Dismissal for Failure to Comply with Board Procedures**
>
> Upon written motion demonstrating good cause, the Board may reinstate a cause dismissed for failure to comply with Board procedures. Generally, administrative oversight, settlement negotiations or a change in representative will not be considered good cause to reinstate. . .

As such, the Board ***denies*** the request for reconsideration. Accordingly, Case No. 19-0315 remains closed.

Board Members Participating:

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

For the Board:

11/14/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Request for Reconsideration of Board's Dismissal of Appeal***
Houston Methodist Hospital (Provider Number 45-0358)
FYE: 12/31/2014
Case Number: 19-2505

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the Request for Reconsideration of Board's Dismissal of Appeal submitted by Houston Methodist Hospital ("Provider") on August 23, 2024. The decision of the Board is set forth below.

Pertinent Facts:

On **April 17, 2024**, the Board dismissed the remaining issue in the appeal, Issue No. 1: DSH Payment – Medicaid Eligible Days and closed the instant appeal. In the dismissal, the Board found the Provider noncompliant with 42 C.F.R. §§ 405.1835(b), 405.1853(b)(2)-(3), and 412.106(b)(4)(iii) and Board Rules 7, 8, 25, and 27.[1]

On **July 15, 2024**, the Provider requested reinstatement of the DSH Payment – Medicaid Eligible Days issue. An updated request was made on **August 23, 2024**.

Provider's Position:

The Provider "asserts that there is no section 1115 waiver days issue, and as such it was not added timely, or untimely to the Provider's appeal."[2]

The Provider's argument is that 1115 waiver days are a component or sub issue of the Medicaid Eligible Days issue, and regulations and Board rules do not place a time limit on adding those.[3] They go on to argue:

[1] The Board also noted a failure to comply with the instructions included in the Board's Notices issued on Aug. 29, 2019 and Aug. 10, 2023).
[2] Request for Reconsideration and Reinstatement of Dismissal of Medicaid Eligible Days & 1115 Medicaid Waiver Days at 1 (Aug. 23, 2024).
[3] *Id*. at 2.

> [T]he Provider timely appealed the non-inclusion of Medicaid eligible days, saying "[t]he MAC, contrary to the regulation, *failed to include all Medicaid eligible days, including but not limited to* Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation." Emphasis added. The italicized language above makes clear that the Provider claimed that the MAC needed to include *all* Medicaid eligible days, and that this in fact was the single issue being appealed. By definition, section 1115 waiver days are Medicaid eligible days. Therefore, by definition, section 1115 waiver days were within the scope of the appeal.
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> Rule 8 is internally inconsistent with Rule 7. Whereas Rule 8 refers to "components" of an issue, and gives section 1115 waiver days as an example, Rule 7.2.1 provides that, for purposes of identifying the "issue" under appeal, the provider needs to give "an issue title and concise issue statement" that describes the cost report adjustment, including the cost report adjustment number, the controlling authority, why the cost report adjustment is incorrect, how the payment should be determined differently, the reimbursement effect, and the basis for jurisdiction before the PPRB. Thus, Rule 8 is both inconsistent with the regulations and Rule 7.[4]

Board's Analysis and Decision:

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

The Board disagrees with the Provider's argument that "there is no section 1115 waiver issue." As the Board indicated in its initial decision, although the Provider appealed Medicaid eligible days, that issue ***is separate and distinct*** from the § 1115 waiver days as recognized by numerous Board, Administrator and Court decisions[5] as well as the Board's Rules in effect when the appeal

[4] *Id*. at 1-2.

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

for this case was filed. At the time of the filing of this appeal, PRRB Rules v. 2.0, effective August 29, 2018, were in effect. In contrast to the Provider's argument that there is no Section 1115 waiver days issue, the plain wording of Rule 8 proves otherwise:

> **Rule 8 Framing Issues for Adjustments Involving Multiple Components**
>
> **8.1 General**
>
> Some issues may have multiple components. *To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7*. Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: dual eligible Medicare Part A/Medicaid, dual eligible Medicare Part C/Medicaid, SSI data matching, state/program specific general assistance days, ***Section 1115 waiver days (program/waiver specific)***, and observation bed days.[6]

Therefore, had the Provider intended to appeal the 1115 waiver days issue, it was required to do so in accordance with regulations and Board rules, which the Provider failed to do. Further, the Provider's argument that there is only one issue is belied by its original appeal which included four different issues [Provider Specific, Systemic Errors, Part C Days, and Dual Eligible Days] related to the SSI Percentage (not one, since it was only one adjustment), and similarly, three separate issues [Medicaid Eligible Days, Dual Eligible Days, and Part C Days] related to the Medicaid Fraction (again, not just one). Clearly, the Provider saw the need for multiple issues for the individual components of the two fractions at the time the appeal was filed.

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).

[6] (Emphasis added).

Further, the Board finds the Provider's request for reinstatement fails to establish good cause. Board Rule 47 reads, in relevant part:

> **Rule 47 Reinstatement**
>
> **47.1 Motion for Reinstatement**
>
> [T]he Board will not reinstate an issue(s)/case if the provider was at fault.
>
> . . .
>
> **47.3 Dismissal for Failure to Comply with Board Procedures**
>
> Upon written motion demonstrating good cause, the Board may reinstate a cause dismissed for failure to comply with Board procedures. Generally, administrative oversight, settlement negotiations or a change in representative will not be considered good cause to reinstate. . .

As such, the Board ***denies*** the request for reconsideration. Accordingly, Case No. 19-2505 remains closed.

Board Members Participating:

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

For the Board:

11/14/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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: ***Board Decision – SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues***
Scott & White Medical Center – Temple (Provider No. 45-0054)
FYE 08/31/2016
Case No. 20-1281

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 20-1281. Set forth below is the decision of the Board to dismiss the 2 remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) and Medicaid Eligible Days.

Background

A. Procedural History for Case No. 20-1281

On **September 27, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end August 31, 2016. The Provider is commonly owned by Baylor Scott & White Health ("BS&W Health").

On **February 7, 2020**, BS&W Health filed the Provider's individual appeal request. The initial Individual Appeal Request contained ten (10) issues:

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

[1] On September 22, 2020, this issue was transferred to Case No. 19-2456GC.
[2] On September 22, 2020, this issue was transferred to Case No. 19-2457GC.
[3] On September 22, 2020, this issue was transferred to Case No. 19-2458GC.

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

As the Provider is commonly owned/controlled by BS&W Health, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **September 22, 2020**, the Provider transferred Issues 2, 3, 4, 6, 7, 9 and 10 to BS&W Health CIRP groups.

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

On **February 28, 2020**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[9]

On **October 1, 2020**, the Provider timely filed its preliminary position paper. With respect to Issue 5, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days." As a result, the Provider

[4] On September 22, 2020, this issue was transferred to Case No. 19-2459GC.
[5] On September 22, 2020, this issue was transferred to Case No. 19-2460GC.
[6] This issue was withdrawn on October 6, 2020.
[7] On September 22, 2020, this issue was transferred to Case No. 19-2760GC.
[8] On September 22, 2020, this issue was transferred to Case No. 19-2462GC.
[9] (Emphasis added.)

included, as an Exhibit, the original "estimated impact" for this issue of $91,548 based on an *estimated* 150 days.

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

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

On **October 27, 2023**, the Board issued the Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

> Provider's Final Position Paper – *For each remaining issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *also include* ***any exhibits*** *the Provider will use to support to support its position*. *See* Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.[10]

On **March 28, 2024**, the Provider timely filed its final position paper. With respect to Issue 5, for the first time in the appeal, the Provider addresses section 1115 waiver days.

On **April 26, 2024**, the Medicare Contractor timely filed its final position paper.

On **June 7, 2024**, the Medicare Contractor timely filed a Jurisdictional Challenge[11] with the Board over Issues 1 and 5, 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, to date, the Provider has never filed a response.

---

[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).

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).
>
> The Provider also contends that CMS inconsistently interpret 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.[12]

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

---

[12] Issue Statement at 1 (Feb. 7, 2020).

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.[13]

On October 1, 2020, the Board received the Provider's preliminary position paper in 20-1281. 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 their calculation based on the Provider's Fiscal Year End (August 31).

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

> 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).[14]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $247,000.

C. Description of Issue 5 in the Appeal Request

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

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

[14] Provider's Preliminary Position Paper at 8-9 (Oct. 1, 2020).

> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 4,46,47,52,58,S-D
>
> Estimated Reimbursement Amount: $91,000[15]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the Jewish Hospital case[16] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[17]

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2, which was transferred to Case No. 19-2456GC. 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.[18] The MAC also argues that Issue 1 should be dismissed because the Provider failed to file a complete preliminary or final position paper.[19]

Issue 5 – DSH Payment – Medicaid Eligible Days

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

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[15] Appeal Request at Issue 5.
[16] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[17] Provider's Preliminary Position Paper at 7-8.
[18] Medicare Contractor's Jurisdictional Challenge at 2 (Sept. 3, 2024)
[19] *Id*.

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

Provider's Jurisdictional Response

The 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.[20] 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, 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 three 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.

1. *First Aspects of Issue 1*

The first aspects 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 Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental

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

Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[21] 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)."[22] 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."[23]

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. 20-1281 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 19-2456GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[24], 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.[25] 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 it can, explain how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2.[26] Moreover, the Board

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[21] Issue Statement at 1.
[22] *Id.*
[23] *Id.*
[24] PRRB Rules v. 2.0 (Aug. 2018).
[25] 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).
[26] It is also not clear whether this is a systemic issue for BS&W Health providers in the same state subject to the CIRP rules or something that is provider specific because, if it was a common systemic issue, it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

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

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

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[27]

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:

[27] (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.[28]

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."[29]

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.

Accordingly, *based on the record before it*,[30] the Board finds that the SSI Provider Specific issue in Case No. 20-1281 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. DSH Payment – Medicaid Eligible Days

1. *Section 1115 Waiver Days*

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

[28] Last accessed Oct. 15, 2024.
[29] (Emphasis added).
[30] Again, the Board notes that the Provider failed to timely respond to the Jurisdictional Challenge and the Board must make its determination based on the record before it.

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 February of 2020 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[31]

Board Rule 7.2.1[32] elaborated on this regulatory requirement instructing providers:

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

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

> Several examples are identified below, but these examples are not

[31] 42 C.F.R. § 405.1835(b).
[32] v. 2.0 (Aug. 2018).

exhaustive lists of categories or issues.

A. Disproportionate Share Hospital Payments

Common examples include:

…

- ***Section 1115 waiver days (program/waiver specific)***[33]

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.[34]
42 C.F.R. § 405.1835(e) provides in relevant part:

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

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

In this regard, the Board notes that section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[35] Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program ***and*** not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction.[20] In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

> (4)*Second computation*. The fiscal intermediary determines, for

[33] (Bold and italic emphasis added).
[34] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[35] 65 FR 47054, 47087 (Aug. 1, 2000).

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

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

2. *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 nor was the listing submitted with 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.[36]

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:

[36] (Bold emphasis added.)

Rule 25 Preliminary Position Papers[37]

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

25.1 Content of Position Paper Narrative

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

25.1.1 The Provider's Position Paper

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

25.2 Position Paper Exhibits

25.2.1 General

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

[37] (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 February 28, 2020, included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(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.[38]

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

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

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

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

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

On October 1, 2020, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[39] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $91,548 based on an estimated 150 days). The Provider's complete briefing of this issue in its position paper is as follows:

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

[38] (Emphasis added.)
[39] Provider's Preliminary Position Paper at 8.

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

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 change in the designated representative to QRS does not excuse the Provider for its failure to include the information with its preliminary position paper. Board Rule 5.2 makes clear that "the

recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings."

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

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[41]

* * * * *

Based on the foregoing, the Board has dismissed the two (2) remaining issues in this case – (Issues 1 and 5). As no issues remain, the Board hereby closes Case No. 20-1281 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:

[40] (Emphasis added.)

[41] *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.

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

11/14/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal of SSI Percentage (Provider Specific) & Medicaid Eligible Days***
MetroSouth Medical Center (Prov. No. 14-0118)
FYE 12/31/2018
Case No. 22-1072

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-1072. Set forth below is the decision of the Board to dismiss the 2 remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) and Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 22-1072*

On **December 17, 2021,** the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2018.

On **May 31, 2022**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. SSI Percentage (Provider Specific)
2. SSI Systemic Errors[1]
3. Medicaid Eligible Days
4. SSI MCD PT C[2]
5. SSI MCD Dual[3]

As the Provider is owned by Quorum 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 Quorum Health groups on December 15, 2022. The remaining issues in this appeal are Issues 1 and 3.

[1] On December 15, 2022, this issue was transferred to Case No. 22-0977GC.
[2] On December 15, 2022, this issue was transferred to Case No. 23-0395GC.
[3] On December 15, 2022, this issue was transferred to Case No. 23-0394GC.

On **Feb 27 2023,** the Board issued the final Notice of Case Acknowledgement and Critical Due Dates (original notice was sent 6/1/2022), providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

On **June 15, 2023**, the Provider filed its Preliminary Position Paper. With respect to Issue 3, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2018 cost report does not reflect an accurate number of Medicaid eligible days."

On **October 12, 2023,** the Medicare Contractor filed a Jurisdictional Challenge[5] over Issue 1: SSI Percentage (Provider Specific) and Issue 3: Medicaid Eligible Days.

A. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 22-0977GC – Quorum Health CY 2018 DSH SSI Percentage CIRP Group

In their Individual Appeal Request, the Provider summarizes its 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.

---

[4] (Emphasis added.)

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

> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it 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.[6]

The Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 22-0977GC, Quorum Health CY 2018 DSH SSI Percentage CIRP Group, on December 15, 2022.The Group issue Statement in Case No. 22-0977GC 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

[6] Issue Statement at 1 (May 31, 2022).

> Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
>
> 2. Paid days vs. Eligible days,
>
> 3. Not in agreement with provider's records,
>
> 4. Fundamental problems in the SSI percentage calculation
>
> 5. Covered days vs. Total days and
>
> 6. Failure to adhere to required notice and comment rulemaking procedures.[7]

On June 15, 2023, the Board received the Provider's preliminary position paper in 22-1072. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a full and complete set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. See 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in Baystate Medical Center v. Leavitt, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the

[7] Group Appeal Issue Statement in Case No. 22-0977GC.

> Medicare fraction. The hereby incorporates 8 all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[8]

The Provider's amount in controversy for Issue 1 in Case No. 22-1072 and Issue 2 which was transferred to 22-0977GC is $38,386.

MAC's Contentions

Issue 1 – SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the SSI Percentage (Provider Specific) issue. 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 sub-issue should be dismissed because they are duplicative of Case No. 22-0977GC. 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] Moreover, the MAC contends that the Provider did not file a complete preliminary position paper with all supporting documentation in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25.[10]

Issue 3 – Medicaid Eligible Days

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

…failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of their claim in the preliminary position papers.
. . .

…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.
. . .

…failed to respond to the MAC's various requests to submit the required documentation
. . .

…failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats its appeal request.. . .

[8] Provider's Preliminary Position Paper at 7-8 (June 15, 2023).
[9] Medicare Contractor's Jurisdictional Challenge at 2 (Dec. 12, 2023).
[10] *Id* at 4 -9.

…essentially abandoned the issue by failing to properly develop their arguments and to provide supporting documents or to explain why they cannot produce those documents, as required by the regulations and the Board Rules.

Additionally, the MAC argues that the Provider has attempted to add an additional issue, Section 1115 Waiver days issue to the appeal and that the late briefing of the issue is improper 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. [11]

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

Provider's Jurisdictional Response

> The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[12] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. 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.

A. 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

[11] *Id* at 10 - 15.
[12] Board Rule 44.4.3, v. 3.2 (Dec. 2023).

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 of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 22-0977GC.

The SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[13] Per the appeal request, the Provider's legal basis for its SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[14] The Provider argues in its issue statement, which was included in the appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[15]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 22-0977GC 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 SSI Percentage (Provider Specific) issue in Case No. 22-1072 is duplicative of the DSH SSI Percentage Group issue in Case No. 22-0977GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[16], the Board dismisses this aspect of the 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 22-0977GC, 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.[17] 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

[13] Issue Statement at 1.
[14] *Id.*
[15] *Id.*
[16] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[17] 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)

distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 22-0977GC.

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. 22-0977GC, but instead refers to systemic *Baystate* data matching issues and a failure to include all patients that were entitled to SSI benefits. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with 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" and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents (Nov. 1, 2021)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[18]

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."

[18] (Italics and underline emphasis added.)

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from CMS, as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[19]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data.[20]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 22-0977GC.

Accordingly, *based on the record before it*, the Board finds that the SSI Provider Specific issue in Case No. 22-1072 and the group issue from the CIRP group under Case No. 22-0977GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

The second aspect of the SSI Percentage (Provider Specific) issue - the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is 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. DSH Payment – Medicaid Eligible Days

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal in either the initial appeal or the position papers. The position paper indicated that it would submit a listing under separate cover.

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[19] Last accessed July 16, 2024.
[20] Emphasis added.

The Provider's Position Paper was filed with a redacted list of Medicaid Eligible days pending finalization upon receipt of State eligibility data. The Medicare Contractor has stated "the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover."[21]

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Nov. 2021) states:

> **No Access to Data**
>
> If the provider elects 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.

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.

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.[22]

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**

[21] Jurisdictional Challenge at 10.
[22] 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.

> **timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[23]

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

Board Rule 25 (Nov. 2021) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

> **Rule 25 Preliminary Position Papers**[24]
>
> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the following sub-sections.
>
> **25.1.1 The Provider's Position Paper**
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
> B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
> C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
> D. Provide a conclusion applying the material facts to the controlling authorities.

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

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, 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 June 1, 2022, included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

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

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[25]

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

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

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

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

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

On June 15, 2023, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[26] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case. The Provider's complete briefing of this issue in its position paper is as follows:

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[25] (Emphasis added.)
[26] Provider's Preliminary Position Paper at 10 (June 15, 2023).

Calculation of Medicaid Eligible Days

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

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

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

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

Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2018 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

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

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be

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

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

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

C. Late add of Section 1115 Waiver Days to the appeal

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

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[27] (Emphasis added.)

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

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

The appeal was filed with the Board in May of 2022 and the regulations required the following:

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

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

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

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

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include:

[29] 42 C.F.R. § 405.1835(b).
[30] v. 2.0 (Aug. 2018).

…

- ***Section 1115 waiver days (program/waiver specific)***[31]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[32] 42 C.F.R. § 405.1835(e) provides in relevant part:

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

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

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

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

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

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

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

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

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

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

* * * *

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. 22-0977GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. 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. 22-1072 and removes it from the Board's docket.

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

Board Members Participating: For the Board:

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

11/18/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Case Closures***
Case No. 13-0088 Clarian West Med. Ctr. (Prov. No. 15-0158, FYE 12/31/2008)
Case No. 16-0457 IU Health Arnett Hosp. (Prov. No. 15-0173, FYE 12/31/2010)

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has learned that on November 6, 2024, the Group Representative in the above referenced cases filed a Complaint in the District Court for the District of Columbia[1] concerning the same providers and fiscal years. The Board's decision to close the cases pursuant to 42 C.F.R. § 405.1842(h)(3) is set forth below.

Background:

Clarian West Medical Center ("Clarian") filed an individual appeal request on November 20, 2012 appealing from a Notice of Program Reimbursement ("NPR") dated May 25, 2012 for its fiscal year ending ("FYE") December 31, 2008. The appeal request had two issues: Outlier Reconciliation (Operating and Capital), and Outlier Reconciliation Interest (Operating and Capital). Clarian and the Medicare Contractor filed Preliminary Position Papers ("PPP") on June 24, 2013[2] and October 22, 2013,[3] respectively. The case was postponed at the request of Clarian at least nine (9) times since July, 2015.

IU Health Arnett Hospital ("Arnett") filed an individual appeal request on December 21, 2015 appealing from a NPR dated July 2, 2015 for its FYE December 31, 2010. The appeal request had two issues: Outlier Reconciliation (Operating and Capital), and Outlier Reconciliation Interest (Operating and Capital). Arnett and the Medicare Contractor filed PPPs on August 29, 2016 and December 11, 2017, respectively.

The PPPs are materially identical except for the "Facts Specific to this Case" section in each, which outlines the issuance of each hospital's NPRs, their specific amount in controversy, etc.[4] Both Clarian and Arnett filed identical Requests for Expedited Judicial Review ("EJR") on August 30, 2024.

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[1] *See* Complaint, Clarian Health West, LLC et al. v. Becerra, Case No. 1:2024cv03153 (D.D.C.) (Nov. 6, 2024).
[2] *See* PRRB Case 13-0088, Provider's Petition for Expedited Judicial Review, Ex. P-1 (Aug. 30, 2024).
[3] *See id.* at Ex. P-17.
[4] There are other immaterial, fact specific differences that do not impact the legal arguments made. *E.g.*, PRRB Case 13-0088, Provider's Preliminary Position Paper, 27 (June 24, 2013) ("That was the very situation that occurred in this case . . . .").

