DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Board Decision* – SSI Percentage (Provider Specific) Issue**
Metrosouth Medical Center (Provider Number: 14-0118)
FYE: 12/31/2015
Case Number: 19-0598

Dear Mr. Ravindran and Ms. VanArsdale,

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

Background:

A. *Procedural History for Case No. 19-0598*

On **August 29, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2015.

On **November 23, 2018**, the Board received the Provider's individual appeal request. The Individual Appeal contained six (6) issues:

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

[1] On June 19, 2019, this issue was transferred to PRRB Case No. 18-1333GC.
[2] This issue was withdrawn on February 16, 2024.
[3] On June 19, 2019, this issue was transferred to PRRB Case No. 18-0594GC.
[4] On June 19, 2019, this issue was transferred to PRRB Case No. 18-0595GC.
[5] This issue was withdrawn on July 22, 2019.

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 CIRP groups. After the withdrawal of Issues 3 and 6, the remaining issue in this appeal is Issue 1 (DSH Payment/SSI Percentage (Provider Specific).

On **July 16, 2019**, the Provider timely filed its preliminary position paper.

On **October 8, 2019**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1.

On **November 13, 2019**, the Medicare Contractor timely filed its preliminary position paper.

On **August 18, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **October 11, 2023**, the Board issued a corrected Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

> Provider's Final Position Paper – *For each remaining issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *also include* ***any exhibits*** *the Provider will use to support to support its position*. *See* Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.[6]

On **February 19, 2024**, the Provider timely filed its final position paper.

On **March 18, 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. 18-1333GC

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

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

[6] (Emphasis added).

> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[7]

The group issue statement in Case No. 18-1333GC, QRS Quorum 2015 DSH SSI Percentage CIRP Group, to which the Provider transferred Issue 2 reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[8]

[7] Issue Statement at 1 (Nov. 23, 2018).
[8] Group Issue Statement, Case No. 18-1333GC.

On **February 19, 2024**, the Provider filed its final position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its 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-2).[9]

MAC's Contentions

The MAC argues that the Board lacks jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue for several reasons. First, the MAC argues that the appeal is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election and not a final MAC determination.
>
> . . .
>
> The MAC has not made a determination on the realignment of the SSI percentage to the hospital fiscal year end as the Provider has not yet requested realignment. Since the Provider did not request SSI realignment as required by 42 C.F.R. § 412.106(b)(3), the

[9] Provider's Final Position Paper at 7-8 (Feb. 19, 2024).

> MAC could not have made a final determination for this issue. The Provider's appeal is premature. The Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue. The MAC requests that the PRRB dismiss this subsidiary realignment issue consistent with its jurisdictional decisions.[10]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH/SSI Percentage (Systemic Errors) issue that was transferred to PRRB Case No. 18-1333GC are considered the same issue by the Board.[11]

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."

Board Analysis and Decision:

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

The jurisdictional analysis for Issue 1 has several relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period; and 3) the Provider incorporating the arguments from *Advocate Christ*[13] into its appeal. As set forth below, the Board dismisses all aspects of Issue 1.

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[10] Jurisdictional Challenge at 5-6 (Oct. 8, 2019).
[11] *Id*. at 3-5.
[12] Board Rule 44.4.3, v. 2 (Aug. 2018).
[13] The Provider has included the Appellants' Reply Brief in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214 (D.C. Cir.), which is on appeal from the decision in *Advocate Christ Med. Ctr. V. Azar*, 17-cv-1519 (TSC), 2022 WL 2064830, (D.D.C. June 8, 2022).

1. First Aspect 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 duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 18-1333GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[14] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[15] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[16]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 18-1333GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 18-1333GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6,[17] the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 18-1333GC, 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.[18] 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

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

distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 18-1333GC.

To this end, the Board also reviewed the Provider's Final Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 18-1333GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Final Position Paper failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Final Position Paper and include *all* exhibits.

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

> **25.2 – Position Paper Exhibits**
>
> **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.

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule,

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

> set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year.

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

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

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[20]

Accordingly, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue and the group issue from Group Case 18-1333GC are the same issue.[21] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

Additionally, in its Final Position Paper, the Provider stated, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-2)." The Board finds that this purported argument does not comply with the regulations and Board rules to *fully* develop the Provider's position in the Final Position Paper, because the Provider merely lists a case name and does not explain further what the arguments are that it would like to incorporate into its appeal.

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[22]

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[19] Last accessed February 24, 2023.
[20] Emphasis added.
[21] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Quorum CIRP group, per 42 C.F.R. § 405.1837(b)(1).
[22] (Emphasis added).