On September 25, 2024, the Board issued a Request for Information which noted that the "30-day period for Board review of an EJR request does not begin until the Board finds jurisdiction and, since the Board has not yet completed its jurisdictional review, the 30-day period has not yet begun.[5]"

The Board also ordered the Group Representative to supplement the EJR Request:

> The Board hereby exercises its authority under 42 C.F.R. § 405.1842(e)(3) to require that, ***within twenty-one (21) days of the date of this letter's signature date [no later than October 16, 2024]***, the Group Representative file a supplement to their EJR request to clarify the following:
>
> 1. The first question generically states that the providers are challenging "whether the outlier payment *rules* . . . are invalid"[6] and such challenged rules "***include[e]*** the regulations at 42 C.F.R. § 412.84(h) and manuals at Medicare Claims Processing Manual, ch. 3, § 20.1.2."[7] Board Rule 42.3 requires an EJR request to "identif[y] the controlling law, regulation, Federal Register notice, or CMS ruling that is being challenged." Accordingly, the Board requires the Provider to specifically identify ***each*** such "outlier payment rule" whose validity is being challenged in the EJR Request and explain why the Board does not have authority to decide the legal question relative to that authority.
>
> 2. In particular, the Board notes that, in addition to challenging the regulation at 42 C.F.R. § 412.84(h), the Providers have stated that they are challenging the validity of the "manuals at Medicare Claims Processing Manual, ch. 3, § 20.1.2." In light of the D.C. Circuit's decision in *Clarian* (as discussed above), the Board requests clarification on whether the Provider is, in fact, challenging the "manuals at Medicare Claims Processing Manual, ch. 3, § 20.1.2." If so, the Board requires the Provider to clarify why the Board does not have jurisdiction over whether such "manuals at Medicare Claims Processing Manual, ch. 3, § 20.1.2" are or are not valid, particularly in light of the D.C. Circuit's decision in *Clarian* and the fact that 42 C.F.R. § 405.1867 specifies only that "The Board shall afford ***great weight*** to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS."[8]

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[5] *See* 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii) and (e)(3)(ii); 42 C.F.R. § 405.1842(a)(4) (stating "The provider has a right to seek EJR of the legal question under section 1878(f)(1) of the Act only if - . . . (ii) The Board fails to make a determination of its authority to decide the legal question no later than 30 days *after finding jurisdiction* over the matter at issue and notifying the provider that the provider's EJR request is complete. (emphasis added)); 42 C.F.R. § 405.1842(b)(2) (stating "the 30-day period for the Board to make a determination under section 1878(f)(1) of the Act *does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue* in the EJR request and notifies the provider that the provider's request is complete" (emphasis added)). *See also Aria Health v. Becerra*, No. 22-cv-2272, 2024 WL 1344405 (D.D.C. 2024) *Saint Francis v. Becerra*, No. 22-cv-1960, 2023 WL 6294168, *5 (D.D.C. 2023) ("The first sentence of § 405.1842(e)(1) fixes when the thirty-date period for determining authority defined in the second sentence becomes operative, specifically, after the Board determines it has jurisdiction." (citation omitted)).

[6] (Emphasis added.)

[7] (Emphasis added.)

[8] (Emphasis added.)

> *The Board reminds the parties that the above-requested information is necessary for the Board to rule on the EJR requests*[9] *and that its review of jurisdiction is* ***not yet complete*** *such that the 30-day clock for Board review of the EJR request has not yet begun.*

The Group Representative filed its Response to the Board's RFI and Scheduling Order on October 16, 2024 (the last day before the filing deadline elapsed). The response generally claims that the Board already had all materials necessary to establish its jurisdiction over these appeals and objects to the Board "extending" the "30-day clock for an EJR determination." It claims that the information sought by the Board was not related to its jurisdiction so the delay in granting EJR is unwarranted, and further emphasizes that EJR is appropriate (and has been granted for different FYs for Clarian).

Pursuant to the Board's September 25, 2024 Scheduling Order and RFI, the Medicare Contractor had twenty-one (21) days to file a reply to the Group Representative's response, meaning it was due no later than November 6, 2024. The Medicare Contractor did not file a response in either case, but on November 6, 2024, the Group Representative filed a Complaint in the District Court for the District of Columbia[10] based on the Board's failure to issue a decision on the EJR Requests within thirty (30) days of their filing.

Board's Determination to Close Cases 13-0088 and 16-0457:

A. Providers' Federal Complaint was Premature

The Board reiterates that it had the authority to request additional information and briefing before ruling on the Providers' EJR Requests because (1) it was still evaluating whether it had jurisdiction over the two appeals, and (2) the questions related to the Board's jurisdiction and the scope of the EJR Request illustrated that the EJR Requests were not "complete."

As thoroughly detailed in the Board's September 25, 2024 Scheduling Order, the 30-day timeline for the Board to determine whether it has the authority to grant the relief requested does not begin until the Board has established it has jurisdiction over the appeal.

Additionally, 42 C.F.R. § 405.1842(e)(1) requires the Board "to make a determination of its authority to decide the legal question raised in a review request . . . by issuing an EJR decision no later than 30 days ***after receiving a complete provider request*** as defined in paragraph (e)(2) of this section."[11] A complete provider request must contain "[a]ll of the information and documents ***found necessary by the Board*** for issuing a decision in accordance with paragraph (f) of this section."[12] Issuing a decision in accordance with 42 C.F.R. § 405.1842(f) requires more than a finding of jurisdiction; it requires the Board to grant EJR if it has jurisdiction to conduct a hearing *and* lacks the authority to decide a specific legal question relevant to the specific matter at issue. Thus, the Board must only issue a decision (including on whether it has the authority to decide a specific legal question) if the EJR Request has "all of the information . . . found necessary by the Board" to do so.

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[9] *See* 42 C.F.R. § 405.1842(f)(2)(iii).
[10] *See* Complaint, Clarian Health West, LLC et al. v. Becerra, Case No. 1:2024cv03153 (D.D.C.) (Nov. 6, 2024).
[11] (Emphasis added).
[12] 42 C.F.R. § 405.1842(e)(2)(ii).

The Board's Scheduling Order requested clarity on two items: (1) to specifically identify each "outlier payment rule" whose validity is being challenged and why the Board does not have authority to decide the legal question relative to that authority; and (2) whether the groups were challenging the manuals at Medicare Claims Processing Manual, ch. 3, § 20.1.2 and, if so, why the Board does not have jurisdiction over whether those manual provisions were valid.

The Group Representative's general position is that the Board could only delay the 30-day timeline to issue an EJR determination if it was unable to determine whether it had jurisdiction, but that the Board's Scheduling Order only sought information on whether the Board had the authority to decide the legal questions at issue. First, the Board specifically requested additional briefing on whether it has jurisdiction over the validity of certain manual provisions in light of the D.C. Circuit's decision in *Clarian* and the fact that 42 C.F.R. § 405.1867 specifies only that "The Board shall afford ***great weight*** to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS."

Second, the Board is only required to issue an EJR decision if it has a "complete" EJR Request. A complete EJR Request must contain "all of the information and documents ***found necessary by the Board*** for issuing a decision[,]" including whether the Board has the authority decide a specific legal question relevant to the specific matter at issue. In its Scheduling Order, the Board sought clarification on the scope of the EJR Request (*i.e.*, which outlier payment rule(s), specifically, were being challenged), implicitly finding the EJR Requests were not "complete" because it was necessary for the Board to gather more information as to what "specific legal question" was being challenged.

B. Effect of Filing of the Complaint in Federal Court

Even though the Providers' federal Complaint was premature, the regulation at 42 C.F.R. § 405.1842(h)(3) addresses how Provider lawsuits relating to an EJR request affect Board proceedings:

> (3) *Provider lawsuits*. (i) If the provider files a lawsuit seeking judicial review (whether on the basis of the EJR provisions of section 1878(f)(1) of the Act or on some other basis) pertaining to a legal question that is allegedly relevant to a specific matter at issue in a Board appeal to which the provider is a party and that is allegedly not within the Board's authority to decide, the Office of the Attorney Advisor must promptly provide the Board with written notice of the lawsuit and a copy of the complaint.
>
> ****
>
> (iii) *If the lawsuit is filed before a final EJR request is issued on the legal question*, ***the Board may not conduct any further proceedings*** on the legal question or the matter at issue until the lawsuit is resolved.[13]

[13] (Emphasis added.)

This regulation ***bars any further Board proceedings*** in these two group cases, including proceedings on *pre-requisite* jurisdictional issues or other procedural issues. Consistent with FRCP 62.1, the Board issues this ruling on a Motion for Relief that is barred by a pending appeal and, as explained below, is deferring further action in these two group cases until, or if, the Administrator remands these cases back to the Board.

To confirm the proper application of § 405.1842(h)(3), the Board reviewed the preambles to the proposed rule, dated June 5, 2004,[14] and the May 23, 2008 final rule[15] that promulgated the regulation at 42 C.F.R. § 405.1842(h)(3)(iii). The preamble to the proposed rule described this regulation as follows:

> Proposed § 405.1842(h)(3) would specify the effect that a provider lawsuit would have on the Board's ability to conduct further proceeding on the legal matter at issue. In general, if a provider files a lawsuit on the same legal issue for the same cost year that is currently pending before the Board - that is, the provider goes into court without waiting for a final administrative decision on EJR, we would seek to have the lawsuit dismissed, and we would prohibit the Board from conducting further proceedings on that issue until the lawsuit is resolved.[16]

The discussion in the final rule includes additional guidance on 42 C.F.R. § 405.1842(h)(3):

> *Comment*: One commenter stated that the proposed rule would provide that, if any allegedly relevant lawsuit was filed before a final EJR decision, the Board would be precluded from conducting any further proceedings on the EJR decision until the lawsuit was resolved, and that it appears that the proposed policy would apply, regardless of the basis for the lawsuit. The commenter suggested that the final rule provide that the Board be required to conduct further proceedings on an EJR decision when the provider subsequently files a lawsuit brought on jurisdictional grounds other than the Social Security Act. If the Board were allowed to grant EJR, the issues jurisdictionally under the Medicare statute could be added to the pending matter in court, thus preserving judicial resources and avoiding multiple lawsuits.
>
> *Response*: The commenter is correct that the proposed policy would apply regardless of the jurisdictional basis for the lawsuit. However, we decline to adopt the commenter's suggestion that we make a distinction based on the jurisdictional basis pleaded in the complaint. **We do not agree that it would be appropriate for the Board or the intermediary <u>to spend its limited resources</u> to spend time on a Board appeal if the provider has filed a complaint that involves a legal matter that is relevant to a legal issue in the Board**

[14] 69 Fed. Reg. 35716 (June 25, 2004).
[15] 73 Fed. Reg. 30190 (May 23, 2008).
[16] 69 Fed. Reg. at 35732.

> **appeal**. If the court properly has jurisdiction over the appeal, the decision, that it or a higher court renders, may resolve the issue or issues in the Board case, or otherwise inform the Board in reaching a decision, or affect the parties' decision as to whether they should attempt to settle the Board case. On the other hand, where the basis for the court's jurisdiction is defective (which we believe would most likely be the situation when a provider attempts to file a complaint based on a legal issue related to an appeal still pending before the Board), a contrary rule would not discourage providers from filing improper appeals with the court. We believe our proposal to be in line with the general rule practiced by courts that an appeal to a higher court deprives the lower court of jurisdiction to conduct further proceedings until the appeal is resolved by the higher court.[17]

Based on the above explanation regarding the intent and purpose for 42 C.F.R. § 405.1842(h)(3)(iii), the Board finds that Clarian and Arnett's filing of the Complaint in the District Court for the District of Columbia on November 6, 2024 prohibits the Board from conducting any further proceedings on the EJR requests for the two cases at issue therein as filed, including any proceedings related to the prerequisite jurisdiction and claims filing requirements.

C. Board Decision and Order

Based on the foregoing, the Board hereby takes the following actions:

1. Closes the case 13-0088 and 16-0457 consistent with 42 C.F.R. § 405.1842(h)(3)(iii); and
2. Suspends the ongoing jurisdictional review process.

Accordingly, the Board hereby closes these cases and removes them from the Board's docket. No further proceedings will occur, except upon remand from the Administrator, pursuant to 42 C.F.R. § 405.1877(g)(2).

Board Members Participating:

Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

FOR THE BOARD:

11/19/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

[17] 73 Fed. Reg at 30214-15 (bold and underline emphasis added).

cc: Jacqueline Vaughn, Office of the Attorney Advisor
Byron Lamprecht, WPS Government Health Administrators (J-8)
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

Michael Newell
Southwest Consulting Associates
2805 North Dallas Parkway
Suite 620
Plano, TX 75093-8724

RE: ***Expedited Judicial Review Determination***
Case Number: 24-2559GC - *Baystate Health CY 2012 Medicare Part C CIRP Group*
Case Number: 24-2561GC - *Baystate Health CY 2011 Medicare Part C CIRP Group*

Dear Mr. Newell:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' two Petitions for Expedited Judicial Review ("EJR") filed on November 1, 2024, in the two (2) above-referenced group appeals. The Board's decision on jurisdiction and EJR for the two (2) above-referenced group appeals is set forth below.

Background and Issue:

On September 19, 2024, the Board received requests to establish two Common Issue Related Party ("CIRP") groups for Baystate Health's CYs 2011 and 2012. The two CIRP groups are appealing from Revised Notices of Program Reimbursement ("RNPRs") which were issued to implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to their CYs 2011 and 2012.

The issue in this appeal is the proper treatment in the Medicare disproportionate share hospital ("DSH") calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Allina* litigation. The Providers contend that "part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction for patients eligible for Medicaid".[2] Each group filed a Petition for EJR on November 1, 2024 seeking to challenge the CMS policy adopted in the June 2023 Final Rule which is to be applied *retroactively* for periods prior to October 1, 2013.

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] Issue Statement at 1 (Sept. 19, 2024).

Statutory and Regulatory Background:

A. RNPR Appeals

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2023), which provides in relevant part:

> (a) General. (1) A Secretary determination, a contractor determination, or a decision by a reviewing entity (as described in § 405.1801(a)) may be reopened, with respect to specific findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the contractor (with respect to contractor determinations), or by the reviewing entity that made the decision. . . .

Additionally, 42 C.F.R. § 405.1889 (2023)[3] explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

As outlined above, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[4]

B. Medicare DSH Payment

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

The PPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[7] This case involves the hospital-specific DSH adjustment, which requires the Secretary

to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[8]

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

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[12]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[13]

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under***

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[3] *See also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).
[4] 42 C.F.R. § 405.1889(b)(1).
[5] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[6] *Id.*
[7] *See* 42 U.S.C. § 1395ww(d)(5).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[11] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[12] (Emphasis added.)
[13] 42 C.F.R. § 412.106(b)(2)-(3).

> ***part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[14]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[15]

C. Establishment of Medicare Part C and Treatment of Part C Days in the DSH Calculation

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations ("HMOs") and competitive medical plans ("CMPs") is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to an eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A [of this subchapter] and enrolled under part B [of this subchapter] . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In the September 4, 1990 Federal Register, the Secretary[16] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[17]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[18]

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[14] (Emphasis added.)
[15] 42 C.F.R. § 412.106(b)(4).
[16] of Health and Human Services.
[17] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[18] *Id.*

With the creation of Medicare Part C in 1997,[19] the benefits of Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer administered under Medicare Part A.[20] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed to clarify that,

> *. . . . once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .*[21]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated that her intention to address the comments received on that proposal in the FFY 2005 IPPS Final Rule. In that final rule, the Secretary purportedly changed her proposal/position by noting that she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[22] In response to a comment regarding this change, the Secretary explained that:

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations*

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[19] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

[20] 68 Fed. Reg. 27154, 27208 (May 19, 2003).

[21] *Id.* (emphasis added).

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

> *at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[23]

This statement would require inclusion of Medicare Part C inpatient days in the Medicare fraction of the DSH calculation.

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[24] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[25] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[26]

There has been substantial litigation over whether enrollees in Part C plans are "entitled to benefits" under Medicare Part A when determining their placement in either the DSH Medicare or Medicaid fraction.

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[27]
In 2014, the U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[28] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[29] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[30] However, the Secretary has not acquiesced to that decision.

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[23] *Id.* (emphasis added).
[24] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[25] *Id*. at 47411.
[26] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[27] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[28] 746 F. 3d 1102 (D.C. Cir. 2014).
[29] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[30] *Id.* at 2011.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[31] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014, the Secretary published Medicare fractions for FFY 2012 which included Part C days.[32] A number of hospitals appealed this action.[33] In *Azar v. Allina Health Services* ("*Allina II*"),[34] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[35] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[36] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[37]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[38] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under

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[31] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[32] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[33] The Board takes administrative notice that, in the Complaint filed to establish the Allina II litigation, none of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(ii). Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo(a)(1)(B) as implemented at 42 C.F.R. § 405.1835(c) (2014). Allina Health Servs. v. Burwell, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, the [9] plaintiff Hospitals timely filed appeals to the Board, pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B), to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[34] 139 S. Ct. at 1804 (2019).
[35] *Id.* at 1817.
[36] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[37] 139 S. Ct. at 1814.
[38] 85 Fed. Reg. 47723 (Aug. 6, 2020).

> 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[39]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[40] Relevant to the instant EJR Request, the June 2023 Final Rule provides the following guidance on the extent to which it is to be applied *retroactively*:

> [T]he Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals whose DSH payments ***for those periods are still open or have not yet been finally settled***, encompassing thousands of cost reports.[41]

Further, the June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[42]

Finally, the following excerpts from the June 9, 2023 Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule or subsequent publication of SSI ratios to be an appealable "final determination":

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October

[39] CMS Ruling 1739-R at 1-2.
[40] 88 Fed. Reg. 37772 (June 9, 2023).
[41] *Id.* at 37774 (emphasis added).
[42] 88 Fed. Reg. at 37788.

1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports****. In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[43]

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

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

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

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[43] 88 Fed. Reg. at 37774-75 (emphasis added).
[44] *Id.* at 37787 (underline, italics, and bold emphasis added).
[45] *Id.* at 37788 (emphasis added).
[46] *Id.* (emphasis added).

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

Providers' Position:

A. Providers' Appeal Requests

The Providers' appeal requests include a "Statement of Jurisdiction" asserting that the Providers have met the applicable statutory conditions for appeal because they are dissatisfied with their RNPRs which apply the June 9, 2023 retroactive final rule related to Part C days. They cite language from that final rule which outlined Providers' ability to challenge this final rule once they were issued RNPRs implementing the rule.[47]

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

The Provider characterized the relevant background facts as follows:

1. In the FY 2005 IPPS Final Rule, CMS first announced a policy change to count Part C days "in the SSI fraction and to exclude those days from the numerator of the Medicaid fraction."[49]

2. In *Allina I*, the D.C. Circuit vacated that policy change.[50]

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking. The Supreme Court's decision "did not address the D.C. Circuit's alternate ruling that the readopted standard was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the policy could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[51]

4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.[52]

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[47] Appeal Request, Statement of Jurisdiction (Case No. 24-2561GC) (citations omitted).
[48] Appeal Request, Statement of Issue (Case No. 24-2561GC).
[49] *Id.*
[50] *Id.*
[51] *Id.* (citing to 139 S. Ct. at 1816).
[52] *Id.*

Based on the above, the Provider maintains that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule "is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, exceeded the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[53]

B. Providers' Petitions for EJR

The Providers have requested EJR over the "post-*Allina* retroactive Part C policy issue" because they believe they have met the requirements for a hearing before the Board, but that the Board lacks "the authority to decide the substantive and procedural validity of CMS' final rule published in the Federal Register on June 9, 2023."[54] They seek a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.[55] The Provider contends "that the new, post-*Allina* retroactive part C days rule . . . is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[56] Since the Board is bound by this regulation,[57] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

On November 8, 2024, the Medicare Contractor's representative, Federal Specialized Services ("FSS"), filed timely responses to the Petitions for EJR in both cases. It simply advised that, in each case, "a jurisdictional challenge will not be filed. A substantive claim challenge will not be filed. The MAC will not challenge Provider's request for expedited judicial review."[58]

Decision of the Board:

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

A. Jurisdiction

A group of Providers generally have a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if:

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[53] *Id.* (citing 4 U.S.C. § 706(2)).
[54] Providers' Petition for Expedited Judicial Review, 12 (Nov. 1, 2024).
[55] *Id.* at 15.
[56] *Id.* at 1-2.
[57] 42 C.F.R. § 405.1867.
[58] FSS EJR Response (Nov. 8, 2024).

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [59]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[60]

For both of these CIRP Groups, the providers all appealed from RNPRs issued to implement the new, retroactive Part C days rule as set forth in the June 9, 2023 Final Rule. All of the providers were directly added to the group within 180 days of the issuance of their RNPRs and the amount in controversy exceeds $50,000 in both groups.

42 C.F.R. § 405.1889 governs the scope of appeals once a contractor determination is "reopened as provided in § 405.1885[.]" In this circumstance, Providers have *limited* appeal rights and are only able to appeal issues or matters that were "specifically revised" in the RNPR. In the June 9, 2023 Final Rule, however, the Secretary made clear that the Part C Days rule could be appealed following the issuance of a new NPR or RNPR "***even if the Medicare fraction or DSH payment does not change numerically.***"[61] Thus, the new rule could be appealed even if the treatment of Part C Days was not "specifically revised."

Following the issuance of a RNPR, the Secretary stated that Providers "***will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions contained in the NPRs or revised NPRs***[,]" "**will be able to challenge the agency's interpretation** [of the treatment of Part C days in this final action] by appealing those NPRs and revised NPRs[,]" and further stated that they "**can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[62]

The Board finds that the Providers in Cases 24-2559GC and 24-2561GC have all filed timely appeals from their RNPRs concerning the same common issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these RNPRs, even if there was no change in payment. The Board also finds that the amount in controversy in each case exceeds $50,000 as required by 42 C.F.R. § 405.1837(a)(3). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

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[59] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[60] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[61] 88 Fed. Reg. at 37788 (emphasis added).
[62] *Id.* at 37787-88 (emphasis added).

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in these cases and that the Providers in these group appeals are entitled to a hearing before the Board;

2) Based upon the Providers' assertions regarding the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, is valid.

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

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

Board Members Participating:

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

FOR THE BOARD:

11/20/2024

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Regional Hospital of Jackson, Prov. No.: 44-0189
FYE: 09/30/2015
Case No.: 19-1041

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-1041. Set forth below is the decision of the Board to dismiss the two remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage ("Provider Specific") and Medicaid Eligible Days payments.

Background

A. *Procedural History for Case No. 19-1041*

On **January 14, 2019**, Regional Hospital of Jackson ("Jackson"), Provider No. 44-0189, fiscal year end ("FYE") 09/30/15, filed a timely individual appeal request from a **July 18, 2018** Notice of Program Reimbursement ("NPR") appealing the following five issues:

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

After all issues were transferred, two issues remain in the appeal: Issue 1, DSH SSI Percentage ("Provider Specific") and Issue 3, DSH Medicaid Eligible Days.

On **February 8, 2019**, the Board issued a Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position

[1] On August 23, 2019, this issue was transferred to Case No. 18-0552GC.
[2] On August 23, 2019, this issue was transferred to Case No. 18-0555GC.
[3] On August 23, 2019, the issue was transferred to Case No. 18-0554GC.

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

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

On **March 6, 2019**, the Medicare Contractor filed a Jurisdictional Challenge[5] with the Board over Issue 1, SSI Percentage ("Provider Specific"), requesting that the Board dismiss this issue. The Provider filed a timely response on **March 27, 2019**.[6]

On **September 6, 2019**, the Provider filed its preliminary position paper. With respect to Issue 3, Medicaid eligible days, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made, and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the 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."[7]

On **January 3, 2020**, the Medicare Contractor filed its preliminary position paper. With respect to Issue 3, Medicaid eligible days, the Medicare Contractor's preliminary position paper noted that the Provider had failed to include a Medicaid eligible days listing with its preliminary position paper, notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position

On **January 12, 2023**, the Medicare Contractor filed its 3rd and final request for documentation in connection with Issue 3, Medicaid eligible days. Within this filing, the Medicare Contractor

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[4] (Emphasis added.)
[5] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).
[6] Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the jurisdictional challenge.
[7] Provider's September 6, 2019 Preliminary Position Paper at 8.

included its February 14, 2019 1st request for documentation in which it had requested that the Provider send it documentation to resolve Issue 3. The Medicare Contractor also sent the Provider a 2nd request for documentation on July 26, 2021. As no response was received from the Provider, the Medicare Contractor filed the 3rd and final request for documentation to formally request that a listing of the Medicaid eligible days at issue plus supporting documentation be provided to the Medicare Contractor. Notwithstanding the formal request, the Provider failed to file any response to the Medicare Contractor.[8]

On **August 26, 2024**, the Provider filed its final position paper. With its final position paper, the Provider submitted a "redacted list" of days and indicated that it would send an unredacted list to the Medicare Contractor.[9] The Medicare Contractor has not received the "unredacted list." At the top of the list, the Provider states, "Listing pending finalization upon receipt of State eligibility data."[10]

On September 5, 2024, the Medicare Contractor filed a second jurisdictional challenge relative to Issue 1, SSI Percentage ("Provider Specific") and Issue 3, Medicaid eligible days, and requested that the Board dismiss these issues. The Provider did not file a response to the second jurisdictional challenge.

On **September 9, 2024**, the Provider appointed Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS") as its designated representative for the above-referenced appeal.

On **September 19, 2024**, the Medicare Contractor timely filed its final position paper.

On **October 31, 2024**, the Provider submitted a Request for Postponement requesting that the Board postponed the November 25, 2024, hearing to give the parties time to finalize an Administrative Resolution asserting:

> [a] listing of additional days is currently being finalized for submission to the MAC. Due to unforeseen delays, the processing of the eligibility response by the State has taken longer than anticipated to produce a final listing for the MAC.

The Provider noted that the Medicare Contractor does not approve a postponement.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-0552GC – QRS CHS 2015 DSH SSI Percentage CIRP Group

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

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[8] Medicare Contractor's September 19, 2024 Final Position Paper Exhibit C-1; Medicare Contractor July 26, 2021Request for Documentation and Withdrawal of Duplicate Issue at 1.
[9] Provider's August 26, 2024 Final Position Paper Ex. P-1 at P0002.
[10] *Id*.

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).[11]

The Group issue Statement in Case No. 18-0552GC, to which the Provider transferred Issue 2, reads, in part:

> **Statement of the Issue:**
>
> Whether the Medicare/SSI fraction used in the Medicare Disproportionate Share Hospital and LIP payment calculations accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSI fraction calculation per the Medicare Statute at 42 U.S.C. §1395ww(d)(5)(F)(vi).
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) 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(s) contend(s) 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.

[11] Provider's January 14, 2019 Individual Appeal Request, Issue Statement, Issue 1.

> The Provider(s) also contend(s) 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 SST payment.
>
> The Provider(s) further contend(s) 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 0. 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.
>
> Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the *Baystate* case:
>
> 1. Availability of MEDPAR and SSA Records
> 2. Failure to adhere to required notice and comment rulemaking procedures
> 3. Fundamental problems in the SSI percentage calculation
> 4. Not in agreement with provider's records
> 5. Paid days vs. Eligible days, and
> 6. Covered days vs. Total days [12]

On September 6, 2019, the Board received the Provider's preliminary position paper in Case No. 19-1041.The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Tennessee and the Provider that does not support the SSI percentage issued by CMS.

[12] Provider's January 18, 2018 Group Appeal Request, Group Issue Statement at 1.

> The Provider has worked with the State of Tennessee and has learned that similar to *Loma Linda Community Hospital v. Dept of Health and Human Services,* No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt,* 545 F. Supp: 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[13]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $44,000.

Medicare Contractor's Contentions

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

The Medicare Contractor argues that the Board lacks jurisdiction over Issue 1, the DSH – SSI Percentage ("Provider Specific") issue. The Medicare Contractor asserts 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 first and third sub-issues should be dismissed because they are duplicative of Issue 2.[14] The portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[15] Further, the Provider has abandoned the SSI realignment issue because the Provider did not brief the issue within its preliminary position paper nor file a complete preliminary or final position paper.[16]

Issue 3 – DSH – Medicaid Eligible Days

The Medicare Contractor contends that the Provider failed to properly develop its arguments within its preliminary and final position papers in accordance with 42 C.F.R. § 405.1853(b)(2)

[13] Provider's September 6, 2019 Preliminary Position Paper at 8-9.
[14] Medicare Contractor's September 5, 2024 Jurisdictional Challenge at 4.
[15] *Id*. at 7.
[16] *Id*. at 6-7.

and Board Rule 25. The Medicare Contractor argues the Provider has not submitted a final Medicaid eligible days listing and therefore, requests the Board dismiss the issue.

Additionally, the Medicare Contractor contends the Provider is attempting to add the Section 1115 Waiver days issue improperly and untimely. The Section 1115 Waiver days were not part of the initial appeal request and untimely added via its Final Position Paper.[17]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the Medicare Contractor's Jurisdictional Challenges must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[18] The Provider timely filed a response to the Medicare Contractor's first Jurisdictional Challenge addressing Issue 1, DSH SSI Percentage ("Provider Specific") on March 27, 2019, arguing that each of the appealed SSI issues are separate and distinct issues. Thus, the Board should find jurisdiction over the case.[19] The Provider did not respond to the Medicare Contractor's second Jurisdictional Challenge over Issue 1, DSH SSI Percentage ("Provider Specific") and Issue 2., DSH Medicaid eligible days.

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (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.

[17] *Id*. at 11. 14.
[18] Board Rule 44.4.3, v. 2.0 (Aug. 2018).
[19] Provider's March 27, 2019 Jurisdictional Response at 1.

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage ("Systemic Errors") issue that was appealed in Case No. 18-0552GC.

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."[20] 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)."[21] 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."[22]

The Provider's DSH/SSI Percentage ("Systemic Errors") issue in group Case No. 18-0552GC 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. 19-1041 is duplicative of the DSH/SSI Percentage ("Systemic Errors") issue in Case No. 18-0552GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6,[23] 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.[24] 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

[20] Provider's January 14, 2019 Individual Appeal Request, Issue Statement at 1.
[21] *Id.*
[22] *Id.*
[23] PRRB Rules v. 2.0 (Aug. 2018).
[24] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

the SSI issue in Case No. 18-0552GC, 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"[25] but fails to explain how it can, explain how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2.[26] 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. Once the documents become available, promptly forward them to the Board and the opposing party.[27]

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

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[25] Provider's September 6, 2019 Preliminary Position Paper at 9.
[26] 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.
[27] (Italics and underline emphasis added.)

can obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[28]

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."[29]

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. 18-0552GC.

Accordingly, *based on the record before it*,[30] the Board finds that the SSI Provider Specific issue in Case No. 19-1041 and the group issue from the CIRP group under Case No. 18-0552GC 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.

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[28] Last accessed September 19, 2024.
[29] Emphasis added.
[30] The Board notes that the Provider failed to respond to the second Jurisdictional Challenge and the Board must make its determination based on the record before it.

B. DSH Payment – Medicaid Eligible Days

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal in either the initial appeal or the preliminary position paper. With its final position paper, the Provider submitted a "redacted list" of days and indicated that it would send an unredacted list to the Medicare Contractor. However, the list does not comply with the Medicare Contractor's requests.[31] The list submitted with the final position paper is not a *final* list of days that the Provider expects the Medicare Contractor to include in a revised settlement. The Provider's list includes the caption "Listing pending finalization upon receipt of State eligibility data." The Medicare Contractor has not received the "unredacted list."

Regarding 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.[32]

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

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[31] For documentation dated February 14, 2019, July 26, 2021, and January 12, 2023.
[32] (Bold emphasis added.)

As cited above, Board Rule 25 requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation.

Rule 25 Preliminary Position Papers

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

25.1 Content of Position Paper Narrative

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

25.1.1 The Provider's Position Paper

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

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

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

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

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

> paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[33]

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

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

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

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

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

On September 6, 2019, the Provider filed its preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[34] Significantly, the preliminary position paper did ***not*** include the *material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request. The Provider's complete briefing of this issue in its preliminary 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.

[33] (Emphasis added.)
[34] Provider's September 6, 2019 Preliminary Position Paper at 8.

> 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.[35]

In its second Jurisdictional Challenge, the Medicare Contractor asserts that the Provider has failed to submit a final list of additional Medicaid eligible days and neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. The Medicare Contractor maintains the list that the Provider presented with its final position paper does not represent a list of days it expected to be included in the DSH computations. The Provider acknowledges that it is not a *final* list.

The Provider failed to timely include a list of additional Medicaid eligible days with its preliminary position paper, or submit such list under separate cover as instructed, or when requested from the Medicare Contractor. The Medicare Contractor thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide

[35] Provider's September 6, 2019 Preliminary Position Paper at 7-8.

supporting documents or to explain why it failed to produce those documents, as required by the regulations and the Board Rules.[36]

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 identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

Pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[37] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single final Medicaid eligible day as being in dispute as part of the position paper filings (much less provide the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[38] As such, the Board dismisses this issue from the appeal.

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[36] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable. Medicare Contractor's September 5, 2024 Jurisdictional Challenge at 8.

[37] (Emphasis added.)

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

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

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[39] (many of which were issued prior to the Provider's March 15, 2019 deadline for adding issues to this appeal).[40]

The appeal was filed with the Board in January of 2019 and 42 C.F.R. § 405.1835(b) 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

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.

[39] *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).

[40] Here, the NPR at issue was issued on July 18, 2018, and the Provider had until Thursday, January 19, 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). Accordingly, the deadline to add issues is 60 days beyond that date, *i.e.* March 15, 2019.

> 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.[41]

Board Rule 7 (Aug. 29, 2018) elaborated on these regulatory "contents" requirements instructing providers:

> **7 - Support for Final Determination, Issue-Related Information and Claim of Dissatisfaction**
>
> The Provider must support the determination being appealed and the basis for its dissatisfaction for <u>each</u> issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Board Rules 7.2 and 7.3 provider further information regarding issue pleading and specificity:

> **7.2 - Issue Related Information**
>
> **7.2.1 General Information**
>
> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
> • An issue title and a concise issue statement describing:

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

- 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.

7.2.2. Additional Information

Providers must submit additional information not specifically addressed above in order to support jurisdiction or appropriate claim for the appealed issue(s). Example: Revised NPR workpapers and applicable cost report worksheets to document that the issue under appeal was specifically adjusted. NPR or Revised NPR Adjustments

7.3 Self Disallowed Items (Applies to Cost Reporting Periods Ending On or Before 12/31/15)

7.3.1 Authority Requires Self-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.

7.3.2 No Access to Data

> If the Provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.
>
> **7.3.3 Protest**
>
> Effective for cost reporting periods ending on or after December 31, 2008, items claimed under protest on the cost report must follow the applicable procedures as contained in CMS Pub. 15-2, Section 115. See 42 C.F.R.§ 405.1835(a)(1)(ii). [*March 2013*][42]
>
> For the appeal, you must:
>
> • identify the amount that was protested for the specific item being appealed,
> • attach a copy of the protested items worksheet submitted with your as-filed cost report, and
> • the as-filed Worksheet E or audit adjustment report to demonstrate the total protested claim.
> Note: CMS Ruling 1727-R governs for cost reporting periods ending on or after 12/31/08 and beginning before 1/1/16.

Board Rule 8 (Aug. 29, 2018) 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***…".[43] Board Rule 8.1 (Aug. 29, 2018) 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

[42] (Italics emphasis in initial paragraph for Rule 7 added.)
[43] (Emphasis added.)

> outlined in Rule 7. Several examples are identified below, ***but these are not exhaustive lists of categories or issues.***[44]
>
> **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, general assistance, charity care, HMO days, etc.)
>
> **B. Bad Debts**
> Common examples include: crossover bad debts, collection effort, use of collection agency, 120-day presumption, indigence determination.
>
> **C. Graduate Medical Education/Indirect Medical Education**
> Common examples include: managed care days, new programs, current year resident count, prior year count, penultimate year count, intern to bed ratio, and rotations to non-hospital settings.
>
> **D. Wage Index**
> Common examples include: wage data corrections, occupational mix, wage vs. wage-related costs, pension, rural floor, and data corrections.[45]

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*.[46] As a result of this final rule, 42 C.F.R. § 405.1835(e) (Sept. 2015) provides in relevant part:

> (b) *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

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[44] (Emphasis added.)
[45]Board Rules are available https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-rules-and-board-orders (last visited September 19, 2024).
[46] *See* 73 Fed. Reg. 30190 (May 23, 2008).

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 August 26, 2024 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 ***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).[47] 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) 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**

[47] 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).").

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.[48]

*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**.*[49] 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[50] 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.[51] In contrast, every state has a Medicaid state

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[48] (Bold emphasis added.)

[49] 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.

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

[51] 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

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.[52]

In this regard, documentation needed to verify eligibility for a § 1115 waiver day is materially different than that for a traditional Medicaid eligible day[53] 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.[54] 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.[55] 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

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> 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.

[52] (Emphasis added.)

[53] 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 41 and litigation in *supra* note 30.

[54] *See* litigation in *supra* note 30.

[55] 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.

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[56] 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.[57] 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, not included in any listing, 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,[58] 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.[59] 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***."[60] 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

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[56] 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.

[57] 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).

[58] 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.)*

[59] *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.

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

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.

* * * * *

Based on the foregoing, the Board dismisses the final two (2) remaining issues in this case, – Issue 1, DSH SSI Percentage ("Provider Specific") and Issue 3, DSH Medicaid eligible days. As no issues remain, the Board hereby closes Case No. 19-1041 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

11/21/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Byron Lamprecht, WPS Government Health Administrators
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***
Bayfront Health Port Charlotte, Prov. No. 10-0077, FYE 12/31/2017
Case No. 21-1331

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 21-1331. 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 payments.

Background

A. *Procedural History for Case No. 21-1331*

On **December 8, 2020**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2017. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **May 27, 2021**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained seven (7) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH SSI 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[4]

[1] On December 14, 2021, this issue was transferred to Case No. 20-0997GC.
[2] On December 14, 2021, this issue was transferred to Case No. 20-1333GC.
[3] On December 14, 2021, this issue was transferred to Case No. 20-1334GC.
[4] On June 21, 2023, the Medicare Contractor filed a jurisdictional challenge over Issue 5 and Motion to Dismiss.

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]

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 **December 14, 2021**, the Provider transferred Issues 2, 3, 4, 6 and 7 to CHS CIRP groups. As a result of the case transfers, there are two (2) remaining issues in this appeal: Issue 1 (DSH – SSI Percentage Provider Specific) and Issue 5 (DSH – Medicaid Eligible Days).

On **May 27, 2021**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[7]

On **December 30, 2021**, the Provider timely filed its preliminary position paper. With respect to Issue 5, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made, and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2017 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions." As a result, the Provider included, as an Exhibit, the original "estimated impact" for this issue of $57,395 based on an *estimated* 100 days.

[5] On December 14, 2021, this issue was transferred to Case No. 20-1333GC.
[6] On December 14, 2021, this issue was transferred to Case No. 20-1336GC.
[7] (Emphasis added.)

On **May 4, 2022**, the Medicare Contractor timely filed a Jurisdictional Challenge[8] with the Board over Issue 1 requesting that the Board dismiss this issue. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **May 13, 2022**, the Medicare Contractor filed its preliminary position paper. With regard to Issue 5, the Medicare Contractor's position paper noted that: (1) the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position; and (2) the Provider had failed to respond to any of the Medicare Contractor's requests for that Medicaid eligible days listing.

On **January 5, 2023**, the Medicare Contractor filed its 2nd and Final Request for DSH Package in connection with Issue 5. In this filing, the Medicare Contractor noted that it had previously requested that the Provider send a DSH package to resolve Issue 5 on August 4, 2021. As no response was received, the Medicare Contractor formally filed the 2nd and Final Request for DSH Package to formally request that a listing of the Medicaid eligible days at issue plus supporting documentation be provided to the Medicare Contractor on or before February 4, 2023 (*i.e.*, within 30 days). Notwithstanding the formal request, the Provider failed to file any response to the Medicare Contractor.

As no response was received from the Provider, on **August 17, 2023**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to furnish documentation in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); (2) the Provider failed to furnish the Medicaid eligible days listing with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2; and (3) the Provider has effectively abandoned Issue 3. Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** timely respond to that Motion.

On **November 8, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **November 9, 2023**, almost 3 months after the deadline for responding to the Motion to Dismiss Issue 5, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the *caveat* that the "Listing [is] *pending finalization* upon receipt

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[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).

of State eligibility data."[9] The Listing was 11 pages and did not include a total calculation of Medicaid eligible days. QRS' filing did not explain why the listing of was being submitted at this late date nor why it was not final (*i.e.*, why it was "pending finalization") at this late date, ***more than 6 years after the fiscal year at issue had closed***.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20-0997GC - CHS CY 2017 DSH SSI Percentage CIRP Group

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

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

The Group Issue Statement in Case No. 20-0997GC, to which the Provider transferred Issue 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

[9] (Emphasis added.)
[10] Provider's Individual Appeal at 20 (Dec. 30, 2021).

> Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[11]

On May 4, 2020, the Board received the Provider's preliminary position paper in 21-1331. 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 (December 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services,* No. CV-94-0055 (C.D. Cal June 2, 1995), the SSI entitlement of individuals can be ascertained from [s]tate records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the completed MEDPAR data, the

[11] Group Appeal Issue Statement in Case No. 20-0997GC.

> 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 $71,000.

MAC's Contentions

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

In its jurisdictional challenge, the Medicare Contractor contends the following:

> The MAC requests that the Board dismiss the portions of Issue 1 concerning SSI data accuracy and individuals who are eligible for SSI but did not receive SSI payment, as they are duplicative of the issue under appeal in Group Case Nos. 20-0997GC, "CHS CY 2017 DSH SSI Percentage CIRP Group." The Provider cannot have this issue in more than one appeal for the same fiscal year.
>
> Further, the Provider's appeal over SSI realignment should be dismissed because there is not a MAC determination, the Provider did not pursue its available remedy, and, therefore, it is not appropriate to include this issue in a Board appeal. The MAC requests the Board dismiss this issue consistent with other jurisdictional decisions cited previously.
>
> Lastly, the MAC contends that the Provider has failed to file a complete preliminary position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25. Therefore, the MAC respectfully requests that the Board dismiss this issue for the reasons stated above.[13]

Issue 5 – DSH Payment – Medicaid Eligible Days

In its Motion to Dismiss, the Medicare Contractor contends the following:

> Wherefore, the MAC respectfully requests that the Board make the following findings and enter an Order providing as follows:

[12] Provider's Preliminary Position Paper at 11-12 (Dec. 30, 2021).
[13] Medicare Contractor's Jurisdictional Challenge at 10-11 (May 4, 2022).

a. That the Provider has failed to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable.

b. That the Provider has made affirmative statements in its Preliminary Position Paper that it was submitting such supporting documentation to the MAC.

c. That the Provider's failure to furnish such documentation (or describe why such documentation is unavailable) is in violation of PRRB Rules 7, 25.2.1 and 25.2.2.

d. That the Provider has effectively abandoned its claim for additional Medicaid Eligible Days.

e. That the Provider's claim for additional Medicaid Eligible Days is therefore dismissed.[14]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[15] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

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

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in

[14] Medicare Contractor Motion to Dismiss at 4-5 (Aug, 17, 2023).
[15] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

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. 20-0997GC.

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

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-0997GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 21-1331 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-0997GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[19], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

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

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[20] 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. 20-0997GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records" but fails to explain how it can, explain how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2.[21] 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. Once the documents become available, promptly forward them to the Board and the opposing party.[22]

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

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

[21] 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.

[22] (Italics and underline emphasis added.)

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.[23]

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."[24]

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

Accordingly, *based on the record before it*,[25] the Board finds that the SSI Provider Specific issue in Case No. 21-1331 and the group issue from the CHS CIRP group under Case No. 20-0997GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

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[23] Last accessed Nov. 15, 2024.
[24] (Emphasis added).
[25] 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.

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 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.[26]

[26] (Bold emphasis added.)

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

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

> **Rule 25 Preliminary Position Papers**[27]
>
> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the following sub-sections.
>
> **25.1.1 The Provider's Position Paper**
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
> B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
> C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
> D. Provide a conclusion applying the material facts to the controlling authorities.
>
> **25.2 Position Paper Exhibits**
>
> **25.2.1 General**

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

> With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.
>
> **25.2.2 Unavailable and Omitted Documents**
>
> If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.
>
> **25.2.3 List of Exhibits**
>
> Parties must attach a list of the exhibits exchanged with the position paper.
>
> **25.3 Filing Requirements to the Board**
>
> Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.
>
> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on May 27, 2021 included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 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.[28]

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

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

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

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

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

On December 30, 2021, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[29] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $57,395 based on an estimated 100 days). The Provider's complete briefing of this issue in its position paper is as follows:

---

[28] (Emphasis added.)
[29] Provider's Preliminary Position Paper at 11 (May 4, 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' 2017 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[30]

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

[30] Provider's Preliminary Position Paper at 10-11 (Dec. 30, 2021).