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

2. Second Aspect of Issue 1

The second aspect of the DSH SSI Percentage - Provider Specific issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

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In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 18-1333GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. As no issues remain pending, the Board hereby closes Case No. 19-0598 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

5/2/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Expedited Judicial Review Decision***
23-0701G: *Bass, Berry & Sims, PLC CYs 2016 - 2017 Capital DSH Group*
23-0926G: *Bass, Berry & Sims, PLC CY 2019 Capital DSH Group*
23-1514GC: *Hartford Health CY 2020 Capital DSH CIRP Group*
24-1269GC: *Corewell Health CY 2019 Capital DSH CIRP Group*

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the February 26, 2024 consolidated request for expedited judicial review[1] ("EJR") for the above-referenced optional and common issue related party ("CIRP") group appeals. The decision with respect to EJR is set forth below.[2]

Issue under Dispute

In these group cases, the Providers are challenging:

> [t]he validity of the regulation at 42 C.F.R. § 412.320(a)(1)(iii), which bars hospitals that are geographically urban and reclassify as rural under 42 C.F.R. § 412.103 from receiving a capital disproportionate share hospital ("DSH") add-on payment, known as the capital DSH adjustment. The Providers challenge the validity of 42 C.F.R. § 412.320(a)(1)(iii) on a number of grounds including that the regulation (a) is inconsistent with the controlling Medicare statute, (b) was adopted in violation of the Administrative Procedure Act, and (c) is arbitrary and capricious.[3]

Background:

Under the inpatient prospective payment system ("IPPS"), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for operating costs ("operating IPPS") as set forth at § 1395ww(d); and one for capital costs

[1] Providers' Petition for Expedited Judicial Review (Feb. 26, 2024) ("Request for EJR").
[2] The Request for EJR encompasses six (6) group cases. On March 19, 2024, the Board issued a Request for Information and Scheduling Order in Case Nos. 23-0926G, 23-0701G, 23-1514GC, and 24-1269GC. That order stayed the 30-day period for the Board to rule on the Request for EJR in those cases. The Board issued a separate determination adjudicating Case Nos. 23-1210G and 23-1645GC on March 27, 2024.
[3] Request for EJR at 1.

("capital IPPS") as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.[4] This case focuses on the capital IPPS.

A. Geographic Reclassification

In 1989, Congress created the Medicare Geographic Classification Review Board ("MGCRB") which implemented a geographic reclassification system in which IPPS hospitals can be reclassified to a different wage index area[5] for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.[6] This includes an IPPS hospital reclassifying from a rural to an urban labor market, or vice versa.

B. Operating DSH Adjustment Under Operating IPPS

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under operating IPPS.[7] Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[8]

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.[9] One of the adjustments is the hospital-specific Disproportionate Share Hospital ("DSH") adjustment as set forth at 42 U.S.C. § 1395ww(d)(5)(F), which requires the Secretary to provide an adjustment (*i.e.*, an increase in the operating IPPS payment) to hospitals that serve a significantly disproportionate number of low-income patients.[10]

A hospital may qualify for a DSH adjustment to its operating IPPS payments based on its disproportionate patient percentage ("DPP").[11] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[12]

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[4] Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), *available at* https://oig.hhs.gov/oas/reports/region1/11700500.pdf (last visited Oct. 20, 2022) ("*Significant Vulnerabilities*").
[5] *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).
[6] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). *See also Significant Vulnerabilities* at 4-5.
[7] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[8] *Id.*
[9] *See* 42 U.S.C. § 1395ww(d)(5).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[12] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

The DSH adjustment provided under operating IPPS is ***not*** at issue in this case. The DSH adjustment is relevant because certain standards set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment that the Secretary adopted for purposes of capital IPPS.

C. Capital DSH Adjustment Under Capital IPPS

A hospital's *capital* costs are paid separately under capital IPPS (*i.e.*, separate and apart from payment for a hospital's *operating* costs under the operating IPPS). Specifically, on December 22,1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987 ("OBRA-87") and OBRA-87 § 4006(b) required the Secretary to establish the capital IPPS for cost reporting periods beginning in FY 1992.[13] OBRA-87 § 4006(b) was codified at 42 U.S.C. § 1395ww(g) which states, in pertinent part:

> **(g) Prospective payment for capital-related costs; return on equity capital for hospitals**
>
> (1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall,* for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .
>
> (B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;
>
> (ii) *may provide for <u>an adjustment</u> to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located*;
>
> (iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and
>
> (iv) may provide for suitable adjustment to reflect hospital occupancy rate.
>
> (C) In this paragraph, the term ''capital-related costs'' has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.[14]

[13] Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).
[14] (Underline and italics emphasis added.)