Notably, the Medicare Contractor sent two separate requests for the Provider's list of Medicaid Eligible days (and also discussed the lack of the listing in the Medicare Contractor's own position paper filing). The first notice was sent to the Provider on August 4, 2021and the second, final, request was sent to the Provider on January 5, 2023, *six years after the end of the Provider's cost reporting period*. The Medicare Contractor also informed the Provider in its final request for information that the deadline to respond was February 4, 2023. The Provider failed to file any response to the 2nd and final request.

Due to the non-responsiveness of the Provider, on **August 17, 2023**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish the list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2 (or when request by the Medicare Contractor 3 separate times after that). The Medicare Contractor thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the regulations and the Board Rules.[31]

Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** timely respond to that Motion by the September 17, 2023 filing deadline (*i.e*., 30 days after August 17, 2023).

However, on November 9, 2023 (3 months after the deadline to respond to the Motion), QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the caveat that the "Listing [is] pending finalization upon receipt of State eligibility data." The Listing was 11 pages with no total calculation of Medicaid eligible days. QRS' filing did not explain why the listing of days was being submitted at this late date or why it was not final (*i.e*., why it was "pending finalization") at this late date, ***more than 6 years after the fiscal year at issue had closed***. Regardless, this filing was more than 3 months past the deadline for responding to the Motion to Dismiss *and, more importantly,* ***was almost 2 years past the deadline for including it with its preliminary position paper*** since the position paper deadline was January 22, 2022.

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

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

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 day after the Provider changed its designated representative to QRS does not excuse the Provider for its failure to include the information with its preliminary position paper or its failure to timely respond to the Motion to Dismiss. Board Rule 5.2 makes clear that "the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings." Moreover, the Board rejects the Provider's attempt to label the November 9, 2023 filing as a "Supplement to Position Paper" and does not accept that filing because:

1. The alleged "Supplement" was filed ***more than 2 years*** *after the deadline* for that exhibit to be included with its preliminary position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)). Indeed, the Provider failed to timely reply to the Medicare Contractor's Motion to Dismiss Issue 5 and the alleged "Supplement" was filed ***more than 3 months*** *after the deadline* for filing a response to the Motion to Dismiss Issue 5.

2. The alleged "Supplement" fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); (b) *why* the listing of days was not previously available, *in whole or in part* (*i.e*., it is not clear why the Provider failed to identify a single day at issue until more than 2 years after this appeal was filed and more than 6 years after the fiscal year at issue had closed); and (c) why the listing still was ***not*** a "*final*" listing at this late date.

3. Neither the Board Rules nor the May 27, 2021 Case Acknowledgment and Critical Due Dates permit the Provider to file a "Supplement" to its preliminary position paper (nor did the Provider allege in the "Supplement" filing that they do).

4. Given the fact that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the position paper filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its preliminary position paper or a supplement of documents that were identified in the preliminary position paper as being unavailable consistent with Board Rule 25.2.2. However, neither the preliminary position paper nor the alleged "Supplement" identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the alleged "Supplement" cannot be considered a refinement of the position paper since no specific days or listing were included with the preliminary position.[32]

[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."

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 regarding filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[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. 21-1331 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

11/21/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[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.

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***
Carolinas Hospital System, Prov. No. 42-0091
FYE 06/30/2015
Case No. 19-0513

Dear Mr. Summar:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-0513. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific).

Background

A. Procedural History for Case No. 19-0513

On **May 30, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2015. The Provider is commonly owned by Community Health Systems, Inc. ("CHS" or "Community Health").

On **November 20, 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 Payment – Medicaid Eligible Days[2]
4. Uncompensated Care ("UCC") Distribution Pool[3]
5. 2 Midnight Census IPPS Payment Reduction[4]

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory

[1] On June 17, 2019, this issue was transferred to PRRB Case No. 18-0552GC.
[2] The Provider withdrew this issue on October 22, 2024.
[3] On June 17, 2019, this issue was transferred to PRRB Case No. 18-0555GC.
[4] On June 17, 2019, this issue was transferred to PRRB Case No. 18-0554GC.

common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on June 17, 2019, the Provider transferred Issues 2, 4, and 5.

On **December 17, 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.[5]

On **July 16, 2019**, the Provider timely filed its preliminary position paper.

On **October 17, 2019**, the Medicare Contractor timely filed a Jurisdictional Challenge[6] with the Board over Issue 1, requesting that the Board dismiss this issue. The Provider filed a timely Jurisdictional Response on **November 18, 2019**.[7]

On **October 23, 2019**, the Medicare Contractor filed its preliminary position paper.

On **April 29, 2024**, the Board issued the Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

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

[5] (Emphasis added.)
[6] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).
[7] Per Board Rule 4.4.3 (v. 2.0, Aug. 2018), if a due date falls on a Saturday or Sunday, the deadline is the next day the Board is able to conduct business.

> *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.[8]

On **October 16, 2024**, the Provider timely filed its final position paper.

On **October 22, 2024**, the Provider withdrew Issue 3 from the appeal. As a result of the case transfers and withdrawn issue, there is only one (1) remaining issue in the appeal: Issue 1 (DSH – SSI Percentage Provider Specific).

On **November 13, 2024**, the Medicare Contractor timely filed its final position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-0552GC – QRS CHS 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[.]
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).[9]

The group issue statement in Case No. 18-0552GC, QRS CHS 2015 DSH SSI Percentage CIRP Group, to which the Provider is a participant, reads in part:

> **Statement of the Issue:**
>
> Whether the Medicare/SSI fraction used in the Medicare Disproportionate Share Hospital and LIP payment calculations accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the

[8] (Emphasis added.)
[9] Issue Statement at 1 (Nov. 20, 2018).

Medicare/SSI fraction calculation per the Medicare Statute at 42 U.S.C. §1395ww(d)(5)(F)(vi)?

Statement of the Legal Basis:

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

The Provider(s) further contend(s) 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.

Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:

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

6. Covered days vs. Total days[10]

On July 16, 2019, the Board received the Provider's preliminary position paper in 19-0513. 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.
>
> Similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services,* No. CV-94-0055 (C.D. Cal June 2, 1995), the SSI entitlement of individuals can be ascertained from [s]tate records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the completed MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008).[11]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $80,000.

On October 16, 2024, the Provider submitted its final position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**

[10] Group Issue Statement in PRRB Case No. 18-0552GC.
[11] Provider's Preliminary Position Paper at 8-9 (Aug. 23, 2019).

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. **The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).**[12]

MAC's Contentions

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. 18-0552GC, "QRS CHS 2015 DSH SSI Percentage CIRP Group" and should be dismissed.
>
> With respect to the portion of Issue 1 related to SSI data accuracy, the Provider states:

[12] Provider's Final Position Paper at 7-8 (Oct. 16, 2024). (Emphasis added).

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

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.

The MAC contends that the Provider makes the same arguments in Issue 2 that was transferred to Case No. 18-0552GC. The Provider states in its appeal request for Issue 2.

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 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 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.[13]

Provider's Jurisdictional Response

The Provider argues that the issues are not duplicative because "issues #1 and 2 represent different components of the SSI issue, which was specifically adjusted during the audit."[14] Additionally, the Provider argues that the issue is not duplicative because the 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."[15]

Finally, the Provider contends the Provider Specific issue is appealable "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 2015 resulting from its understated SSI percentage due to errors of omission and commission."[16]

Decision of the Board

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

As set forth below, the Board hereby ***dismisses*** the Provider's DSH Payment/SSI Percentage (Provider Specific) issue.

The analysis for Issue No. 1 has three 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) individuals who are eligible for SSI but did not receive SSI payment.

1. *First and Third Aspects of Issue 1*

The first and third aspects 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

[13] Medicare Contractor's Jurisdictional Challenge at 2-4 (Oct. 17, 2019).
[14] Jurisdictional Response at 1 (Nov. 18, 2019).
[15] *Id*. at 2.
[16] *Id*.

duplicative of the DSH/SSI Percentage (Systemic Errors) issue that is being appealed in Case No. 18-0552GC.

The DSH Payment/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. 18-0552GC 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 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 18-0552GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[20], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[21] 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. 18-0552GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records" but fails to explain how it can, explain how that information is relevant, and whether such a review was done for purposes of the

[17] Issue Statement at 1.
[18] *Id.*
[19] *Id.*
[20] PRRB Rules v. 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).

year in question consistent with its obligations under Board Rule 25.2.[22] Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Aug. 29, 2018), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[23]

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

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

[23] (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.[24]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[25]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 18-0552GC.

Accordingly, *based on the record before it*, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Issue 1 and the group issue from the CHS CIRP group under Case No. 18-0552GC 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 remaining issue in this case. As no issues remain, the Board hereby closes Case No. 19-0513 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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[24] Last accessed Oct. 15, 2024.
[25] (Emphasis added).

Board Members Participating:

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

For the Board:

11/25/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Wilson Leong, FSS

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

Cindy Hulen
St. Vincent Infirmary Medical Center
Two St. Vincent Circle
Little Rock, AR 72205-5499

RE: ***Notice of Dismissal***
St. Vincent Infirmary Medical Center-Little Rock, AR (Provider Number 04-0007)
FYE: 06/30/2011
Case Number: 16-0065

Dear Ms. Hulen:

The Provider Reimbursement Review Board ("Board" or "PRRB") received St. Vincent Infirmary Medical Center-Little Rock, AR's ("Provider") Individual Appeal Request *over nine years ago* on **October 15, 2015**, appealing from a Notice of Program Reimbursement ("NPR") dated **April 27, 2015**. The sole issue appealed is "Disproportionate Share Hospital – Medicaid Eligible Days." The Provider and Medicare Contractor filed Preliminary Position Papers on **June 29** and **October 31, 2016**, respectively.

The most recent Notice of Hearing was issued on **September 16, 2024**, which set a hearing **for January 15, 2025.** The Board notes that this case has been postponed at least five times since the initial Notice of Hearing was issued on August 17, 2021, primarily because the Medicare Contractor was not permitted to issue NPRs for hospitals which qualified for a Disproportionate Share Hospital ("DSH") payment. The hold on the issuance of those NPRs was lifted effective March 25, 2024.[1]

In its September 16, 2024 decision to grant the Provider's most recent ***untimely*** request for postponement, the Board admonished the Provider's Representative "for failing to timely respond to the Board's correspondence" regarding the status of this case "as required by Board Rule 5.2."[2] The Board also admonished the Provider's Representative "for filing a factually inaccurate and misleading Request for Postponement, which is wholly inapplicable to the instant case and fails to demonstrate good cause for the belated filing as required by Board Rule 30.3.1."[3]

Nevertheless, the Board granted the request for postponement but required a status report be filed no later than **Monday, November 11, 2024** which was required to include: "(1) a description of the parties' efforts to resolve the case since the issuance of this decision; (2) a description of any

[1] *See* CMS Transmittal 12513 (available at https://www.cms.gov/files/document/r12513otn.pdf).
[2] Postponement Decision at 4 (Sept. 16, 2024).
[3] *Id.*

remaining planned actions or steps needed to facilitate resolution, including whether any additional documentation exchange(s) may be needed; and (3) a timeline for those actions/steps."[4] The Board specifically noted that "***[f]ailure of the Provider*** *to timely file a proper status report or request for postponement may result in the dismissal of this case*."[5]

No Status Report (or any other correspondence) has been received from the parties in this case since the Board's September 16, 2024 decision.

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

- ***if it has a reasonable basis to believe that the issues have been fully settled or abandoned***,
- ***upon failure of the provider or group to comply with Board procedures or filing deadlines . . .***,
- if the Board is unable to contact the provider or representative at the last known address; or
- upon failure to appear for a scheduled hearing.[6]

Discussion of the failure to comply with the a deadline established by the Board in an order can also be found at 42 C.F.R. § 405.1868:

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

[4] *Id.*
[5] *Id.*
[6] (Emphasis added.)

Further, Board Rule 5.2 addresses the Representative's responsibilities:

> The case representative is responsible for being familiar with the following rules and procedures for litigating before the Board:
>
> - The Board's governing statue at 42 U.S.C. § 1395oo;
> - The Board's governing regulations at 42 C.F.R. Part 405, Subpart R; and
> - These rules, which include any relevant Orders posted at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-rules-and-board orders (*see* Rule 1.1).
>
> Further, the case representative is responsible for:
>
> - Ensuring his or her contact information is current with the Board, including a current email address and phone number;
> - Meeting the Board's deadlines; and
> - Responding timely to correspondence or requests from the Board or the opposing party.
>
> Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.

In the Board's September 16, 2024 decision, it admonished the Provider's Representative for failing to respond to correspondence from the Board and for filing an untimely, factually inaccurate and misleading Request for Postponement. As a result, the Board issued an order requiring a Status Report be filed no later than November 11, 2024. The order specifically noted that failure to file the status report may result in the case's dismissal. Based on the history of non-compliance with the Board's Rules and the Provider's failure to comply with the Board's September 16, 2024 order to file a status report, the Board is exercising its discretion, pursuant to 42 C.F.R. § 405.1868(b)(1), to dismiss Case 16-0065 with prejudice and hereby removes it from its docket.

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

Board Members:

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

For the Board:

11/25/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Heather Mogden
Hall, Render, Killian, Heath & Lyman, P.C.
330 E. Kilbourn Ave.
Suite 1250
Milwaukee, WI 53202

RE: ***Notice of Dismissal***
Community Health Network CY 2009 DSH Dual Eligible Days RNPR CIRP Group
Case Number: 25-0456GC

Dear Ms. Mogden:

The Provider Reimbursement Review Board ("Board" or "PRRB") received a request to establish a Common Issue Related Party ("CIRP") Group on October 28, 2024. The group currently contains one Provider which is appealing a Dual Eligible Days issue from a Revised Notice of Program Reimbursement ("RNPR")[1] dated July 12, 2024. The decision of the Board to ***dismiss*** the appeal is set forth below.

Procedural history:

The Board received a request to establish a Common Issue Related Party ("CIRP") Group on October 28, 2024. The group currently contains one Provider with a listed amount in controversy of $1,013,766. The Provider is appealing from a RNPR dated July 12, 2024. The audit adjustments included with the appeal show that tentative payments to the provider on Worksheet E-1, Line 5.03, were adjusted by "0" and the Provider acknowledges the RNPR was "issued as a result of the June 9, 2023 Final Rule (88 Fed. Reg. 37772) and Change Request 13294 (Feb. 21, 2024)."[2]

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

> Whether the Medicare Disproportionate Share Hospital (DSH) calculation was understated due to the failure of the Centers for Medicare & Medicaid Services (CMS) and the Fiscal Intermediary to properly include all Dual Eligible Days, including all Dual Eligible Days that are Medicare Non-Covered Days ("DE MNC Days"), which include but are not limited to Medicare Exhaust Days and MSP (Medicare Secondary Payor) Days where Medicare

[1] The document is titled a Notice of Correction of Program Reimbursement.
[2] *See* Provider Number 15-0113, Provider's Memorandum Regarding Notice of Reopening.

> is secondary to another payor, in the numerator of the Medicare or Medicaid Fraction of the DSH percentage as applicable pursuant to 42 U.S.C. § 1395ww(d)(5)(F).[3]

The Provider argues that individuals who are eligible for Medicaid and SSI also become eligible for Medicare (and are thus "Dual Eligible"), and that "they should be included in the numerator of the Medicare fraction," but that many such patient days are not so captured.[4] It notes that CMS Ruling 1498-R pledges "to mandate [Medicare Contractor] review of Dual Eligible, including Medicare Non-Covered, Days Appeals, the Ruling explicitly does not do so for cases with patient discharges on or after October 1, 2004. . . . because CMS Ruling 1498-R claims such days were included in the SSI Medicare Fraction after that date."[5] The Provider disputes this position. It argues that "entitled" to SSI must be interpreted as "eligible" for SSI (even days where the patient only receives their SSI/Medicaid benefits, and receives no Medicare benefits), and that all Dual Eligible days where a patient is "eligible" for SSI must be included in the Medicare fraction numerator.[6]

Relevant Law:

A. RNPR Appeals

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2023), which provides in relevant part:

> (a) General. (1) A Secretary determination, a contractor determination, or a decision by a reviewing entity (as described in § 405.1801(a) of this subpart) may be reopened, with respect to specific findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the contractor (with respect to contractor determinations), or by the reviewing entity that made the decision. . . .

Additionally, 42 C.F.R. § 405.1889 (2023)[7] explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834,

[3] Issue Description for DSH SSI Ratio Dual Eligible Days.
[4] *Id.*
[5] *Id.*
[6] *Id.*
[7] *See also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

> 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

As outlined above, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[8]

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

i. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system ("PPS").[9] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[10]

The PPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[11] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[12]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[13] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[14] The DPP is defined as the sum of two fractions expressed as percentages.[15] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[16]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[17]

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[18]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[19]

ii. Establishment of Medicare Part C and Treatment of Part C Days in the DSH Calculation

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations ("HMOs") and competitive medical plans ("CMPs") is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to an eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A and enrolled under part B . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

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[16] (Emphasis added.)
[17] 42 C.F.R. § 412.106(b)(2)-(3).
[18] (Emphasis added.)
[19] 42 C.F.R. § 412.106(b)(4).

In the September 4, 1990 Federal Register, the Secretary[20] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that are associated with Medicare patients. Therefore, since that time we have been including HMO days in SSI/Medicare percentage [of the DSH adjustment].[21]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[22]

With the creation of Medicare Part C in 1997,[23] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal years 2001-2004.[24]

No further guidance regarding the treatment of Part C days in the DSH calculation was provided until the 2004 Inpatient Prospective Payment System ("IPPS") proposed rules were published in the Federal Register. In that notice the Secretary stated that:

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A

[20] of Health and Human Services.
[21] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[22] *Id.*
[23] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization has a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[24] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).

> *. . . . once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .*[25]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[26] In response to a comment regarding this change, the Secretary explained that:

> *. . . we do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[27]

This statement would require inclusion of Medicare Part C inpatient days in the Medicare fraction of the DSH calculation.

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[28] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[29] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to

[25] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[26] 69 Fed. Reg. at 49099.
[27] *Id.* (emphasis added).
[28] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[29] *Id*. at 47411.

§§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[30]

There has been substantial litigation over whether enrollees in Part C plans are "entitled to benefits" under Medicare Part A when determining their placement in either the DSH Medicare or Medicaid fraction.

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[31] In 2014, the U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[32] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[33] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[34] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for fiscal years 2014 and beyond.[35] However, at that point, no new rule had been adopted for fiscal years 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the 2004 rule. In 2014 the Secretary published Medicare fractions for fiscal year 2012 which included Part C days.[36] A number of hospitals appealed this action. In *Azar v. Allina Health Services* ("*Allina II*"),[37] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[38] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with

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[30] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[31] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[32] 746 F. 3d 1102 (D.C. Cir. 2014).
[33] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[34] *Id.* at 2011.
[35] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[36] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[37] 139 S. Ct. 1804 (2019).
[38] *Id.* at 1817.

[its] opinion."[39] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[40]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[41] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[42]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[43] The June 2023 Final Rule provides the following guidance on the extent to which it is to be applied *retroactively*:

> [T]he Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports.[44]

Further, the June 2023 Final Rule provided the following clarification on the intent and purpose

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[39] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[40] 139 S. Ct. at 1814.
[41] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[42] CMS Ruling 1739-R at 1-2.
[43] 88 Fed. Reg. 37772 (June 9, 2023).
[44] *Id.* at 37774 (emphasis added).

of CMS Ruling 1739-R:

> ***The Ruling was not intended to cut off appeal rights and will not operate to do so***. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[45]

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

1. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[46]

2. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and ***will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary will likewise receive NPRs or revised NPRs reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and **the new or revised NPRs will provide hospitals with a vehicle to appeal the**

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

> **new final action *even if the Medicare fraction or DSH payment does not change numerically*.**"[47]

3. "When the Secretary's treatment of Part C days in this final action is reflected in NPRs and revised NPRs, providers, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], **will be able to challenge the agency's interpretation by appealing those NPRs and revised NPRs.** While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, **the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings.**"[48]

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

Decision of the Board:

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

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

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

Conclusion:

The issue being appealed in this case is related to Dual Eligible Days in the Medicare Fraction. The appeal was taken from an RNPR that was issued specifically to reflect and implement the

[47] *Id.* at 37788 (emphasis added).
[48] *Id.* (emphasis added).
[49] *Id.* (emphasis added).
[50] *Id.* at 37787-88 (emphasis added).

treatment of Part C days as set forth in the June 23, 2023 Final Rule, but the Provider has not briefed any Part C Days issues. The RNPR makes no changes at all to the Provider's payment or cost report related to Dual Eligible Days in the Medicare Fraction. The Board finds that (1) the RNPR did not "specifically revise" Dual Eligible Days and thus, pursuant to 42 C.F.R. § 405.1889(b)(1), that issue is beyond the scope of any appeal from the RNPR, and (2) the only appeal rights afforded from the RNPR as set forth in the June 23, 2023 Final Rule are to challenge the treatment of Part C Days in the RNPR. Based on the foregoing, the Board hereby ***dismisses*** the instant CIRP group appeal and removes it from the Board's docket.

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

Board Members:

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

For the Board:

11/25/2024

X Kevin D. Smith, CPA

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

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

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

David Vernon, Esq.
Hooper, Lundy and Bookman
401 9th Street, NW, Ste. 550
Washington, D.C. 20004

RE: ***Expedited Judicial Review Determination***
24-0744GC *et al. FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction Groups* (See **Appendix A**)

Dear Mr. Vernon:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' consolidated request for expedited judicial review ("EJR") filed on October 29, 2024 covering thirty-one (31) common issue related party ("CIRP") and optional group appeals. The Board's decision on jurisdiction and EJR for the twenty-two (22) group appeals set forth in **Appendix A** are set forth below.[1]

Issue:

The issue for which EJR has been requested is:

> [W]hether the Hospitals' [FY] 2024 standardized amount and hospital-specific operating [inpatient prospective payment system] payment rate[s] were improperly reduced by approximately 0.2598% for Federal Fiscal Year ("FFY") 2024.[2]

Statutory and Regulatory Background:

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[3] known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs").

[1] As noted *infra*, Substantive Claim Challenges have been filed in the remaining nine (9) cases encompassed in the Consolidated Request for EJR and will be addressed under separate cover.
[2] Consolidated request for Expedited Judicial Review at 3 (Oct. 29, 2024).
[3] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).

The base payment rate is comprised of a standardized amount[4] for all subsection (d) hospitals located in an "urban" or "rural" area.[5]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[6] adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).[7]

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts.[8]

A. Changes to the Wage Index Calculation

In the FFY 2019 IPPS proposed rule,[9] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information ("RFI") as part of the FFY 2020 IPPS proposed rule.[10] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates

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[4] The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994). Section 1395ww(d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).
[5] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[6] of the Department of Health and Human Services.
[7] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index (last visited November 23, 2024).
[8] *Id.*
[9] 83 Fed. Reg. 20164 (May 7, 2018).
[10] 84 Fed Reg 19158, 19393-94 (May 3, 2019).

and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[11] Based on these concerns, the Secretary proposed "[t]o help mitigate these wage index disparities" by "reduc[ing] the disparity between high and low wage index hospitals by increasing wage index values for certain hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values to maintain budget neutrality, and changing the calculation of the rural floor . . . ."[12]

In the FY 2020 IPPS final rule, the Secretary summarized his proposal as follows:

> [N]otwithstanding the challenges associated with comprehensive wage index reform, we agree with respondents to the request for information who indicated that some current wage index policies create barriers to hospitals with low wage index values from being able to increase employee compensation due to the lag between when hospitals increase the compensation and when those increases are reflected in the calculation of the wage index. (We noted that this lag results from the fact that the wage index calculations rely on historical data.) We also agreed that addressing this systemic issue did not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure. Therefore, in response to these concerns, in the FY 2020 IPPS/LTCH PPS proposed rule . . . , we proposed a policy that would provide certain low wage index hospitals with an opportunity to increase employee compensation without the usual lag in those increases being reflected in the calculation of the wage index.[13]

In the FFY 2020 IPPS Final Rule, the Secretary finalized the "proposal to increase the wage index for hospitals with a wage index value below the 25th percentile wage index by half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value across all hospitals is 0.8457."[14] In doing so, the Secretary determined that "quartiles are a reasonable method of dividing the distribution of hospitals' wage index values" and that "identifying hospitals in the lowest quartile as low wage index hospitals, hospitals in the second and third 'middle' quartiles as hospitals with wages index values that are neither low nor high, and hospitals in the highest quartile as hospitals with high

[11] *Id.*at 19393.
[12] *Id.*
[13] 84 Fed. Reg. at 42326 (citations omitted).
[14] *Id.* at 42328.

wage index values, is then a reasonable method of determining low wage index and high wage index hospitals for purposes of our proposals . . . addressing wage index disparities."[15]

The Secretary acknowledged that "there is no set standard for identifying hospitals as having low or high wage index values"; however, he believes his "proposed quartile approach is reasonable for this purpose, given that . . . quartiles are a common way to divide distributions, and that our proposed approach is consistent with approaches used in other areas of the Medicare program."[16] The Secretary stated in the proposed rule that, based on the data for the proposed rule, for FY 2020, the 25th percentile wage index value across all hospitals was 0.8482 and that this number would be updated in the final rule based on the final wage index values.[17] When the FFY 2020 IPPS final rule was published the 25th percentile wage index value across all hospitals for FFY 2020 was 0.8457.[18]

Under the Secretary's methodology, it was decided to increase the wage index for hospitals with a wage index value below the 25th percentile wage index. The increase in the wage indices for these hospitals would be equal to half of the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year for all hospitals.[19] The Secretary announced that this policy would be in effect for at least four years beginning in FFY 2020, in order to allow employee compensation increases implemented by low wage index value hospitals sufficient time to be reflected in the wage index calculation. The Secretary explained that, for the FFY 2020 wage index, data from 2016 cost reports was used to calculate the wage indices and four years is the minimum time before increases in employee compensation included in Medicare cost reports could be reflected in the wage index. The Secretary acknowledged that additional time may be necessary to determine the duration of the policy.[20]

In the FFY 2021 IPPS Final Rule, the Secretary indicated he was "continuing the low wage index hospital policy [for FY 2021], and also applying this policy in a budget neutral manner by applying an adjustment to the standardized amounts."[21] Based on the data for this final rule, for FFY 2021, the 25th percentile wage index value across all hospitals was 0.8465, which was later corrected to 0.8469.[22]

Thereafter, in the FY 2022 IPPS Final Rule, the Secretary again indicated he was "continuing the low-wage index hospital policy" for FY 2022, and "also applying this policy in a budget neutral manner by applying an adjustment to the standardized amounts."[23] Based on the data for this final rule, for FY 2022, the 25th percentile wage index value across all hospitals was 0.8437.[24]

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[15] *Id.* at 42326.
[16] *Id.*
[17] *Id.*
[18] *Id.* at 42328.
[19] *Id.*
[20] *Id.* at 42326-7.
[21] 85 Fed. Reg. 58432, 58436 (Sept. 18, 2020).
[22] *Id.* at 58768; 85 Fed. Reg. 78748, 78754 (Dec. 7, 2020) (Correction).
[23] 86 Fed. Reg. 44774, 44778 (Aug. 13, 2021).
[24] *Id.* at 45178.

Again, in the FY 2023 IPPS Final Rule, the Secretary indicated he was continuing the low wage index hospital policy for FY 2023, and also applying this policy in a budget neutral manner by applying an adjustment to the standardized amounts.[25] Based on the data for this final rule, for FY 2023, the 25th percentile wage index value across all hospitals was 0.8427.[26]

Finally, in the FY 2024 IPPS Final Rule, the Secretary indicated he was continuing the low wage index hospital policy for FY 2024, and also applying this policy in a budget neutral manner by applying an adjustment to the standardized amounts.[27] Based on the data for this final rule, for FY 2023, the 25th percentile wage index value across all hospitals was 0.8667.[28]

B. Budget Neutrality and the Wage Index

In the 2020 Proposed IPPS Rule, the Secretary explained that he believed that "while it would not be appropriate to create a wage index floor or a wage index ceiling," it would be appropriate to "provide a mechanism to increase the wage index of low wage index hospitals . . . . while maintaining budget neutrality for that increase through an adjustment to the wage index of high wage index hospitals."[29] The Secretary maintained that this action had two key merits: (1) "by compressing the wage index for hospitals on the high and low ends, that is, those hospitals with a low wage index and those hospitals with a high wage index, such a methodology increases the impact on existing wage index disparities more than by simply addressing one end;" and (2) "such a methodology ensures those hospitals in the middle, that is, those hospitals whose wage index is not considered high or low, do not have their wage index values affected by this proposed policy."[30] Thus, the Secretary concluded that, "given the growing disparities between low wage index hospitals and high wage index hospitals, . . . it would be appropriate to maintain budget neutrality for the low wage index policy proposed . . . by adjusting the wage index for high wage index hospitals."[31]

Following significant criticism from commenters to the proposed rule, the Secretary acknowledged that "some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between the proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States."[32] Based on this feedback, the Secretary decided to "finaliz[e] a budget neutrality adjustment for our low wage hospital policy but . . . not [to] finaliz[e] our proposal to target that budget neutrality adjustment on high wage hospitals" given that: (1) budget neutrality is required under [§ 1395ww(d)(3)(E)]; (2) even if it were not required, he believes that "it would be inappropriate to use the wage index to increase or decrease overall IPPS spending;" and (3) he wished to

[25] 87 Fed. Reg. 48780, 49006 (Aug. 10, 2022).
[26] *Id.*
[27] 88 Fed. Reg 58640, 58978-58979 (Aug. 28, 2023).
[28] *Id.* at 58978.
[29] 84 Fed. Reg. at 42329.
[30] *Id*.
[31] *Id*.
[32] *Id.* at 42331.

"consider further the policy arguments raised by commenters regarding [the] budget neutrality proposal."[33] Specifically, "consistent with [the Secretary's] current methodology for implementing wage index budget neutrality under [§1395ww(d)(3)(E)] and the alternative approach we considered in the proposed rule (84 FR 19672), we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in the rule, is implemented in a budget neutral manner."[34]

As indicated above, the Secretary has continued the low wage index hospital policy the following four years, for FFYs 2021 to 2024, and continued to apply this policy in a budget neutral manner by applying an adjustment to the labor portion of the standardized amounts.[35]

Positions of the Parties:

The Providers are challenging their IPPS payments for FFY 2024 on the grounds that those payments were and continue to be improperly understated as a result of the reduction to the standardized amount, which the Secretary allegedly unlawfully imposed as part of the new policy increasing the Area Wage Index ("AWI") values of hospitals with an AWI value in the lowest quartile.

The Providers explain that the Secretary continues to implement, without any changes, his policy that increases the AWI values of hospitals with an AWI in the lowest quartile, nationally (the "Low Wage Index Redistribution") that he first adopted for FFY 2020. The Low Wage Index Redistribution was implemented in 2020 to address what the Secretary called "wage index disparities" by impacting the AWI values and the IPPS Medicare reimbursement that hospitals receive. Specifically, the Providers contend that "the Low Wage Index Redistribution increases the AWI values of hospitals with an AWI in the lowest quartile, nationally, by half the difference between their accurately calculated AWI and the 25th percentile AWI value."[36]

The Providers note that in the FFY 2024 IPPS Final Rule, the Secretary reiterated his assertion that he had the authority to implement this new policy under 42 U.S.C. § 1395ww(d)(3)(E) despite acknowledging that the district court in *Bridgeport Hospital, et al. v. Becerra,* No. 1:20-cv-01574 (D.D.C.)[37] held that the Secretary did not have legal authority under 42 U.S.C. §§ 1395ww(d)(3)(E) or 1395ww(d)(5)(I)(i) to adopt the FFY 2020 Low Wage Index Redistribution. This section of the statute authorizes the Secretary to adjust the labor-related portion of IPPS payments to account "for area differences in hospital wage levels" by a "factor" (the wage index) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level, citing 42 U.S.C. § 1395ww(d)(3)(E). The

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[33] *Id*.
[34] *Id*.
[35] 85 Fed. Reg. at 58436 (Sept. 18, 2020); 86 Fed. Reg. at 44778 (Aug. 13, 2021); 87 Fed. Reg. at 49006 (Aug. 10, 2022); 88 Fed. Reg 58640, 58978-58979 (Aug. 28, 2023).
[36] Consolidated EJR Request at 3-4 (Oct. 29, 2024).
[37] 589 F. Supp. 3d 1 (2022), *aff'd in part and rev'd in part*, *Bridgeport Hospital, dba Yale New Haven Health, et al. v. Becerra,* 2024 WL 3504407 (D.C. Cir. 2024). The Providers note the same conclusions were made in the 9th Circuit in *Kaweah Delta Health Care District et al. v. Becerra*, 2022 WL 18278175 (C.D. Cal. 2022).

Secretary must "update" the wage index annually "on the basis of a survey . . . of the wages and wage-related costs of [IPPS-participating] hospitals in the United States."[38]

The Providers contend that the Secretary again elected to implement his Low Wage Index Redistribution in a budget neutral manner for FFY 2024. As a result, the Providers allege, the Secretary decreased the standardized payment amounts of all IPPS hospitals by 0.2598% to offset the AWI increases to those hospitals in the lowest AWI quartile.[39]

The Providers point out that the Secretary "continues to assert that he has the authority to implement this budget neutrality adjustment under 42 U.S.C. § 1395ww(d)(3)(E), however, [he] continues to note that even if he did not have such authority under [§ 1395ww(d)(3)(E)], he would invoke his special statutory "exceptions and adjustments" authority . . . . in support of such a budget neutrality adjustment . . . . This statutory provision, codified at 42 U.S.C. § 1395ww(d)(5)(I)(i), addresses IPPS payments and states: 'The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.'"[40] The Providers contend that "no statute precludes administrative or judicial review of the Secretary's adjustments for different area wage levels under 42 U.S.C. § 1395ww(d)(3)(E) or the Secretary's adjustments or exceptions under 42 U.S.C. § 1395ww(d)(5)(I)."[41]

The Providers argue that "the Secretary lacks the authority to (a) continue the Low Wage Index Hospital Policy in the manner set forth in the FFY 2024 Final IPPS Rule and (b) continue to implement such policy in a budget neutral manner under the [AWI] statutory provision, the exceptions or adjustments authority, or otherwise. Therefore, the [Providers] challenge the adjustment to the standardized amount on several grounds, including, but not limited to, that it exceeds statutory authority, contradicts the [AWI] congressional mandate, was developed in an arbitrary and capricious manner, lacks support from substantial evidence, and is otherwise defective both procedurally and substantively."[42]

The Providers note that, "[t]he immediate detrimental effect will be a 0.2598% negative adjustment of the standardized amount and the hospital-specific operating payment rate for FFY 2024 for every IPPS hospital, resulting in a reduction in overall MS-DRG IPPS payments for all IPPS hospitals, including the [Providers]."[43] Further, as this is the fourth year of the implementation of the Low Wage Index Redistribution and the related budget neutrality adjustment, the Providers already suffered an unlawful negative adjustment in FFYs 2020 to 2023. The request continues, stating, "[b]ased on the foregoing, the [Providers] are challenging the Low Wage Index Hospital Policy in this group appeal for several reasons, including but not limited to, whether the Secretary (1) improperly exercised the authority granted through 42 U.S.C. § 1395ww(d)(3)(E) and 42 U.S.C. § 1395ww(d)(5)(I)(i); and (2) improperly reduced FFY 2024 payments to IPPS hospitals, including the [Providers], as a result of the budget neutral

[38] Consolidated EJR Request at 4.
[39] *Id.*
[40] *Id.*
[41] *Id.*
[42] *Id.*
[43] *Id.* at 5.

implementation of the Low Wage Index Hospital Policy, which has been in effect since October 1, 2019, and continues through FFY 2024. The [Providers] seek their proper IPPS payments plus interest calculated under 42 U.S.C. § 1395oo(f)(2) and/or 42 U.S.C. § 1395g(d)."[44]

The Providers believe EJR is appropriate because the Board has jurisdiction over the appeals, the Providers are dissatisfied with the final determination of the Secretary, but the Board lacks the authority to decide the question at issue and cannot grant the relief sought. Pursuant to 42 C.F.R. § 405.1867, the Board must comply with all the provisions of Title XVIII of the Social Security Act and is therefore, bound to apply the 0.2598% reduction issued by the Secretary in the FFY 2024 IPPS Final Rule.[45]

Medicare Contractor's Position:

On November 4, 2024, the Medicare Contractor's Representative, Federal Specialized Services ("FSS"), made a timely[46] certification that it would be filing Substantive Claim and/or Jurisdictional Challenges in the following cases:

- 24-0810GC (Substantive Claim Challenge forthcoming)
- 24-0729GC (Substantive Claim Challenge forthcoming)
- 24-0735GC (Potential Jurisdictional Challenge)
- 24-0828GC (Substantive Claim Challenge forthcoming)
- 24-0836GC (Substantive Claim Challenge forthcoming)
- 24-0774GC (Substantive Claim Challenge forthcoming)
- 24-0823GC (Noting documentation was absent from OH CDMS)
- 24-0821GC (Substantive Claim Challenge forthcoming)[47]

On November 5, 2024, the Medicare Contractor in Case 24-0782GC also submitted a notice that it would be filing a Substantive Claim Challenge, but FSS filed an update on November 18, 2024 noting that the participants that would have been challenged were withdrawn from the case, so no Substantive Claim Challenge would be incoming.

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[44] *Id.*
[45] *Id.* at 6-8.
[46] Board Rule 44.6 (2023) governs the timing of Substantive Claim Challenges in cases where a Request for EJR is filed less than sixty (60) days from the filing of a Final Schedule of Providers (or Board Rule 20 Certification filed in lieu of a Final SOP which certifies that the group is complete and fully populated in OH CDMS). In such instances, Board Rule 44.6 requires any party questioning the Board's jurisdiction or whether an appropriate cost report claim was made to file the challenge, or a certification that a challenge is forthcoming, within five (5) business days of the date the EJR Request was filed. The Request for EJR in these cases was filed on October 29, 2024, so any challenges (or certification that a challenge was forthcoming) was due no later than close of business November 5, 2024.
[47] The certification also noted that, in case 24-0718GC, no cost report had yet been filed, but did not note any forthcoming challenge(s) based on this fact.

On November 12, 2024, FSS filed a timely[48] Substantive Claim Challenge in Case 24-0810GC. On November 13, FSS filed a timely Substantive Claim Challenge in Case 24-0821GC. On November 17, 2024, FSS filed a Substantive Claim Challenge covering seven (7) cases:

- 24-0718GC
- 24-0729GC
- 24-0733GC
- 24-0735GC
- 24-0774GC
- 24-0828GC
- 24-0836G

These nine (9) cases with challenges will be addressed under separate cover. In the remaining twenty-two (22) cases set forth in **Appendix A**, no Substantive Claim or Jurisdictional Challenges have been filed and the time for doing so has elapsed.[49]

Decision of the Board:

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

A. Jurisdiction and Request for EJR

As previously noted, all of the participants in all of the group cases at issue appealed from the FFY 2024 IPPS Final Rule.[50] The Board has determined that (1) the participants' documentation in each of the group appeals shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal;[51] (2) the appeals were timely filed; and (3) Board review of the matter in these appeals is not precluded by statute or regulation. In finding that the groups meet the $50,000 amount in controversy, the Board recognizes that the Group Representative has explained that the amount in controversy ("AiC") calculation is simply based on the estimated IPPS payments for the period at issue multiplied by 0.2598 percent (*i.e.,* the adjustment to the wage index that they are challenging in this appeal) and this AiC unmistakably demonstrates each of the groups more than clears the minimum $50,000 AiC hurdle. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractors for the actual final amounts in each case.

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[48] Board Rule 44.6 (2023) requires that, following a certification that Substantive Claim and/or Jurisdictional Challenges will be filed, that they actually be filed within twenty (20) days of the date of the EJR Request being filed. The EJR Requests in these cases were filed October 29, 2024, so any challenges were due no later than close of business November 18, 2024.

[49] *See id.*

[50] The CMS Administrator confirmed that, consistent with the D.C. Circuit's decision in *Washington Hosp. Ctr. v. Bowen*, 795 F.3d 139 (D.C. Cir. 1986, a wage index notice published in the Federal Register is a final determination from which a provider may appeal to the Board within the meaning of 42 U.S.C. § 1395oo(a)(1)(A)(ii). *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993*)*, *rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015); 42 C.F.R. § 405.1837.

[51] *See* 42 C.F.R. § 405.1837.

B. Application of 42 C.F.R. §§ 405.1873 and 413.24(j)

1. Regulatory Background

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 405.1873 and 413.24(j) are applicable. The regulation 42 C.F.R. § 413.24(j) requires that:

> (1) *General Requirement*. In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), **must include an appropriate claim for the specific item**, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **and describing** how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[52]

In conjunction with the regulation above, 42 C.F.R. § 405.1873(a) states:

[52] (Bold and underline emphasis added.)

(a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider **must include in its cost report an appropriate claim for the specific item** (as prescribed in § 413.24(j) of this chapter). If the provider files an appeal to the Board seeking reimbursement for the specific item and any party to such appeal questions whether the provider's cost report included an appropriate claim for the specific item, the Board must address such question in accordance with the procedures set forth in this section.

(b) *Summary of Procedures*.

***

(2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .

***

(d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*

***

(2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f)(1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .

(e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*

(1) Board jurisdictional dismissal decision. **If the Board issues a jurisdictional dismissal decision** regarding the specific item under appeal (pursuant to § 405.1840(c)), **the Board's specific findings of fact and conclusions of law** (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost

> report included an appropriate claim for the specific item, **must not be included in such jurisdictional dismissal decision**.[53]

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

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

As explained above, at issue in this appeal are cost reports beginning after January 1, 2016, which are subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[54] The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[55] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[56] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[57]

However, the Board notes that, when the participants in a group have not filed their cost report, then § 405.1873(b) would not be triggered because the issue of whether the relevant participants' cost reports included an appropriate claim for the specific item under appeal would not yet be ripe.[58] Section 405.1873(b) sets forth the procedures for Board review of Substantive Claim Challenges:

> The Board must give the parties an adequate opportunity to submit factual evidence and legal argument regarding the question of whether the provider's cost report included an appropriate claim for the specific item under appeal. Upon receipt of timely submitted

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[53] (Bold and underline emphasis added.)
[54] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").
[55] (Emphasis added.)
[56] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[57] *See* 42 C.F.R. § 405.1873(a),
[58] The preamble to the final rule that adopted the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1973 responded to a comment about appeals from the Federal Register and confirmed that the substantive claim regulations applied to them. 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015). However, this preamble discussion does not address the manner in which they apply. Rather, the response concludes with the following directive in § 405.1873(a)-(b): "if a party to an appeal questions whether there was an appropriate cost report claim for a specific PPS item, the Board must take evidence and argument on that question; issue findings of fact and conclusions of law on such matter; and include those findings and conclusions in both the administrative record and certain types of overall Board decisions." *Id.* at 70570.

> factual evidence or legal argument (if any), the Board must review such evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with, for the specific item under appeal, the cost report claim requirements prescribed in § 413.24(j) of this chapter.

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

That said, *if subsequent to the Federal Register appeal being filed*, one or more participants files its cost report, then any party may raise a Substantive Claim Challenge regarding those participants and submit argument and evidence supporting their position. Here, for the twenty-two (22) appeals set forth in **Appendix A**, no party has asserted that any of the participants in these Federal Register appeals later filed its cost report and failed to properly make a cost report substantive claim for the matter at issue.

Moreover, all of the participants in the above-referenced group cases are appealing the FFY 2024 Federal Register Notice and many of the cost reports impacted by such notice appear to have not yet been filed to trigger § 413.24(j)'s general substantive payment requirement for cost reports.[59] Accordingly, the Board is not obligated under 42 C.F.R. § 405.1873 to include findings on substantive claim challenges in these cases for any of the participants.