Significantly, the statute governing capital IPPS does not specifically mandate or address the use of a capital DSH adjustment. Rather, it specifies generally that the Secretary "may provide for an adjustment to account variations in relative costs." As described below, the Secretary exercised his discretion to establish the c*apital* DSH adjustment at issue in this case which is limited in that it ***only*** applies to *urban* hospitals with 100 or more beds and that serve low income patients.[15]

1. Initial Implementation of Capital IPPS and the Capital DSH Adjustment

To the end, the Secretary published a final rule on August 30, 1991 to establish the capital IPPS.[16] In implementing the capital IPPS, the Secretary recognized that he had discretion on whether to apply many of the adjustments statutorily required under operating IPPS to capital IPPS:

> We are persuaded by the argument advanced by some commenters, including ProPAC, that in the long run the ***same*** adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. *While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process),* ***we have the latitude to develop adjustments based on combined costs for the capital prospective payment system***.
>
> We do not believe that it would be appropriate to use the current operating payment adjustments in the capital prospective payment system either permanently or on an interim basis until legislation is enacted changing the operating adjustments to the level appropriate for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME) exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should reflect only the higher Medicare costs associated with teaching activity and treating low income patients.[17]

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more than 100 beds. The proposal was described as follows:

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[15] 42 C.F.R. § 412.320(a)(1). *See also* MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 2 (rev. Nov. 2021), *available at* https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Oct. 20, 2022).
[16] 56 Fed. Reg. 43356 (Aug. 30, 1991).
[17] *Id.* at 43369-70 (emphasis added).

> In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to ({1 +DSHP)$^{0\text{-}4176}$ - 1)), where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.
>
> Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.[18]

In adopting his proposal, the Secretary gave the following justification:

> *Comment*: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.
>
> *Response*: In the final rule, we are providing that urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level than other hospitals. For FY 1992, the minimum payment level is 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also be eligible for the higher minimum payment level. We are not extending the special protection to other hospitals that receive disproportionate share payments under the operating prospective payment system. In urban areas, we believe that our criteria properly focuses on those hospitals that serve a large disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income

[18] *Id* at 43377.

> patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries**.[19]

In response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to rural hospitals with 500 or more beds:

> As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1,1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(l){ii) of the regulations.[20]

Similarly, in response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to other classes of hospitals such as "[a]ll small urban hospitals, hospitals with high Medicare usage, rural hospitals, rural hospitals with at least 100 beds, rural referral centers, or those hospitals with high 'total government' usage":

> In developing the capital disproportionate share adjustment for this final rule, we examined the relationship between the disproportionate share patient percentage and total costs per case

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

> for each class of hospital that is currently receiving an operating payment adjustment. We believe that only those hospitals that merit the adjustment according to our regression analysis should receive additional capital payments for serving low income patients. The regression results did not indicate any significant relationship between total costs per case and disproportionate share patient percentage for any of the special groups mentioned above.[21]

In response to comments, the Secretary also looked at setting a threshold DSH percentage to qualify for a capital DSH adjustment but rejected that alternative approached based upon the following explanation:

> We examined closely the possibility of using a disproportionate share patient percentage threshold in our total cost regression analysis. We were unable to find any threshold level of disproportionate share percentage below which no payment adjustment was merited, or a threshold above which a higher adjustment was merited. As a result, we believe that it is most equitable to make a capital disproportionate share payment to all qualifying hospitals with a positive patient percentage, rather than penalize some hospitals that have a higher cost of treating low income patients but whose patient percentage is below the artificial level we would set.[22]

Further, in response to comments, the Secretary rejected not providing *any* capital DSH adjustment based on the explanation:

> We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We believe that it is appropriate for Medicare's payment to recognize these higher Medicare patient care costs.[23]

Finally, the Secretary addressed how MGCRB reclassifications, in certain circumstances, affect whether an IPPS hospital qualifies for the capital DSH adjustment:

> *Comment*: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.
>
> *Response*: Any hospital that is reclassified to an urban area by the MGCRB for purposes of its standardized amount is considered to

[21] *Id.* at 43378.
[22] *Id.* at 43379.
[23] (Emphasis added.)

> be urban for all prospective payment purposes other than the wage index. As such, if any hospital reclassified by the MGCRB to an urban area for purposes of the standardized amount has at least 100 beds, it would be eligible for capital disproportionate share payments. We note that a rural hospital reclassified for purposes of the wage index only is still considered a rural hospital, and as such, will not be eligible for capital disproportionate share payments.

The resulting regulations governing capital IPPS were codified at 42 C.F.R. Part 412, Subpart M (§§ 412.300 to 412.374). The regulation governing the capital DSH adjustment was codified at § 412.320 which, at initial implementation, stated:

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).
>
> (b) *Payment adjustment factor*. (1) <u>If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments</u>, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital's disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.
>
> (2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.[24]

2. *Reclassification of Certain IPPS Urban Hospitals as Rural for Purposes of Operating IPPS Pursuant to BBRA § 401 and Impact on Capital IPPS Adjustments*

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA") and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.[25] IPPS hospitals are reclassified per BBRA § 401 are often referred to as "§ 401 hospitals."

On August 1, 2000, the Secretary published the interim final rule to, in part, implement BBRA

[24] *Id*. at 43452-53.
[25] BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).