C. Analysis Regarding Appealed Issue

As set forth below, the Board finds that the Secretary's determination to finalize a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals was implemented in a budget neutral manner was made through notice and comment in the form of an uncodified regulation.[60] Specifically, in the preamble to FFY 2020 IPPS Final Rule, the Secretary announced the following wage index issues:

1. "To help mitigate . . . wage index disparities [between high and low wage index hospitals], including those resulting from the inclusion of hospitals with rural reclassifications under 42 CFR 412.103 in the calculation of the rural floor, . . . we . . . reduce the disparity between high and low wage index hospitals by increasing wage index values for certain low wage index hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values to maintain budget neutrality, and changing the calculation of the rural floor . . . .";[61] and

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[59] *See* 80 Fed. Reg. at 70556, 70569-70.
[60] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals."
[61] *Id.* at 42326.

2. "[A]ddressing this systemic issue does not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure."[62]

The Secretary did not incorporate the above new policy setting forth a modification to the wage index calculation determination by finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that there was an increase in the wage index for low wage index hospitals into the Code of Federal Regulations. However, it is clear from the use of the following language in the preamble to the FFY 2020 IPPS Final Rule that the Secretary intended to bind the regulated parties and establish a binding uniform payment policy through formal notice and comment:

> We acknowledge, however, that some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between our proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States. Therefore, given that budget neutrality is required under section 1886(d)(3)(E) of the Act, given that even if it were not required, we believe it would be inappropriate to use the wage index to increase or decrease overall IPPS spending, and given that we wish to consider further the policy arguments raised by commenters regarding our budget neutrality proposal, we are finalizing a budget neutrality adjustment for our low wage hospital policy, but we are not finalizing our proposal to target that budget neutrality adjustment on high wage hospitals. Instead, consistent with CMS's current methodology for implementing wage index budget neutrality under section 1886(d)(3)(E) of the Act and the alternative approach we considered in the proposed rule . . . we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in this rule, is implemented in a budget neutral manner.[63]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as the "Uncodified Regulation on Wage Index." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[64]

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[62] *Id.*
[63] 84 Fed. Reg. at 42331.
[64] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

While this appeal involves the FFY 2024 IPPS Final Rule, the continuation of this policy was implemented in the same way as it was initially for FFY 2020.[65] The proposed rule did not propose any changes to this policy. The Final Rule for FFY 2024 refers to the responses to comments provided in the FFY 2020 Final Rule and applied the policy in the same manner as it was applied in FFY 2020.[66] Therefore, the Board finds that this policy continues to be a binding but uncodified regulation for FFY 2024.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulation on Wage Index published in the FFY 2024 IPPS Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulation on Wage Index which they allege improperly reduces the standardized amount of 0.2598 percent for FFY 2024. As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in the cases set forth in **Appendix A**.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the AWI Issue for the subject year in the cases set forth in **Appendix A** and that the Providers in these group appeals are entitled to a hearing before the Board;

2) While the Providers appealed cost reporting periods beginning after January 1, 2016, no substantive claim challenges[67] have been filed pursuant to 42 C.F.R. § 405.1873(a) to trigger either Board review under § 405.1873(b) or reporting under § 405.1873(d)(2);

3) Based upon the Providers' assertions regarding the FFY 2024 IPPS Final Rule, there are no findings of fact for resolution by the Board;

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

5) It is without the authority to decide the legal question of whether the Uncodified Regulation on Wage Index published in the FFY 2024 IPPS Final Rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified Regulation on Wage Index as published in the FFY 2024 IPPS Final Rule properly falls within the provisions of

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[65] 88 Fed. Reg 58640, 58978-58979 (Aug. 28, 2023).
[66] *Id.* at 58980.
[67] As the Board explained in Board Rule 44.5, "[t]he Board adoption of the term "Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject year.

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

Board Members Participating:

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

FOR THE BOARD:

11/25/2024

X Kevin D. Smith, CPA

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

Enclosure: Schedules of Providers

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Danelle Decker, National Government Services, Inc. (J-K)
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-L)

Appendix A
(Listing of 22 Cases)

24-0744GC	*Pipeline FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0820GC	*Sutter Health FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0819GC	*Stanford Health Care FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0815GC	*Sharp Healthcare FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0812GC	*Scripps Health FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0822GC	*Univ of California FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0742GC	*PIH Health FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0739GC	*Palomar Health FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0737GC	*MemorialCare FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0734GC	*LA County FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0736GC	*Loma Linda University FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0732GC	*Keck Medicine of USC FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0730GC	*Kaiser Health FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0728GC	*Hoag FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0727GC	*Emanate Health FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0726GC	*Cottage Health FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0725GC	*Community Med Ctrs FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0724GC	*Cedars-Sinai Health FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0722GC	*Alameda Health System FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*

24-0720GC	*AHMC Healthcare FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0782GC	*Prospect Medical Holdings FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0823GC	*UHS FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*

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

Heather Mogden
Hall, Render, Killian, Heath & Lyman, P.C.
330 E. Kilbourn Ave.
Suite 1250
Milwaukee, WI 53202

RE: **Notice of Dismissal**
Hall Render DSH Dual Eligible Days RNPR CIRP and Optional Groups
Case Numbers: 25-0414GC *et al.* (60 Cases – *See* **Appendix A**)

Dear Ms. Mogden:

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

Procedural history:

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

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

> Whether the Medicare Disproportionate Share Hospital (DSH) calculation was understated due to the failure of the Centers for Medicare & Medicaid Services (CMS) and the Fiscal Intermediary to properly include all Dual Eligible Days, including all Dual Eligible Days that are Medicare Non-Covered Days ("DE MNC Days"), which include but are not limited to Medicare Exhaust Days and MSP (Medicare Secondary Payor) Days where Medicare is secondary to another payor, in the numerator of the Medicare or Medicaid Fraction of the DSH percentage as applicable pursuant to 42 U.S.C. § 1395ww(d)(5)(F).[2]

[1] *See, e.g.*, Case 25-0414GC, Provider Number 34-0013, Provider's Memorandum Regarding Notice of Reopening.
[2] *E.g.*, Case 25-0414GC, Issue Description for DSH SSI Ratio Dual Eligible Days.

The Providers argue that individuals who are eligible for Medicaid and SSI also become eligible for Medicare (and are thus "Dual Eligible"), and that "they should be included in the numerator of the Medicare fraction," but that many such patient days are not so captured.[3] It notes that CMS Ruling 1498-R pledges "to mandate [Medicare Contractor] review of Dual Eligible, including Medicare Non-Covered, Days Appeals, the Ruling explicitly does not do so for cases with patient discharges on or after October 1, 2004 . . . . because CMS Ruling 1498-R claims such days were included in the SSI Medicare Fraction after that date."[4] The Providers dispute this position. They argue that "entitled" to SSI must be interpreted as "eligible" for SSI (even days where the patient only receives their SSI/Medicaid benefits, and receives no Medicare benefits), and that all Dual Eligible days where a patient is "eligible" for SSI must be included in the Medicare fraction numerator.[5]

Relevant Law:

A. RNPR Appeals

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2023), which provides in relevant part:

> (a) General. (1) A Secretary determination, a contractor determination, or a decision by a reviewing entity (as described in § 405.1801(a) of this subpart) may be reopened, with respect to specific findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the contractor (with respect to contractor determinations), or by the reviewing entity that made the decision. . . .

Additionally, 42 C.F.R. § 405.1889 (2023)[6] explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.

[3] Issue Description for DSH SSI Ratio Dual Eligible Days.
[4] *Id.*
[5] *Id.*
[6] *See also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

As outlined above, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[7]

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

i. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system ("PPS").[8] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[9]

The PPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[10] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[11]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[12] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[13] The DPP is defined as the sum of two fractions expressed as percentages.[14] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which

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

> were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[15]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[16]

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[17]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[18]

ii. Establishment of Medicare Part C and Treatment of Part C Days in the DSH Calculation

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations ("HMOs") and competitive medical plans ("CMPs") is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to an eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A and enrolled under part B . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In the September 4, 1990 Federal Register, the Secretary[19] stated that:

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

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that are associated with Medicare patients. Therefore, since that time we have been including HMO days in SSI/Medicare percentage [of the DSH adjustment].[20]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[21]

With the creation of Medicare Part C in 1997,[22] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal years 2001-2004.[23]

No further guidance regarding the treatment of Part C days in the DSH calculation was provided until the 2004 Inpatient Prospective Payment System ("IPPS") proposed rules were published in the Federal Register. In that notice the Secretary stated that:

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient*

[20] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[21] *Id.*
[22] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization has a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[23] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).

> *days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .*[24]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[25] In response to a comment regarding this change, the Secretary explained that:

> *. . . we do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[26]

This statement would require inclusion of Medicare Part C inpatient days in the Medicare fraction of the DSH calculation.

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[27] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[28] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to

[24] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[25] 69 Fed. Reg. at 49099.
[26] *Id.* (emphasis added).
[27] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[28] *Id*. at 47411.

§§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[29]

There has been substantial litigation over whether enrollees in Part C plans are "entitled to benefits" under Medicare Part A when determining their placement in either the DSH Medicare or Medicaid fraction.

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[30] In 2014, the U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[31] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[32] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[33] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for fiscal years 2014 and beyond.[34] However, at that point, no new rule had been adopted for fiscal years 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the 2004 rule. In 2014 the Secretary published Medicare fractions for fiscal year 2012 which included Part C days.[35] A number of hospitals appealed this action. In *Azar v. Allina Health Services* ("*Allina II*"),[36] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[37] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with

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[29] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[30] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[31] 746 F. 3d 1102 (D.C. Cir. 2014).
[32] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[33] *Id.* at 2011.
[34] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[35] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[36] 139 S. Ct. 1804 (2019).
[37] *Id.* at 1817.

[its] opinion."[38] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[39]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[40] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[41]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[42] The June 2023 Final Rule provides the following guidance on the extent to which it is to be applied *retroactively*:

> [T]he Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports.[43]

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[38] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[39] 139 S. Ct. at 1814.
[40] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[41] CMS Ruling 1739-R at 1-2.
[42] 88 Fed. Reg. 37772 (June 9, 2023).
[43] *Id.* at 37774 (emphasis added).

Further, the June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> ***The Ruling was not intended to cut off appeal rights and will not operate to do so***. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[44]

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

1. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[45]

2. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and ***will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary will likewise receive NPRs or revised NPRs reflecting fractions calculated pursuant to this new

[44] 88 Fed. Reg. at 37788 (bold emphasis added).
[45] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).

final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and **the new or revised NPRs will provide hospitals with a vehicle to appeal the new final action *even if the Medicare fraction or DSH payment does not change numerically*.**"[46]

3. "When the Secretary's treatment of Part C days in this final action is reflected in NPRs and revised NPRs, providers, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], **will be able to challenge the agency's interpretation by appealing those NPRs and revised NPRs.** While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, **the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings.**"[47]

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

Decision of the Board:

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

The appeal rights detailed in the June 9, 2023 Final Rule specifically limit a provider's appeal rights to specific matters related to the actual RNPR (*i.e.*, the Part C Days policy). First, the Secretary made clear that the Part C Days rule could be appealed following the issuance of a new NPR or RNPR "***even if the Medicare fraction or DSH payment does not change numerically.***"[48] Thus, the new rule could be appealed even if the treatment of Part C Days was not "specifically revised."

The appeal rights, however, are strictly limited to the policy related to the treatment of Part C days. Following the issuance of a RNPR, the Secretary stated that Providers "***will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions contained in the NPRs or revised NPRs***[,]" "**will be able to challenge the agency's interpretation** [of the treatment of Part C days in this final action] by appealing those NPRs and revised NPRs[,]" and further stated that they "**can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[49]

[46] *Id.* at 37788 (emphasis added).
[47] *Id.* (emphasis added).
[48] *Id.* (emphasis added).
[49] *Id.* at 37787-88 (emphasis added).

Conclusion:

The issue being appealed in the sixty (60) cases listed in **Appendix A** is related to Dual Eligible Days in the Medicare Fraction. The appeals were taken from an RNPRs that were issued specifically to reflect and implement the treatment of Part C days as set forth in the June 23, 2023 Final Rule, but the Providers have not briefed any Part C Days issues. The RNPRs make no changes at all to the Provider's payment or cost report related to Dual Eligible Days in the Medicare Fraction. The Board finds that (1) the RNPRs did not "specifically revise" Dual Eligible Days and thus, pursuant to 42 C.F.R. § 405.1889(b)(1), that issue is beyond the scope of any appeal from the RNPRs, and (2) the only appeal rights afforded from the RNPRs as set forth in the June 23, 2023 Final Rule are to challenge the treatment of Part C Days in the RNPRs. Based on the foregoing, the Board hereby ***dismisses*** the sixty (60) CIRP and optional group appeals listed in **Appendix A** and removes them from the Board's docket.

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

Board Members:

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

For the Board:

11/26/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq. Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-5 & J-8)
Cecile Huggins, Palmetto GBA (J-J)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Judith Cummings, CGS Administrators (J-15)
Dean Wolfe, Noridian Healthcare Solutions (J-F)

Appendix A
(60 Cases)

Case No.	Case Name
25-0414GC	*LifePoint Health CY 2010 DSH Dual Eligible Days RNPR CIRP Group*
25-0411G	*Hall Render CY 2012 DSH Dual Eligible Days RNPR Group*
25-0410GC	*IU Health CY 2008 DSH Dual Eligible Days RNPR CIRP Group*
25-0403GC	*Community Health Network CY 2012 DSH Dual Eligible Days RNPR CIRP Group*
25-0398GC	*Community Health Network CY 2014 DSH Dual Eligible Days RNPR CIRP Group*
25-0397GC	*IU Health CY 2007 DSH Dual Eligible Days RNPR CIRP Group*
25-0392GC	*Ascension Health CY 2010 DSH Dual Eligible Days RNPR CIRP Group*
25-0386GC	*IU Health CY 2010 DSH Dual Eligible Days RNPR CIRP Group*
25-0385GC	*IU Health CY 2009 DSH Dual Eligible Days RNPR CIRP Group*
25-0359GC	*ProMedica Health CY 2012 DSH Dual Eligible Days RNPR CIRP Group*
25-0356GC	*ProMedica Health CY 2011 DSH Dual Eligible Days RNPR CIRP Group*
25-0353GC	*Parkview Health CY 2010 DSH Dual Eligible Days RNPR CIRP Group*
25-0320GC	*St. Elizabeth Healthcare CY 2010 DSH Dual Eligible Days RNPR CIRP Group*
25-0313GC	*Community Health Network CY 2010 DSH Dual Eligible Days RNPR CIRP Group*
25-0293GC	*Parkview Health CY 2009 DSH Dual Eligible Days RNPR CIRP Group*
25-0290GC	*Parkview Health CY 2008 DSH Dual Eligible Days RNPR CIRP Group*
25-0285GC	*Beacon Health CY 2013 DSH Dual Eligible Days RNPR CIRP Group*
25-0276GC	*Community Health Network CY 2011 DSH Dual Eligible Days RNPR CIRP Group*
25-0265GC	*LifePoint Health CY 2011 DSH Dual Eligible Days RNPR CIRP Group*
25-0263GC	*LifePoint Health CY 2014 DSH Dual Eligible Days RNPR CIRP Group*
25-0255GC	*Baptist Healthcare KY CY 2011 DSH Dual Eligible Days RNPR CIRP Group*
25-0242GC	*Valley Health CY 2010 DSH Dual Eligible Days RNPR CIRP Group*
25-0221GC	*St. Elizabeth Healthcare CY 2013 DSH Dual Eligible Days RNPR CIRP Group*
25-0217GC	*St. Elizabeth Healthcare CY 2012 DSH Dual Eligible Days RNPR CIRP Group*
25-0215GC	*St. Elizabeth Healthcare CY 2011 DSH Dual Eligible Days RNPR CIRP Group*
25-0210GC	*Franciscan Alliance CY 2013 DSH Dual Eligible Days RNPR CIRP Group*
25-0208GC	*Franciscan Alliance CY 2011 DSH Dual Eligible Days RNPR CIRP Group*
25-0199GC	*LifePoint Health CY 2013 DSH Dual Eligible Days RNPR CIRP Group*
25-0146GC	*Community Health Network CY 2013 DSH Dual Eligible Days RNPR CIRP Group*
25-0137GC	*Powers Health CY 2012 DSH Dual Eligible Days RNPR CIRP Group*
25-0133GC	*Powers Health CY 2011 DSH Dual Eligible Days RNPR CIRP Group*
25-0085GC	*Ascension Health CY 2009 DSH Dual Eligible Days RNPR CIRP Group*

25-0077GC	*LifePoint Health CY 2012 DSH Dual Eligible Days RNPR CIRP Group*
25-0061GC	*IU Health CY 2013 DSH Dual Eligible Days RNPR CIRP Group*
25-0057G	*Hall Render CY 2010 DSH Dual Eligible Days RNPR Group*
25-0055G	*Hall Render CY 2009 DSH Dual Eligible Days RNPR Group*
25-0050G	*Hall Render CY 2008 DSH Dual Eligible Days RNPR Group*
24-2803G	*Hall Render CY 2014 DSH Dual Eligible Days RNPR Group*
24-2746GC	*Ascension Health CY 2012 DSH Dual Eligible Days RNPR CIRP Group*
24-2744GC	*Ascension Health CY 2013 DSH Dual Eligible Days RNPR CIRP Group*
24-2742GC	*Ascension Health CY 2014 DSH Dual Eligible Days RNPR CIRP Group*
24-2740GC	*Ascension Health CY 2011 DSH Dual Eligible Days RNPR CIRP Group*
24-2663GC	*Parkview Health CY 2013 DSH Dual Eligible Days RNPR CIRP Group*
24-2658G	*Hall Render CY 2011 DSH Dual Eligible Days RNPR Group*
24-2654GC	*Parkview Health CY 2012 DSH Dual Eligible Days RNPR CIRP Group*
24-2653G	*Hall Render CY 2013 DSH Dual Eligible Days RNPR Group*
24-2647GC	*Parkview Health CY 2011 DSH Dual Eligible Days RNPR CIRP Group*
24-2628GC	*Beacon Health CY 2012 DSH Dual Eligible Days RNPR CIRP Group*
24-2535GC	*IU Health CY 2012 DSH Dual Eligible Days RNPR CIRP Group*
24-2530GC	*IU Health CY 2011 DSH Dual Eligible Days RNPR CIRP Group*
25-0716GC	*ScionHealth CY 2013 DSH Dual Eligible Days RNPR CIRP Group*
25-0645GC	*Franciscan Alliance CY 2010 DSH Dual Eligible Days RNPR CIRP Group*
25-0631GC	*Premier Health Partners CY 2013 DSH Dual Eligible Days RNPR CIRP Group*
25-0626GC	*Premier Health Partners CY 2012 DSH Dual Eligible Days RNPR CIRP Group*
25-0620GC	*Premier Health Partners CY 2008 DSH Dual Eligible Days RNPR CIRP Group*
25-0599GC	*Premier Health Partners CY 2011 DSH Dual Eligible Days RNPR CIRP Group*
25-0596GC	*Premier Health Partners CY 2009 DSH Dual Eligible Days RNPR CIRP Group*
25-0513GC	*LifePoint Health CY 2009 DSH Dual Eligible Days RNPR CIRP Group*
25-0507GC	*LifePoint Health CY 2008 DSH Dual Eligible Days RNPR CIRP Group*
25-0505GC	*ProMedica Health CY 2008 DSH Dual Eligible Days RNPR CIRP Group*

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

David Vernon, Esq.
Hooper, Lundy and Bookman, P.C.
401 9th Street NW, Ste. 550
Washington, D.C. 20004

RE: ***Expedited Judicial Review Determination***
24-0718GC *et al* (9 cases) (*See* **Appendix A**)

Dear Mr. Vernon:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' consolidated request for expedited judicial review ("EJR") filed on October 29, 2024, covering thirty-one (31) Common Interest Related Part ("CIRP") and optional group appeals. The Board's decision on jurisdiction and EJR for the nine (9) group appeals set forth in **Appendix A** is set forth below.

Issue:

The issue for which EJR has been requested is:

> [W]hether the Hospitals' [FY] 2024 standardized amount and hospital-specific operating [inpatient prospective payment system] payment rate[s] were improperly reduced by approximately 0.2598% for Federal Fiscal Year ("FFY") 2024.[1]

Statutory and Regulatory Background:

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[2] known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs"). The base payment rate is comprised of a standardized amount[3] for all subsection (d) hospitals

[1] Consolidated Request for Expedited Judicial Review at 3 (Oct. 29, 2024).
[2] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).
[3] The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994). Section 1395ww(d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into

located in an "urban" or "rural" area.[4]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[5] adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).[6]

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts.[7]

A. Changes to the Wage Index Calculation

In the FFY 2019 IPPS proposed rule,[8] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information ("RFI") as part of the FFY 2020 IPPS proposed rule.[9] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[10] Based on these concerns, the Secretary proposed "[t]o help mitigate the wage index disparities" by "reduc[ing] the disparity between high and low wage index hospitals by increasing wage index

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labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).
[4] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[5] of the Department of Health and Human Services.
[6] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index (last visited November 23, 2024).
[7] *Id.*
[8] 83 Fed. Reg. 20164 (May 7, 2018).
[9] 84 Fed Reg 19158, 19393-94 (May 3, 2019).
[10] *Id.* at 19393.

values for certain hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values to maintain budget neutrality, and changing the calculation of the rural floor . . . ."[11]

In the FY 2020 IPPS final rule, the Secretary summarized his proposal as follows:

> [N]otwithstanding the challenges associated with comprehensive wage index reform, we agree with respondents to the request for information who indicated that some current wage index policies create barriers to hospitals with low wage index values from being able to increase employee compensation due to the lag between when hospitals increase the compensation and when those increases are reflected in the calculation of the wage index. (We noted that this lag results from the fact that the wage index calculations rely on historical data.) We also agreed that addressing this systemic issue did not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure. Therefore, in response to these concerns, in the FFY 2020 LTCH PPS proposed rule . . . , we proposed a policy that would provide certain low wage index hospitals with an opportunity to increase employee compensation without the usual lag in those increases being reflected in the calculation of the wage index.[12]

In the FFY 2020 IPPS Final Rule, the Secretary finalized the "proposal to increase the wage index for hospitals with a wage index value below the 25th percentile wage index by half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value across all hospitals is 0.8457."[13] In doing so, the Secretary determined that "quartiles are a reasonable method of dividing the distribution of hospitals' wage index values" and that "identifying hospitals in the lowest quartile as low wage index hospitals, hospitals in the second and third 'middle' quartiles as hospitals with wages index values that are neither low nor high, and hospitals in the highest quartile as hospitals with high wage index values, is then a reasonable method of determining low wage index and high wage index hospitals for purposes of our proposals . . . addressing wage index disparities."[14]

The Secretary acknowledged that "there is no set standard for identifying hospitals as having low or high wage index values"; however, he believes his "proposed quartile approach is reasonable for this purpose, given that . . . quartiles are a common way to divide distributions, and that our proposed approach is consistent with approaches used in other areas of the Medicare program."[15] The Secretary stated in the proposed rule that, based on the data for the proposed rule, for FY 2020, the 25th percentile wage index value across all hospitals was 0.8482 and that this number

[11] *Id.*
[12] 84 Fed. Reg. at 42326 (citations omitted).
[13] *Id.* at 42328.
[14] *Id.* at 42326.
[15] *Id.*

would be updated in the final rule based on the final wage index values.[16] When the FFY 2020 IPPS final rule was published the 25th percentile wage index value across all hospitals for FFY 2020 was 0.8457.[17]

Under the Secretary's methodology, it was decided to increase the wage index for hospitals with a wage index value below the 25th percentile wage index. The increase in the wage indices for these hospitals would be equal to half of the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year for all hospitals.[18] The Secretary also confirmed that he was "finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in this rule, is implemented in a budget neutral manner" and asserted that his authority to do so "falls within the scope of the authority of section 1886(d)(3)(E) of the Act" and "even if [budget neutrality] were not required [under section 1886(d)(3)(E)], we would consider it inappropriate to use the wage index to increase or decrease overall IPPS spending."[19]

The Secretary announced that the low wage index policy would be *in effect* ***for at least*** *four years beginning in FFY 2020*, in order to allow employee compensation increases implemented by low wage index value hospitals sufficient time to be reflected in the wage index calculation. The Secretary explained that, for the FFY 2020 wage index, data from 2016 cost reports was used to calculate the wage indices and four years is the minimum time before increases in employee compensation included in Medicare cost reports could be reflected in the wage index. The Secretary acknowledged that additional time may be necessary to determine the duration of the policy.[20]

In the FFY 2021 IPPS Final Rule, the Secretary indicated he was "continuing the low wage index hospital policy [for FY 2021], and also applying this policy in a budget neutral manner by applying an adjustment to the standardized amounts."[21] Based on the data for this final rule, for FFY 2021, the 25th percentile wage index value across all hospitals was 0.8465, which was later corrected to 0.8469.[22]

Thereafter, in the FY 2022 IPPS Final Rule, the Secretary again indicated he was "continuing the low wage index hospital policy" for FY 2022, and "also applying this policy in a budget neutral manner by applying an adjustment to the standardized amounts."[23] Based on the data for this final rule, for FY 2022, the 25th percentile wage index value across all hospitals was 0.8437.[24]

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[16] *Id.*
[17] *Id.* at 42328.
[18] *Id.*
[19] *Id.* at 42331.
[20] *Id.* at 42326-7.
[21] 85 Fed. Reg. 58432, 58436 (Sept. 18, 2020).
[22] *Id.* at 58768; 85 Fed. Reg. 78748, 78754 (Dec. 7, 2020) (Correction).
[23] 86 Fed. Reg. 44774, 44778 (Aug. 13, 2021).
[24] *Id.* at 45178.

Again, in the FY 2023 IPPS Final Rule, the Secretary indicated he was continuing the low wage index hospital policy for FY 2023, and also applying this policy in a budget neutral manner by applying an adjustment to the standardized amounts.[25] Based on the data for this final rule, for FY 2023, the 25th percentile wage index value across all hospitals was 0.8427.[26]

Finally, in the FY 2024 IPPS Final Rule, the Secretary indicated he was continuing the low wage index hospital policy for FY 2024, and also applying this policy in a budget neutral manner by applying an adjustment to the standardized amounts.[27] Based on the data for this final rule, for FY 2023, the 25th percentile wage index value across all hospitals was 0.8667.[28]

B. Budget Neutrality and the Wage Index

In the 2020 Proposed IPPS Rule, the Secretary explained that he believed that "while it would not be appropriate to create a wage index floor or a wage index ceiling," it would be appropriate to "provide a mechanism to increase the wage index of low wage index hospitals . . . . while maintaining budget neutrality for that increase through an adjustment to the wage index of high wage index hospitals."[29] The Secretary maintained that this action had two key merits: (1) "by compressing the wage index for hospitals on the high and low ends, that is, those hospitals with a low wage index and those hospitals with a high wage index, such a methodology increases the impact on existing wage index disparities more than by simply addressing one end;" and (2) "such a methodology ensures those hospitals in the middle, that is, those hospitals whose wage indices are not considered high or low, do not have their wage index values affected by this proposed policy."[30] Thus, the Secretary concluded that, "given the growing disparities between low wage index hospitals and high wage index hospitals, . . . it would be appropriate to maintain budget neutrality for the low wage index policy proposed . . . by adjusting the wage index for high wage index hospitals."[31]

Following significant criticism from commenters to the proposed rule, the Secretary acknowledged that "some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between the proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States."[32] Based on this feedback, the Secretary decided to "finaliz[e] a budget neutrality adjustment for our low wage hospital policy but . . . not [to] finaliz[e] our proposal to target that budget neutrality adjustment on high wage hospitals" given that: (1) budget neutrality is required under [§ 1395ww(d)(3)(E)]; (2) even if it were not required, he believes that "it would be inappropriate to use the wage index to increase or decrease overall IPPS spending;" and (3) he wished to "consider further the policy arguments

[25] 87 Fed. Reg. 48780, 49006 (Aug. 10, 2022).
[26] *Id.*
[27] 88 Fed. Reg 58640, 58978-58979 (Aug. 28, 2023).
[28] *Id.* at 58978.
[29] 84 Fed. Reg. at 42329.
[30] *Id.*
[31] *Id.*
[32] *Id.* at 42331.

raised by commenters regarding the budget neutrality proposal."[33] Specifically, "consistent with the Secretary's current methodology for implementing wage index budget neutrality under [§1395ww(d)(3)(E)] and the alternative approach we considered in the proposed rule (84 FR 19672), we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in the rule, was implemented in a budget neutral manner."[34]

As indicated above, the Secretary has continued the low wage index hospital policy the following four years, for FFYs 2021 to 2024, and continued to apply this policy in a budget neutral manner by applying an adjustment to the labor portion of the standardized amounts.[35]

Providers' Position:

The Providers are challenging their IPPS payments for FFY 2024 on the grounds that those payments were and continue to be improperly understated as a result of the reduction to the standardized amount, which the Secretary allegedly unlawfully imposed as part of the new policy increasing the Area Wage Index ("AWI") values of hospitals with an AWI value in the lowest quartile.

The Providers explain that the Secretary continues to implement, without any changes, his policy that increases the AWI values of hospitals with an AWI in the lowest quartile, nationally (the "Low Wage Index Redistribution") that he first adopted for FFY 2020. The Low Wage Index Redistribution was implemented in 2020 to address what the Secretary called "wage index disparities" by impacting the AWI values and the IPPS Medicare reimbursement that hospitals receive. Specifically, the Providers contend that "the Low Wage Index Redistribution increases the AWI values of hospitals with AWI values in the lowest quartile, nationally, by half the difference between their accurately calculated AWI and the 25th percentile AWI value."[36]

The Providers note that in the FFY 2024 IPPS Final Rule, the Secretary reiterated his assertion that he had the authority to implement this new policy under 42 U.S.C. § 1395ww(d)(3)(E) despite acknowledging that the district court in *Bridgeport Hospital, et al. v. Becerra,* No. 1:20-cv-01574 (D.D.C.)[37] held that the Secretary did not have the legal authority under 42 U.S.C. §§ 1395ww(d)(3)(E) or 1395ww(d)(5)(I)(i) to adopt the FFY 2020 Low Wage Index Redistribution. This section of the statute authorizes the Secretary to adjust the labor-related portion of IPPS payments to account "for area differences in hospital wage levels" by a "factor" (the wage index) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level, citing 42 U.S.C. § 1395ww(d)(3)(E). The

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[33] *Id*.
[34] *Id*.
[35] 85 Fed. Reg. at 58436 (Sept. 18, 2020); 86 Fed. Reg. at 44778 (Aug. 13, 2021); 87 Fed. Reg. at 49006 (Aug. 10, 2022); 88 Fed. Reg 58640, 58978-58979 (Aug. 28, 2023).
[36] Consolidated EJR Request at 3-4 (Oct. 29, 2024).
[37] 589 F. Supp. 3d 1 (2022), *aff'd in part and rev'd in part*, *Bridgeport Hospital, dba Yale New Haven Health, et al. v. Becerra,* 2024 WL 3504407 (D.C. Cir. 2024). The Providers note the same conclusions were made in the 9th Circuit in *Kaweah Delta Health Care District et al. v. Becerra*, 2022 WL 18278175 (C.D. Cal. 2022).

Secretary must "update" the wage index annually "on the basis of a survey . . . of the wages and wage-related costs of [IPPS-participating] hospitals in the United States."[38]

The Providers contend that the Secretary again elected to implement his Low Wage Index Redistribution in a budget neutral manner for FFY 2024. As a result, the Providers allege, the Secretary decreased the standardized payment amounts of all IPPS hospitals by 0.2598% to offset the AWI increases to those hospitals in the lowest AWI quartile.[39]

The Providers point out that the Secretary "continues to assert that he has the authority to implement this budget neutrality adjustment under 42 U.S.C. § 1395ww(d)(3)(E), however, [he] continues to note that even if he did not have such authority under § 1395ww(d)(3)(E), he would invoke his special statutory "exceptions and adjustments" authority . . . . in support of such a budget neutrality adjustment . . . . This statutory provision, codified at 42 U.S.C. § 1395ww(d)(5)(I)(i), addresses IPPS payments and states: 'The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.'"[40] The Providers contend that "no statute precludes administrative or judicial review of the Secretary's adjustments for different area wage levels under 42 U.S.C. § 1395ww(d)(3)(E) or the Secretary's adjustments or exceptions under 42 U.S.C. § 1395ww(d)(5)(I)."[41]

The Providers argue that "the Secretary lacks the authority to (a) continue the Low Wage Index Hospital Policy in the manner set forth in the FFY 2024 Final IPPS Rule; and, (b) continue to implement such policy in a budget neutral manner under the [AWI] statutory provision, the exceptions or adjustments authority, or otherwise. Therefore, the [Providers] challenge the adjustment to the standardized amount on several grounds, including, but not limited to, that it exceeds statutory authority, contradicts the [AWI] congressional mandate, was developed in an arbitrary and capricious manner, lacks support from substantial evidence, and is otherwise defective both procedurally and substantively."[42]

The Providers note that, "[t]he immediate detrimental effect will be a 0.2598% negative adjustment of the standardized amount and the hospital-specific operating payment rate for FFY 2024 for every IPPS hospital, resulting in a reduction in overall MS-DRG IPPS payments for all IPPS hospitals, including the [Providers]."[43] Further, as this is the fourth year of the implementation of the Low Wage Index Redistribution and the related budget neutrality adjustment, the Providers already suffered an unlawful negative adjustment in FFYs 2020 to 2023. The request continues, stating, "[b]ased on the foregoing, the [Providers] are challenging the Low Wage Index Hospital Policy in this group appeal for several reasons, including but not limited to, whether the Secretary (1) improperly exercised the authority granted through 42 U.S.C. § 1395ww(d)(3)(E) and 42 U.S.C. § 1395ww(d)(5)(I)(i); and (2) improperly reduced FFY 2024 IPPS payments to IPPS hospitals, including the [Providers], as a result of the budget neutral

[38] Consolidated EJR Request at 4.
[39] *Id.*
[40] *Id.*
[41] *Id.*
[42] *Id.*
[43] *Id.* at 5.

implementation of the Low Wage Index Hospital Policy, which has been in effect since October 1, 2019, and continues through FFY 2024. The [Providers] seek their proper IPPS payments plus interest calculated under 42 U.S.C. § 1395oo(f)(2) and/or 42 U.S.C. § 1395g(d)."[44]

The Providers believe EJR is appropriate because the Board has jurisdiction over the appeals, the Providers are dissatisfied with the final determination of the Secretary, but the Board lacks the authority to decide the question at issue and cannot grant the relief sought. Pursuant to 42 C.F.R. § 405.1867, the Board must comply with all the provisions of Title XVIII of the Social Security Act and is therefore, bound to apply the 0.2598% reduction issued by the Secretary in the FFY 2024 IPPS Final Rule.[45]

Medicare Contractor's Position:

On November 4, 2024, the Medicare Contractor's Representative, Federal Specialized Services ("FSS"), made a timely[46] certification that it would be filing Substantive Claim and/or Jurisdictional Challenges in the following cases:

- 24-0810GC (Substantive Claim Challenge forthcoming)
- 24-0729GC (Substantive Claim Challenge forthcoming)
- 24-0735GC (Potential Jurisdictional Challenge)
- 24-0828GC (Substantive Claim Challenge forthcoming)
- 24-0836GC (Substantive Claim Challenge forthcoming)
- 24-0774GC (Substantive Claim Challenge forthcoming)
- 24-0823GC (Noting documentation was absent from OH CDMS)
- 24-0821GC (Substantive Claim Challenge forthcoming)[47]

On November 5, 2024, the Medicare Contractor in case 24-0782GC also submitted a notice that it would be filing a Substantive Claim Challenge, but FSS filed an update on November 18, 2024 noting that the participants that would have been challenged were withdrawn from the case, so no Substantive Claim Challenge would be incoming.

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[44] *Id.*
[45] *Id.* at 6-8.
[46] Board Rule 44.6 (2023) governs the timing of Substantive Claim Challenges in cases where a Request for EJR is filed less than sixty (60) days from the filing of a Final Schedule of Providers (or Board Rule 20 Certification filed in lieu of a Final SOP which certifies that the group is complete and fully populated in OH CDMS). In such instances, Board Rule 44.6 requires any party questioning the Board's jurisdiction or whether an appropriate cost report claim was made to file the challenge, or a certification that a challenge is forthcoming, within five (5) business days of the date the EJR Request was filed. The Request for EJR in these cases was filed on October 29, 2024, so any challenges (or certification that a challenge was forthcoming) was due no later than close of business November 5, 2024.
[47] The certification also noted that, in case 24-0718GC, no cost report had yet been filed, but did not note any forthcoming challenge(s) based on this fact.

On November 12, 2024, FSS filed a timely[48] Substantive Claim Challenge in Case 24-0810GC. On November 13, FSS filed a timely Substantive Claim Challenge in Case 24-0821GC. On November 17, 2024, FSS filed a timely Substantive Claim Challenge covering seven (7) cases:

- 24-0718GC
- 24-0729GC
- 24-0733GC
- 24-0735GC
- 24-0774GC
- 24-0828GC
- 24-0836G

The November 17 challenge also noted that the majority of the Providers in these appeals have not yet filed their cost reports, so it is premature for the Medicare Contractor to evaluate whether a substantive claim has been made. In the remaining twenty-two (22) cases, no Substantive Claim or Jurisdictional Challenges were filed and they will be addressed under separate cover.[49]

Substantive Claim Challenges:

A. Medicare Contractor's Challenges

As noted above, on November 12, 2024, FSS filed a timely Substantive Claim Challenge in Case 24-0810GC. On November 13, FSS filed a timely Substantive Claim Challenge in Case 24-0821GC. On November 17, 2024, FSS filed a Substantive Claim Challenge covering seven (7) cases:

- 24-0718GC
- 24-0729GC
- 24-0733GC
- 24-0735GC
- 24-0774GC
- 24-0828GC
- 24-0836G

The Arguments raised in all of the Substantive Claim Challenges are materially identical. The specific Participants and FYEs being challenged in each case (the "Challenged Participants") are set forth in **Appendix B** to this decision. The Medicare Contractor generally notes that the appeals were taken from the Federal Register, but that on the impacted cost reports, each Challenged Participant failed to submit any documentation to support that they claimed reimbursement for the appealed issue. It also notes that, while the Challenged Participants may have filed their cost reports identifying certain amounts as Part A Protested amounts, "a review

[48] Board Rule 44.6 (2023) requires that, following a certification that Substantive Claim and/or Jurisdictional Challenges will be filed, that they actually be filed within twenty (20) days of the date of the EJR Request being filed. The EJR Requests in these cases were filed October 29, 2024, so any challenges were due no later than close of business November 18, 2024.
[49] *See id.*

of the submitted Protest amount detail reveals that the Provider did not establish a self-disallowed item for the Area Wage Index Lowest Quartile IPPS Payment Reduction issue. Accordingly, there is nothing in the record to demonstrate that the Provider claimed an amount for the Area Wage Index Lowest Quartile IPPS Payment Reduction issue as a protested item in the applicable fiscal year Medicare cost reports. Thus, the Provider did not properly establish a self-disallowed item for the specific item in dispute as described at 42 C.F.R. § 413.24(j)(2)."[50]

B. Providers' Responses to Substantive Claim Challenges

On November 20, 2024, the Providers filed a Consolidated Response to all three separate Substantive Claim Challenges (covering the nine (9) cases set forth in **Appendix A**) filed by FSS.[51]

First, the Providers argue that the substantive claim requirement at 42 C.F.R. § 413.24(j) is substantively and procedurally invalid pursuant to the holdings in *Bethesda Hospital Ass'n. v. Bowen*, 485 U.S. 399 (1988) ("*Bethesda*") and *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131 (D.D.C. 2016) ("*Banner Heart Hospital*").[52]

Second, the Providers note they have exercised their statutory right to appeal from a Federal Register publication, namely the FFY 2024 IPPS Final Rule, which was published on August 28, 2023. Thus, their appeals from this final determination were due by late February, 2024, while the first cost reports for the Providers in this appeal were not due until after this date. For this reason, it would have been factually impossible to protest the issue on their cost reports prior to filing the group appeal.[53] They also claim that by filing the group appeal, the Providers gave notice that they were all protesting their IPPS payments based on the reasons set forth in the appeal.[54]

The Providers also argue that a challenge to the policy being appealed is not a "specific item" of reimbursement that could be claimed because it "arises from IPPS claims and, thus, cuts across all IPPS payments."[55] They also believe that all of the participants in this appeal satisfied the substantive claim requirements "by submitting claims on their respective as-filed cost reports for all operating IPPS payments," and that "their cost report claims sought reimbursement for all amounts due under the law, and the AWI Payment Reduction Issue seeks payment only of amounts that would have been paid if the law had been properly applied."[56] Similarly, the Providers believe it is unreasonable to require cost-reporting protests on the AWI Payment Reduction Issue because "the Secretary has long been aware of the AWI Payment Reduction

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[50] *E.g.*, PRRB Cases 24-0718GC *et al.*, Medicare Administrative Contactor's Substantive Claim Challenge at 13 (Nov. 17, 2024).
[51] Providers' Consolidated Response to MACs' November 12, 2024 (Case No. 24-0810GC), November 13, 2024 (Case No. 24-0821GC), and November 17, 2024 (Various Cases) Substantive Claim Letters; *EJR Requests Pending* (Nov. 20, 2024) ("Substantive Claim Response").
[52] *Id.* at 5.
[53] *Id.* at 5-6 & n.5.
[54] *Id.* at 6.
[55] *Id.*
[56] *Id.*

Issue, because it was presented more than four years ago in the *Bridgeport* and *Kaweah Delta* Board appeals and federal court litigation, and in subsequent board appeals every year since."[57]

For the vast majority of the Challenged Participants, the Providers concede that the "MACs are correct that [the challenged] Hospitals did not explicitly repeat their protest of the AWI Payment Reduction Issue on their identified as-filed Medicare cost reports."[58] Arguments related to specific Challenged Participants for which the Providers argue that they *did* comply with the substantive claim requirements (or that a challenge should be disregarded by the Board) are outlined, below.

Decision of the Board:

A. Jurisdiction and Request for EJR

Each of the participants in the nine (9) group cases set forth in **Appendix A** appealed from the FFY 2024 IPPS Final Rule.[59] The Board has determined that: (1) the participants' documentation in each of the group appeals shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal;[60] (2) the appeals were timely filed; and (3) Board review of the matter in these appeals is not precluded by statute or regulation. In finding that the groups meet the $50,000 amount in controversy, the Board recognizes that the Group Representative has explained that the amount in controversy ("AiC") calculation is simply based on the estimated IPPS payments for the period at issue multiplied by 0.2598 percent (*i.e.,* the adjustment to the wage index that they are challenging in this appeal) and this AiC unmistakably demonstrates each of the groups more than clears the minimum $50,000 AiC hurdle. ***Except as noted below***, based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractors for the actual final amounts in each case.

B. Application of 42 C.F.R. §§ 405.1873 and 413.24(j)

1. Regulatory Background

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 405.1873 and 413.24(j) are applicable. The regulation 42 C.F.R. § 413.24(j) requires that:

> (1) *General Requirement*. In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in

[57] *Id.* at 17.
[58] *Id.* at 8.
[59] The CMS Administrator confirmed that, consistent with the D.C. Circuit's decision in *Washington Hosp. Ctr. v. Bowen*, 795 F.3d 139 (D.C. Cir. 1986, a wage index notice published in the Federal Register is a final determination from which a provider may appeal to the Board within the meaning of 42 U.S.C. § 1395oo(a)(1)(A)(ii). *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993*)*, *rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015); 42 C.F.R. § 405.1837.
[60] *See* 42 C.F.R. § 405.1837.

> paragraph (j)(3) of this section), **must include an appropriate claim for the specific item**, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **and describing** how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[61]

In conjunction with the regulation above, 42 C.F.R. § 405.1873(a) states:

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider **must include in its cost report an appropriate claim for the specific item** (as prescribed in § 413.24(j) of this chapter). If the provider files an appeal to the Board seeking reimbursement for the specific item and any party to such appeal questions whether the provider's cost report included an appropriate claim for the specific item, the Board must address such question in accordance with the procedures set forth in this section.