§ 401 and stated in the preamble that a hospital reclassified as rural pursuant to § 401 is treated as rural for ***all*** purposes under operating IPPS, including the DSH adjustment for operating IPPS:

> *A hospital that is reclassified as rural* under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, ***is treated as rural for all purposes*** *of payment under the Medicare inpatient hospital prospective payment system* (section 1886(d) of the Act), *including* standardized amount (§§ 412.60 et seq.), wage index (§ 412.63), and ***disproportionate share calculations*** (§ 412.106) as of the effective date of the reclassification.[26]

On August 1, 2000, the Secretary also published the FY 2001 IPPS Final Rule which included the following discussion on the effect of reclassification of a hospital from urban to rural pursuant to BBRA § 401:

> In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. ***That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes***. In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.
>
> ****
>
> Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).

[26] 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added.)

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. *If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area. Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113*. In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106– 113, which authorizes a 30-percent expansion in a rural hospital's resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME, which are made under section 1886(h) of the Act.)

Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.

****

We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.

****

> *We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary*. ***Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify***. As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.[27]

Thus, both the August 1, 2000 interim final rule and the FY 2001 IPPS Final Rule confirmed that urban hospitals reclassified as rural pursuant to BBRA § 401 would be treated as rural for all purposes of operating IPPS, including DSH adjustments. The Secretary memorialized this policy in regulation at 42 C.F.R. § 412.103 (2000) which states in pertinent part:

> **§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural**.
>
> (a) *General criteria*. A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
>
> 1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration which is available via the ORHP website at http:// www.nal.usda.gov/orph or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857.
>
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
>
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.[28]

Neither the August 1, 2000 interim final rule nor the FY 2001 IPPS Final Rule explicitly discussed the impact on capital DSH adjustments under capital IPPS. However, through

[27] 65 Fed. Reg. 47054, 47088-89 (Aug. 1, 2000).
[28] *Id*. at 47048.

operation of the cross-reference in 42 C.F.R. § 412.320(a) to § 412.63(a) in the phrase "the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area", it would appear that hospitals reclassified from urban to rural were ***not*** eligible for capital DSH adjustments under capital IPPS. In this regard, the Board notes that, following the 2000 rulemaking process, § 412.63(a)-(b) (2001) read, in pertinent part:

> (a) *General rule*. (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.
>
> (2) **Each such rate is determined for hospitals located in urban <u>or</u> rural areas** within the United States and within each such region respectively, **as described in paragraphs (b)** through (g) of this section.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, **except that**, effective January 1, 2000, **a hospital reclassified as rural may mean** a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or **a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103**.[29]

The specific reference in § 412.63(b) to urban to rural reclassifications made under § 412.103 makes clear that capital DSH adjustments would not apply to hospitals reclassified from urban to rural pursuant to BBRA § 401 which as noted above was implemented at § 412.103.

3. Changes to Operating IPPS Required by MMA § 401 and Their Effect on Capital IPPS

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") and MMA § 401 to equalize operating IPPS payments between urban and rural hospitals.[30] Specifically, § 401 specifies that, beginning with FY 2004, all IPPS hospitals are paid on the basis of the large urban standardized amount under operating IPPS.

The Office of Management and Budget publishes information on core-based statistical areas ("CBSAs") and the Secretary has used this information for purposes of defining labor market areas for use in the wage index for operating IPPS.[31] On June 6, 2003, OMB announced the new

[29] (Bold and underline emphasis added.)
[30] Pub. L. 108–173
[31] 69 Fed. Reg. 48916, 49026 (Aug. 11, 2004).

CBSAs, comprised of metropolitan statistical areas ("MSAs") and the new Micropolitan Areas based on Census 2000 data.[32]

On August 11, 2004, the Secretary published the FY 2005 IPPS Final Rule and this rule finalized revisions to the operating IPPS regulations to both implement MMA § 401 as well as adopt OMB's new CBSA designations.[33] With respect to implementing MMA § 401, the Secretary revised 42 C.F.R. § 412.63 to apply only to years through 2004 and added a new § 412.64 to implement MMA § 401 for federal rates for FYs 2005 forward. Specifically, § 412.64 reads in pertinent part:

> **§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.**
>
> (a) *General rule*. CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the following definitions apply:
>
> (i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.
>
> (ii) The term *urban area* means—
>
> (A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or
>
> (B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.
>
> (C) The term *rural area* means any area outside an urban area.
>
> (D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was

[32] *Id.*
[33] 69 Fed. Reg. 48916 (Aug. 11, 2004).

> redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.
>
> (2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.
>
> (3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.
>
> (4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result of redesignation of an MSA by the Executive Office of Management and Budget.[34]

Significantly, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: "A hospital is classified as a 'disproportionate share hospital' for the purposes of capital prospective payments if the hospital is located, *for purposes of receiving payment under § 412.63(a)*, in an urban area."[35] As a result of the FY 2005 IPPS Final Rule, § 412.320(a) was updated to reference § 412.64 as it relates to FYs 2005 forward:

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a ''disproportionate share hospital'' for the purposes of capital prospective payments if either of the following conditions is met:

[34] *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).
[35] (Emphasis added.)

> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64.[36]

Again, as previously noted, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

Finally, in the preamble to the FY 2005 IPPS Final Rule, the Secretary included the following discussion on the impact of the new CBSAs on geographic reclassifications:

> Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB's new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.
>
> ****
>
> The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large

[36] 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

> urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.
>
> ****
>
> As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.[37]

4. August 18, 2006 Revisions to the Capital DSH Adjustment

In the FY 2007 Proposed IPPS Rule, the Secretary[38] announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.[39]

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and Budget's ("OBM's") new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005.[40]

In the FY 2007 IPPS Final Rule published on August 18, 2006, the Secretary finalized these technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment:

> These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.

[37] 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004).
[38] of the Department of Health and Human Services.
[39] 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).
[40] *Id.*

> These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).
>
> We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.[41]

In adopting these changes, the Secretary noted that it did not receive any public comments on the proposed change as published in the proposed rule published on May 17, 2006.[42]

As a result of the FY 2007 IPPS Final Rule, the regulation, subparagraph (iii) was added to 42 C.F.R. § 412.320(a)(1) so that revised § 412.320(a) read, in pertinent part:

> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if either of the following conditions is met:
>
> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic

[41] *Id.*
[42] *Id.*

> classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.
>
> **(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.[43]**

5. Litigation Challenging the Validity of 42 C.F.R. § 412.320(a)(1)(iii) as added by the FY 2007 IPPS Final Rule

The validity of 42 C.F.R. § 412.320(a)(1)(iii) was addressed in *Toledo Hosp. v. Becerra* ("*Toledo*"),[44] wherein the hospital made the following contentions:

> Toledo Hospital contends that the Secretary's 2006rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to "take into account" relative costs of capital for various hospital types and areas of location, as subsection (g) requires.[45]

In *Toledo*, U.S. District Court for the District of Columbia ("D.C. District Court") outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.[46] The Court also noted how Congress enacted legislation in 1999[47] allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into an urban labor market area for the purposes of fixing its wage index.[48] The Court also noted the separate IPPS payment for a hospital's *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R. § 412.320 for large urban hospitals (the capital DSH payment).[49] The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.[50]

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[43] (Bold emphasis added.)
[44] 2021 WL 4502052 (D.D.C. 2021).
[45] *Id.* at *8 (citations omitted).
[46] *Id.* at *2.
[47] 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a "§ 401" hospital.
[48] *Toledo* at *3.
[49] *Id.* at *3-4.
[50] *Id.* at *4.

The appellants in *Toledo* were geographically located in an urban labor market area, but applied to the Secretary (and were approved) to reclassify as rural under § 401. The appellants thereafter applied to the MGCRB to reclassify their wage index to an urban labor market area. The appellants' Medicare Contractor later denied their requests for capital DSH adjustments due to their § 401 rural reclassifications. Before the D.C. District Court, the hospitals argued that 42 C.F.R. § 412.320(a)(1)(iii) violated the plain language of the Medicare Act and that it was promulgated in in an arbitrary and capricious manner.[51]

The D.C. District Court rejected the argument that the capital DSH policy in 42 C.F.R. § 412.320(a)(1)(iii) violated the Medicare Act on its face, finding that the Secretary was not prohibited from treating § 401 reclassified hospitals as rural for operating PPS purposes while denying urban status for the purposes of the capital DSH adjustment.[52] The Court next examined, however, whether the Secretary's decision to do so was reasonable. The D.C. District Court made the following findings:

1. "if the Secretary had any policy concerning Section 401 reclassifications before 2006, he never announced such a policy, much less explained the basis for it."[53]

2. The Secretary's decision to not provide a capital DSH adjustment was arbitrary because:

   - "The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006."[54]
   - "[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements."[55]
   - "The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp*., 797 F.3d at 1161 (upholding Secretary's regulation where the Secretary explained why 'added precision' 'would not justify the added complication') (quotation omitted)."[56]
   - "The agency cannot 'entirely fail[ ] to consider' the "relevant data" and the factors that Congress directed it to review. *State Farm*, 63 U.S. at 43. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did he take costs into account at all."[57]

Notwithstanding these findings, the D.C. District Court declined to vacate 42 C.F.R. § 412.320(a)(1)(iii) because "vacatur of a rule is not an appropriate remedy on review of an

[51] *Id.* at *5.
[52] *Id.* at *6-8.
[53] *Id.* at *11.
[54] *Id.*
[55] *Id.*
[56] *Id.*
[57] *Id.* at *11-12.