[61] (Bold and underline emphasis added.)

> (b) *Summary of Procedures*.
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> ****
>
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ****
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ****
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section—*
>
> (1) Board jurisdictional dismissal decision. **If the Board issues a jurisdictional dismissal decision** regarding the specific item under appeal (pursuant to § 405.1840(c)), **the Board's specific findings of fact and conclusions of law** (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must not be included in such jurisdictional dismissal decision**.[62]

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

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

a. Unchallenged Providers and Providers with no Cost Reports

As explained above, at issue in this appeal are cost reports beginning after January 1, 2016, which are subject the regulations on the "substantive reimbursement requirement" for an

[62] (Bold and underline emphasis added.)

appropriate cost report claim.[63] The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[64] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included *if review under subsection (b)(1) has been triggered by a party raising a question under subsection (a) of whether a provider made an appropriate claim for the specific item under appeal on the relevant as-filed cost report*.

Accordingly, the Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[65] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made on the relevant as-filed cost report.[66] The Board further notes that, when the participants in a group have not filed their cost report, then § 405.1873(b) would not be triggered because the issue of whether the relevant participants' cost reports included an appropriate claim for the specific item under appeal would not yet be ripe.[67] Section 405.1873(b) sets forth the procedures for Board review of Substantive Claim Challenges:

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

Significantly, the regulation simply directs the Board to give an adequate opportunity to take in evidence and argument and does not discuss staying appeals based on Federal Register to allow

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[63] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").
[64] (Emphasis added.)
[65] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[66] *See* 42 C.F.R. § 405.1873(a),
[67] The preamble to the final rule that adopted the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1973 responded to a comment about appeals from the Federal Register and confirmed that the substantive claim regulations applied to them. 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015). However, this preamble discussion does not address the manner in which they apply. Rather, the response concludes with the following directive in § 405.1873(a)-(b): "if a party to an appeal questions whether there was an appropriate cost report claim for a specific PPS item, the Board must take evidence and argument on that question; issue findings of fact and conclusions of law on such matter; and include those findings and conclusions in both the administrative record and certain types of overall Board decisions." *Id.* at 70570.

future review and consideration of Substantive Claim Challenges. In this regard, the fact that a cost report has not been filed would not stop or delay the Board proceedings as set forth in § 405.1873(b). Accordingly, it is the Board's position that in these type instances, any Substantive Claim Challenge would be premature. That said, *if subsequent to the Federal Register appeal being filed*, one or more participants files its cost report, then any party may raise a Substantive Claim Challenge regarding those participants and submit argument and evidence supporting their position.

Here, FSS indicated for some participants, cost reports have not been filed. As previously noted, the fact that cost reports have not yet been filed does not trigger § 405.1873(a) or § 413.24(j)'s general substantive payment requirement for cost reports.[68] Accordingly, the Board is not obligated under 42 C.F.R. § 405.1873 to include findings of fact on substantive claim requirements in the for any of the Unchallenged Participants[69] where no Substantive Claim Challenge was filed or where the applicable cost report has not yet been filed.

b. Challenged Participants

As previously noted, for the vast majority of the Challenged Participants, the Providers concede that the "MACs are correct that [the challenged] Hospitals did not explicitly repeat their protest of the AWI Payment Reduction Issue on their identified as-filed Medicare cost reports."[70] Except as noted below, the Board specifically finds that it is undisputed that these participants failed to include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1).

For the Challenged Participants in three cases, however, the Providers raise different arguments.

i. Case 24-0733GC

The Providers note that the Medicare Contractor did not, on its own or through FSS, make a timely certification that it would be filing a Substantive Claim Challenge in Case 24-0733GC as required by Board Rule 44.6.[71] As a result, the Providers ask the Board to disregard any challenges made in Case 24-0733GC.

The Board concurs. Board Rule 44.6 (2023) governs the timing of Substantive Claim Challenges in cases such as these where a Request for EJR is filed less than sixty (60) days from the filing of a Final Schedule of Providers (or Board Rule 20 Certification filed in lieu of a Final SOP which certifies that the group is complete and fully populated in OH CDMS). In such instances, Board Rule 44.6 requires any party questioning the Board's jurisdiction or whether an appropriate cost report claim was made to file the challenge, or a certification that a challenge is forthcoming, within five (5) business days of the date the EJR Request was filed. The Request for EJR in

[68] *See* 80 Fed. Reg. at 70556, 70569-70.
[69] *See* **Appendix B**.
[70] Substantive Claim Response at 8.
[71] *Id.* at n.1.

these cases was filed on October 29, 2024, so any challenges (or certification that a challenge was forthcoming) was due no later than close of business November 5, 2024.

The results of either party's failure to comply with the Board's rules can be found at 42 C.F.R. § 405.1868:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. ***The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules*** and orders or for inappropriate conduct during proceedings in the appeal.
>
> *****
>
> (c) ***If a contractor fails to meet a filing deadline or other requirement established by the Board, the Board may——***
>
> (1) Take other actions that it considers appropriate, such as—
>
> (i) Issuing a decision based on the written record submitted to that point; or
>
> (ii) Issuing a written notice to CMS describing the contractor's actions and requesting that CMS take appropriate action, such as review of the contractor's compliance with the contractual requirements of §§ 421.120, 421.122, and 421.124 of this chapter; . . .[72]

FSS' November 4, 2024 certification that it would be filing challenges in certain cases did not include Case 24-0733GC. Pursuant to 42 C.F.R. §405.1868(c)(1)(i), the Board finds that it is appropriate to issue its decision in Case 24-0733GC based on the record submitted up to that point with regard to any review of the Final Schedule of Providers and related Substantive Claim issues. Since the Medicare Contractor did not issue a ***timely*** certification that it would be filing a challenge to any participants in Case 24-0733GC, the Board finds that its obligation to make findings of fact under 42 C.F.R. § 405.1873 has not been triggered for that time period and declines to consider any arguments raised in the challenge or make and related findings of fact,

ii. Case 24-0735GC

The Providers claim that "West Covina Medical Center (05-0096) is in the process of preparing its cost report at issue, which will include a protest of the AWI Payment Reduction Issue."[73] The

[72] (Emphasis added).
[73] *Id.* at 8.

Medicare Contractor notes that this Provider has not filed its cost report for FYE 12/31/2023, but that the cost report was due no later than May 31, 2024.[74]

42 U.S.C. 1395oo(a) provides a provider of services with the right to a hearing before the Board only if they have "filed a required cost report within the time specific in regulations[.]" The Medicare Contractor alleges that the cost report was due no later than May 31, 2024, and the Provider has not disputed this fact. Indeed, the FYE for this Provider was December 31, 2023, and cost reports are generally "due on or before the last day of the fifth month following the close of the period covered by the report."[75] Since this Provider did not file its cost report within the time frame specified by the regulations, the Board finds the Provider does not have the right to a hearing before the Board for this issue and fiscal year. Therefore, the Board hereby denies the Request for EJR for West Covina Medical Center (05-0096, FYE 12/31/2023) and dismisses it from the appeal.

iii. Case 24-0774GC

The Medicare Contractor noted the Providers in this case "included a line item for 'Area Wage Index' on the protest listing (except for tied out Provider 45-0099) but the protested amount for this line item is NOT included in the total. In addition, further review of the detail shows the Area Wage Index protest item is specific to FFY 2023 and does **not** include a protest of this issue for FFY 2024 (see documentation at Exhibit C-05)."[76]

The Providers claim that "all of the hospitals at issue explicitly repeated their protests of the AWI Payment Reduction Issue in the narratives submitted with their FYE 12/31/2023 cost reports . . . . Following this description, each provider included hospital-specific calculations for the reimbursement impact, and the same sum was stated in the Hospitals' Summary of Protested Amounts under the "Area Wage Index" issue."[77] They acknowledge that their narrative and protested amounts were labeled "FFY 2023" (which does not overlap with FFY 2024) instead of "FYE 2023" (which does overlap with FFY 2024), so the wage index protest amount was not included in the total protest amount, but that the figures on the cost report are subject to change in an appeal and that, when read together, the documents provided to the Medicare Contractor provided notice of a protest of this issue.[78]

42 C.F.R. §§ 413.24(j) can be satisfied if a provider (1) claims full reimbursement for a specific item on its cost report, or (2) self-disallows the specific item. To properly self-disallow an item, a provider must (i) include an estimated reimbursement amount for ***each item*** in the protested amount line on its cost report, and (ii) attach a separate worksheet to the cost report for each ***specific*** self-disallowed item.

The cost reports in Ex. C-5 are for FYE 12/31/2023, and the calculations attached to the Area Wage Index issue all detail a number of months overlapping with FFYs 2022 and 2023:

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[74] Medicare Administrative Contractor's Substantive Claim Challenge at 8 & n.11 (Nov. 17, 2024).
[75] 42 C.F.R. § 413.24(f)(2)(i).
[76] Medicare Administrative Contractor's Substantive Claim Challenge at 9 & n.12 (Nov. 17, 2024).
[77] Substantive Claim Response at 8 (citing Substantive Claim Challenge Ex. C-5).
[78] *Id.* at 9.

	FFY Beg	FFY End	Cost Report FYE	FFY 2023
FFY 2021	10/1/2020	9/30/2021	CR FYE 12/31/2021	
FFY 2022	10/1/2021	9/30/2022	CR FYE 12/31/2022	3
FFY 2023	10/1/2022	9/30/2023	CR FYE 12/31/2023	9
				12
			% of Cost Rptg Period	100%
			AWI factor	0.002
			DRG Payment	12,822,656
			Estimated AWI Reimbursement Impact	25,645

[79]

This appeal concerns FFY 2024. The Providers in this case did not include worksheets or calculations which specifically protested FFY 2024 – the calculation only reflected the 9 months of FYE 12/31/2023 which fall into FFY 2023. The Board concurs with the Medicare Contractor and specifically finds that the Challenged Providers in Case 24-0774G did not make a substantive claim.

C. Analysis Regarding Appealed Issue

As set forth below, the Board finds that the Secretary's determination to finalize a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals was implemented in a budget neutral manner was made through notice and comment in the form of an uncodified regulation.[80] Specifically, in the preamble to FFY 2020 IPPS Final Rule, the Secretary announced the following wage index issues:

1. "To help mitigate . . . wage index disparities [between high and low wage index hospitals], including those resulting from the inclusion of hospitals with rural reclassifications under 42 CFR 412.103 in the calculation of the rural floor, . . . we . . . reduce the disparity between high and low wage index hospitals by increasing wage index values for certain low wage index hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values to maintain budget neutrality, and changing the calculation of the rural floor . . . .";[81] and

2. "[A]ddressing this systemic issue does not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure."[82]

The Secretary did not incorporate the above new policy setting forth a modification to the wage index calculation determination by finalizing a budget neutrality adjustment to the national

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[79] *E.g.*, Medicare Administrative Contractor's Substantive Claim Challenge at Ex. C-5 at 6 (Nov. 17, 2024).
[80] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals."
[81] *Id.* at 42326.
[82] *Id.*

standardized amount for all hospitals so that there was an increase in the wage index for low wage index hospitals into the Code of Federal Regulations. However, it is clear from the use of the following language in the preamble to the FFY 2020 IPPS Final Rule that the Secretary intended to bind the regulated parties and establish a binding uniform payment policy through formal notice and comment:

> We acknowledge, however, that some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between our proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States. Therefore, given that budget neutrality is required under section 1886(d)(3)(E) of the Act, given that even if it were not required, we believe it would be inappropriate to use the wage index to increase or decrease overall IPPS spending, and given that we wish to consider further the policy arguments raised by commenters regarding our budget neutrality proposal, we are finalizing a budget neutrality adjustment for our low wage hospital policy, but we are not finalizing our proposal to target that budget neutrality adjustment on high wage hospitals. Instead, consistent with CMS's current methodology for implementing wage index budget neutrality under section 1886(d)(3)(E) of the Act and the alternative approach we considered in the proposed rule . . . we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in this rule, is implemented in a budget neutral manner.[83]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but *uncodified* regulation and will refer to the above policy as the "Uncodified Regulation on Wage Index." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services as a regulation."[84]

While this appeal involves the FFY 2024 IPPS Final Rule, the continuation of this policy was implemented in the same way as it was initially for FFY 2020.[85] The proposed rule did not propose any changes to this policy. The Final Rule for FFY 2024 refers to the responses to comments provided in the FFY 2020 Final Rule, and applied the policy in the same manner as it

[83] 84 Fed. Reg. at 42331.
[84] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."
[85] 88 Fed. Reg 58640, 58978-58979 (Aug. 28, 2023).

was applied in FFY 2020.[86] Therefore, the Board finds that this policy continues to be a binding but uncodified regulation for FFY 2024.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulation on Wage Index published in the FFY 2024 IPPS Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulation on Wage Index which they allege improperly reduces the standardized amount of 0.2598 percent for FFY 2024. As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in the cases set forth in **Appendix A**.

D. Board's Decision Regarding the EJR Request

The Board makes the following findings:

1) The Board has jurisdiction over the AWI Issue for the subject year in these cases and that the Providers in these group appeals are entitled to a hearing before the Board **except for** West Covina Medical Center (05-0096, FYE 12/31/2023) in Case No. 24-0735GC which is hereby dismissed from that case;

2) While the Providers appealed cost reporting periods beginning after January 1, 2016, no substantive claim challenges[87] have been filed for the Unchallenged Participants[88] pursuant to 42 C.F.R. § 405.1873(a) to trigger either Board review under § 405.1873(b) or reporting under § 405.1873(d)(2);

3) While the Providers appealed cost reporting periods beginning after January 1, 2016, no ***timely*** certification related to substantive claim challenges was filed for Case 24-0733GC pursuant to Board Rule 44.6 (2023) to trigger either Board review under § 405.1873(b) or reporting under § 405.1873(d)(2);

4) The review process in 42 C.F.R. § 405.1873(a)-(b) has been triggered in the Challenged Cases (***except for Case 24-0733GC***) for the Challenged Participants and FYEs listed in Appendix B, and

    a the Board specifically finds that, except for the Challenged Participants in Cases 24-0733GC and 24-0774GC, it is undisputed that these participants failed to include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1); and

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[86] *Id.* at 58980.
[87] As the Board explained in Board Rule 44.5, "[t]he Board adoption of the term "Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."
[88] *See* **Appendix B**.

b the Board specifically finds that all Challenged Participants in Case 24-0774GC also failed to include "an appropriate claim for the specific item" that is the subject of its group appeal as required under 42 C.F.R. § 413.24(j)(1)

5) Based upon the Providers' assertions regarding the FFY 2024 IPPS Final Rule, there are no findings of fact for resolution by the Board;

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

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

   a Whether the Uncodified Regulation on Wage Index published in the FFY 2024 IPPS Final Rule is valid; and
   b Whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid for any Providers which the Board has specifically found failed to include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1).

Accordingly, the Board finds that the question of the validity of the Uncodified Regulation on Wage Index as published in the FFY 2024 IPPS Final Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject year (**except for** West Covina Medical Center (05-0096, FYE 12/31/2023) in Case No. 24-0735GC which is being dismissed from that case). For any Providers which the Board has specifically found failed to include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1), the Board also finds that the question of the validity of the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the their requests for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes these cases.

Board Members Participating:

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

For the Board:

11/26/2024

X Kevin D. Smith, CPA

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

Enclosure: Schedules of Providers

cc: Scott Berends, Esq., Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Dean Wolfe, Noridian Healthcare Solutions (J-F)
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H)

Appendix A

Nine (9) Cases where Substantive Claim Challenge was Filed:

24-0836G	*Toyon Associates FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction Group*
24-0828GC	*CommonSpirit Health FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0733GC	*KPC Health FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0774GC	*Prime Healthcare FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0735GC	*LA Downtown Med. Ctr. LLC FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0729GC	*John Muir Health FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0718GC	*Adventist Health FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0810GC	*Providence Health FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
24-0821GC	*Tenet Healthcare FFY 2024 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*

Appendix B

The following are the participants in each group for which a Substantive Claim Challenge was made by the Medicare Contractor (collectively the "Challenged Participants"). Any Participants not listed below are collectively the "Unchallenged Participants". The Board notes that some Challenged Participants have been withdrawn from their respective cases, as reflected in the Schedules of Providers enclosed with this decision.

- Case 24-0718GC
  - Heart Hospital of Bakersfield (Prov. No. 05-0724) (tied out 11/26/2023)
- Case 24-0729GC
  - John Muir Med Ctr (Walnut Creek Campus) (Prov. No. 05-0180) (FYE 12/31/2023)
  - John Muir Med Ctr (Concord) (Prov. No. 05-0496) (FYE 12/31/2023)
- Case 24-0733GC
  - Hemet Global Medical Center (Prov. No. 05-0390) (FYE 12/31/2023)
  - Victor Valley Global Medical Center (Prov. No. 05-0517) (FYE 12/31/2023)
  - Menifee Global Medical Center (Prov. No. 05-0684) (FYE 12/31/2023)
  - Anaheim Global Medical Center (Prov. No. 05-0744) (FYE 12/31/2023)
  - Chapman Global Medical Center (Prov. No. 05-0745) (FYE 12/31/2023)
  - Orange County Global Medical Center (Prov. No. 05-0749) (FYE 12/31/2023)
  - Coastal Communities Hospital (Prov. No. 05-0747) (FYE 12/31/2023)
- Case 24-0735GC
  - West Covina Medical Center (Prov. No. 05-0096) (FYE 12/31/2023)
- Case 24-0774GC
  - Saint Francis Medical Center (Prov. No. 05-0104) (FYE 12/31/2023)
  - Paradise Valley Hospital (Prov. No. 05-0024) (FYE 12/31/2023)
  - Encino Hospital Medical Center (Prov. No. 05-0158) (FYE 12/31/2023)
  - Garden Grove Hospital & Medical Center (Prov. No. 05-0230) (FYE 12/31/2023)
  - West Anaheim Medical Center (Prov. No. 05-0426) (FYE 12/31/2023)
  - Huntington Beach Hospital (Prov. No. 05-0526) (FYE 12/31/2023)
  - La Palma Intercommunity Hospital (Prov. No. 05-0580) (FYE 12/31/2023)
  - Chino Valley Medical Center (Prov. No. 05-0586) (FYE 12/31/2023)
  - San Dimas Community Hospital (Prov. No. 05-0588) (FYE 12/31/2023)
  - Desert Valley Hospital (Prov. No. 05-0709) (FYE 12/31/2023)
  - Centinela Hospital Medical Center (Prov. No. 05-0739) (FYE 12/31/2023)
  - Sherman Oaks Hospital (Prov. No. 05-0755) (FYE 12/31/2023)
  - St. Joseph medical Center (Prov. No. 26-0085) (FYE 12/31/2023)
  - Alvarado Hospital Medical Center (Prov. No. 05-0757) (FYE 12/31/2023)
  - Montclair Hospital Medical Center (Prov. No. 05-0758) (FYE 12/31/2023)
  - Shasta Regional Medical Center (Prov. No. 05-0764) (FYE 12/31/2023)
  - Lehigh Regional Medical Center (Prov. No. 10-0107) (FYE 12/31/2023)
  - Southern Regional Medical Center (Prov. No. 11-0165) (FYE 12/31/2023)
  - Monroe Hospital (Prov. No. 15-0183) (FYE 12/31/2023)

  - Lake Huron Medical Center (Prov. No. 23-0031) (FYE 12/31/2023)
  - Saint John Hospital (Prov. No. 17-0009) (FYE 12/31/2023)
  - Providence Medical Center (Prov. No. 17-0146) (FYE 12/31/2023)
  - Garden City Hospital (Prov. No. 23-0244) (FYE 12/31/2023)
  - St. Mary's Medical Center (Prov. No. 26-0193) (FYE 12/31/2023)
  - North Vista Hospital (Prov. No. 29-0005) (FYE 12/31/2023)
  - St. Mary's Regional Medical Center (Prov. No. 29-0009) (FYE 12/31/2023)
  - St. Mary's General Hospital (Prov. No. 31-0006) (FYE 12/31/2023)
  - Sain Clare's Hospital/Denville Campus (Prov. No. 31-0050) (FYE 12/31/2023)
  - St. Michael's Medical Center (Prov. No. 31-0096) (FYE 12/31/2023)
  - Lower Bucks Hospital (Prov. No. 39-0070) (FYE 12/31/2023)
  - Suburban Community Hospital (Prov. No. 39-0116) (FYE 12/31/2023)
  - Roxborough Memorial Hospital (Prov. No. 39-0304) (FYE 12/31/2023)
  - Landmark Medical Center (Prov. No. 41-0011) (FYE 12/31/2023)
  - Pampa Regional Medical Center (Prov. No. 45-0099) (tied out 12/31/2022)
  - Knapp Medical Center (Prov. No. 45-0128) (FYE 12/31/2023)
  - Mission Regional Medical Center (Prov. No. 45-0176) (FYE 12/31/2023)
  - Dallas Medical Center (Prov. No. 45-0379) (FYE 12/31/2023)
  - Dallas Regional Medical Center (Prov. No. 45-0688) (FYE 12/31/2023)
  - Harlingen Medical Center (Prov. No. 45-0855) (FYE 12/31/2023)
- Case 24-0828GC
  - Arizona Orthopedic and Surgical Specialty Hospital (Prov. No. 03-0112) (FYE 12/31/2023)
  - Cantura Longmont United Hospital (Prov. No. 06-0003) (FYE 12/31/2023)
- Case 24-0836G
  - Casa Colina Hospital (Prov. No. 05-0782) (FYE 3/31/2024)
  - Good Samaritan Hospital (Prov. No. 05-0257) (FYE 12/31/2023)
  - Marin General Hospital (Prov. No. 05-0360) (FYE 12/31/2023)
  - Pacifica Hospital of the Valley (Prov. No. 05-0378) (FYE 12/31/2023)
- Case 24-0810GC
  - Grace Medical Center (Prov. No. 45-0162) (FYE 12/31/2023)
- Case 24-0821GC
  - Brookwood Baptist Medical Center (Prov. No. 01-0139) (FYE 12/31/2023)