adjudication."[58] Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants' eligibility for a capital DSH adjustment.[59]

Providers' Request for EJR

As background, each of the Providers is an acute care hospital paid by Medicare pursuant to the inpatient and capital prospective payment systems. During the years under appeal, the hospitals were all geographically located in urban areas, operated more than 100 beds, served low-income patients and received § 401 rural reclassifications pursuant to 42 C.F.R. § 412.103.[60]

The Providers are challenging the validity of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent with the underlying operating PPS statute, in particular 42 U.S.C. § 1395ww(d)(8)(B), which states that hospitals that have undergone a rural reclassification are rural only for purposes of this subsection 1395ww(d). The capital DSH provisions are found at 42 U.S.C. § 1395ww(g), an entirely different section of the statute, and therefore a rural reclassification under the subsection (d) operating PPS provisions does not apply for subsection (g) capital PPS purposes.[61]

The Providers believe that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(g), and the regulation must be found invalid.[62] The Providers assert that the Secretary has implicitly acknowledged that he cannot apply rural status for hospitals that have undergone a rural reclassification to payment provisions outside of subsection (d), and provides as an example, that the Secretary has stated with respect to direct graduate medical education ("GME") that no adjustment to the direct GME cap are available for urban hospitals that have reclassified as rural because subsection (d) reclassification "affects only payments under section 1886(d) of the Act . . . [and] payment for direct GME are made under section 1886(h) of the Act."[63] Further, the regulation fails to take into account any variation in cost based on location, as the capital PPS statute permits at 42 U.S.C. § 1395ww(g)(1)(B)(ii).[64]

The Providers assert that the Secretary's adoption of the regulation was arbitrary and capricious and violates the Administrative Procedure Act because he failed to establish that the adoption of the exception to the capital DSH adjustment, for providers that reclassified as rural, took into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located.[65]

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[58] *Id.* at *12.
[59] *Id.*
[60] Request for EJR at 7.
[61] *Id.* at 1, 7.
[62] *See id.* at 7-8.
[63] *Id.* at 8 (citing 70 Fed. Reg. 47278, 47437 (Aug. 12, 2005)).
[64] *Id.*
[65] *Id.* at 8-9.

Though 42 C.F.R. § 412.320(a)(1)(iii) has not been vacated, the Providers argue that the merits of their position were adopted by the D.C. District Court in *Toledo*.[66] Further, the Providers contend that the Secretary adopted the FY 2024 hospital IPPS proposed rule in which the Secretary, in response to *Toledo*, proposed to amend 42 C.F.R. § 412.320(a)(1)(iii). Specifically, effective for discharges occurring on or after October 1, 2023, an urban hospital that is reclassified as rural under § 412.103 will no longer be considered rural for purposes of determining capital DSH eligibility. Instead, for purposes of § 412.320, the geographic classifications specified under § 412.64 will apply.[67] However, the Providers explain that for the periods under appeal, CMS and its contractors will continue to apply the 2006 regulation, denying capital DSH to the Providers for this period.[68]

The Providers further contend that since the Board is bound by the regulation being challenged,[69] namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), it lacks the authority to decide the legal question presented in the Providers' Request for EJR. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.[70]

Board Decision

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

A. Jurisdiction – CMS Ruling 1727-R (FYEs Dec. 31, 2008 to Dec. 30, 2016)

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending on or after December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming it as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[71] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[72]

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[66] *Id.* at 9-12.
[67] *Id.* at 9-10 (citing 88 Fed. Reg. 58640, 59117, 59334 (Aug. 28, 2023).
[68] *Id.* at 10-12 (citing 88 Fed. Reg. at 27058-59).
[69] *See* 42 C.F.R. § 405.1867.
[70] Request for EJR at 10-12.
[71] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[72] *Bethesda*, 108 S. Ct. at 1258-59.

On August 21, 2008, new regulations governing the Board were effective. Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*"). In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[73]

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

In Case No. 23-0701G, New Hanover Regional Medical Center is a group participant for its FYE September 30, 2016 ("New Hanover 2016"). The Board has determined that the Capital DSH issue in this case is governed by CMS Ruling CMS-1727-R since the Providers are challenging 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule and that Board review of the issue is not otherwise precluded by statute or regulation. In addition, the Board finds that New Hanover 2016 filed its appeal within 180 days after the twelve-month period in which the Medicare Contractor was to issue a final determination,[74] as required by 42 C.F.R. § 405.1835, and that the Providers' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[75]

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[73] *Id.* at 142.

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

> (1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's *perfected cost* report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.
> (2) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section) . . .

[75] *See* 42 C.F.R. § 405.1837.

B. Jurisdiction – Appropriate Cost Report Claim (FYEs Beginning On or After Dec. 31, 2016)

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[76] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[77] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement ("NPR") issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). Since all the participants in Case Nos. 23-1210G & 23-1645GC have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

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

Based on its review of the record, the Board finds that each of the participants in these group appeals filed their appeals within 180 days of the issuance of their respective final determinations, or within 180 days after the twelve month period in which the Medicare Contractor was to issue a final determination,[78] as required by 42 C.F.R. § 405.1835; that the providers in each case appealed the issue in their respective appeals' and that the Board is not precluded by regulation or statute from reviewing the issue in these appeals. Finally, in each case, the amount in controversy meets the $50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3).

C. Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873 (Cost Reports Beginning on or After January 1, 2016

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. The regulation, 413.24(j) requires that:

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[76] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[77] *Id.* at 70555.
[78] Medicare Contractors must issue an NPR within twelve months of receiving a Provider's perfected cost report. Providers are afforded the right to appeal if this NPR is not timely received pursuant to 42 C.F.R. § 405.1835(c), as quoted in *supra* note 74.

> (1) In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), must include an appropriate claim for the specific item, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) Self-disallowance procedures. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.

In conjunction with the regulation above, 42 C.F.R. § 405.1873(a) states:

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider must include in its cost report an appropriate claim for the specific item (as prescribed in § 413.24(j) of this chapter). **If** the provider files an appeal to the Board seeking reimbursement for the specific item and **any party** to such appeal **questions whether the provider's cost report included an appropriate claim for the specific item**, the Board must address such question in accordance with the procedures set forth in this section.

These regulations are applicable to the cost reporting periods under appeal for all of the participants in these group appeals, which all have cost reporting periods ending on or after December 31, 2016. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[79] 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. [80]

On March 1, 2024, the Medicare Contractor's designated representative, Federal Specialized Services ("FSS") filed a Response to Providers' EJR Request, stating:

> Federal Specialized Services, as representative for the various Medicare Administrative Contractors, pursuant to Board Rule 42.4 notes that substantive claim challenges will be filed in 23-0701G, 23-0926G, 23-1514GC; and 23-1210G. Jurisdictional challenges may be filed in each of those cases as well. *The MACs are continuing to review the claims* ***in the remaining cases and additional substantive claim*** *or jurisdictional challenges* ***may be forthcoming***.[81]

Based on this timely certification, the deadline for any Substantive Claim Challenges in these cases was Monday, March 18, 2024.[82]

Despite the certification above, no Substantive Claim Challenge was ever filed in Case No. 23-1210G. However, Challenges were filed in Case Nos. 23-1514GC, 23-0926G, and 23-0701G on March 11, 14, and 15, respectively. Additionally, although not specifically noted in FSS' March 1, 2024 filing, it did file a Substantive Claim Challenge in Case No. 24-1269GC on March 14, 2024 consistent with the notice that "[t]he MACs are continuing to review the claims in the remaining cases and additional substantive claim . . . challenges may be forthcoming." The Substantive Claim Challenges encompassed the following participants in each case (collectively "the Challenged Participants"):

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[79] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[80] *See* 42 C.F.R. § 405.1873(a).
[81] (Emphasis added.)
[82] The EJR Request was filed on February 26, and twenty days from that date was Sunday, March 17, 2024. Pursuant to Board Rule 4.4.3 and 42 C.F.R. § 405.1801(d)(3), the deadline for any responses due were extended to the next business day.

- Case No. 23-0701G:
  - Mount Sinai West (Provider No. 33-0034; FYE Dec. 31, 2017)
  - New Hanover Regional Medical Center (Provider No. 34-0141; FYE Sept. 30, 2017)

- Case No. 24-1269GC
  - Beaumont Hospital Dearborn (Prov. No. 23-0020; FYE Dec. 31, 2019)
  - William Beaumont Hospital Troy (Prov. No. 23-0269; FYE Dec. 31, 2019)
  - Botsford General Hospital (Prov. No. 23-0151; FYE Dec. 31, 2019)
  - William Beaumont Hospital Royal Oak (Prov. No. 23-0130; FYE Dec. 31, 2019)

- Case No. 23-0962GC
  - Owensboro Health Regional Hospital (Prov. No. 18-0038; FYE Mar. 31, 2019)
  - Spectrum Health Butterworth Campus (Prov. No. 23-0038; FYE Jun. 30, 2019)
  - Eisenhower Medical Center (Prov. No. 05-0573; FYE Jun. 30, 2019)
  - Samaritan Medical Center (Prov. No. 33-0157; FYE Dec. 31, 2019)
  - McLeod Regional Medical Center – Pee Dee (Prov. No. 42-0051; FYE Sept. 30, 2019)
  - Billings Clinic Hospital (Prov. No. 27-0004; FYE Jun. 30, 2019)
  - Summa Health System (Prov. No. 36-0020; FYE Dec. 31, 2019)
  - Camden-Clark Memorial Hospital (Prov. No. 51-0058; FYE Dec. 31, 2019)

- Case No. 23-1514GC
  - The William W. Backus Hospital (Provider No. 07-0024; FYE Sept. 30, 2020)
  - Hartford Hospital (Provider No. 07-0025; FYE Sept. 30, 2020)
  - The Hospital of Central Connecticut (Provider No. 07-0035; FYE Sept. 30, 2020)

Based on the foregoing, and pursuant to Board Rule 44.6, the Board issued a Scheduling Order to set a deadline (Tuesday, April 9, 2024) for the Providers' responses to the four Substantive Claim Challenges filed in Case Nos. 23-0926G, 23-0701G, 23-1514GC, and 24-1269GC. In issuing this Scheduling Order, the Board found that FSS has complied with Board Rule 44.6 in submitting these Substantive Challenges, including that for Case No. 24-1269GC.

For all remaining participants in these four group cases (collectively "the Non-Challenged Participants"), since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[83] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d) for the Non-Challenged Participants.

1. Medicare Contractor's Argument for the Challenged Participants

In each of the Substantive Claim Challenges, the Medicare Contractor claims that the Challenged Participants did not file a protested amount relating to the Capital DSH issue, nor have they filed

[83] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."

for Capital DSH on their respective cost reports. While some participants did identify Part A Protested Amounts on their cost reports, the List of Protested Amounts did not list the Capital DSH issue. Finally, the Medicare Contractor states that none of the exceptions found at 42 C.F.R. § 413.24(j)(3)(i) through (3)(iii) apply.

2. Group Representative's Response to Substantive Claim Challenges

The Providers filed a consolidated response to the Substantive Claim Challenges on April 8, 2024 (the day before the deadline to do so).[84] In their response, they object to the Substantive Claim Challenge in Case No. 24-1269GC, arguing that the Substantive Claim Challenge submitted by FSS in that case was not properly filed pursuant to Board Rule 44.6. Specifically, they note that FSS did not specifically certify that it would file a Substantive Claim Challenge in Case No. 24-1269GC within five (5) business days (or at all) of the EJR Request, and yet still filed a Challenge in that case.[85] Significantly, the Providers did ***not*** address the substance of the substantive claim challenge in Case No. 24-1269GC and, as such, its response did not dispute the substance of that challenge.

For the remaining three cases, the "Providers do ***not*** dispute that [the Challenged] Providers did not claim the capital DSH costs at issue either as an allowable cost or a protested amount[.]"[86] Instead, "the Providers challenge the validity of 42 C.F.R. §§ 413.320(j) and 405.1873" because they "contravene the Board's authority as set fort in 42 U.S.C. § 1395oo."[87] They cite *Bethesda Hosp. Ass'n v. Bowen*[88] and *Banner Heart Hospital v. Burwell*[89] in support of their position that these regulations are unlawful.[90]

The Providers request the Board grant EJR for all four cases over the Capital DSH issue and the substantive claim regulations.

3. Appropriate Cost Report Claim: Findings of Fact and Conclusions of Law

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))"[91] 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 Challenged Participants do *not* dispute their failure to comply with the substantive claim requirements at 42 C.F.R. §§ 413.320(j) in Case Nos. 23-0962G, 23-0107G, and 23-1514GC.

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[84] Providers' Response to FSS's Substantive Claim Challenges and Petition for Expedited Judicial Review of the Validity of 42 C.F.R. §§ 413.24(j) and 405.1873 (April 8, 2024) ("Response to Substantive Claim Challenges").
[85] *Id.* at 10.
[86] *Id.* at 11 (emphasis added).
[87] *Id.*
[88] 485 U.S. 399 (1988).
[89] 201 F.Supp.3d 131 (D.D.C. 2016)
[90] Response to Substantive Claim Challenges at 12-15.
[91] (Emphasis added.)

With respect to Case No. 24-1269GC, the Providers argue that the Board should disregard the Substantive Claim Challenge filed in Case No. 24-1269GC because it did not comply with Board Ruel 44.6 since the Medicare Contractor never specifically certified that it would be filing and Substantive Claim Challenge in that case, much less within five (5) business days of the EJR Request being filed.

The Board denies this objection. In its March 1, 2024 filing, FSS specifically noted several cases in which it would be filing Substantive Claim Challenges (which did not include Case No. 24-1269GC), but also stated "[t]he MACs are continuing to review the claims in the remaining cases and additional substantive claim or jurisdictional challenges may be forthcoming." The regulations at 42 C.F.R. § 405.1873(a) states that, **if** a party raises a substantive claim challenge the Board **must** address it, but the regulations do not **prohibit** the Board from addressing any deficiencies it discovers on its own or through other means. The Board was aware of the discrepancy and did not dismiss the Substantive Claim Challenge but instead issued the following Scheduling Order:

> Based on the foregoing, and pursuant to Board Rule 44.6, the Board is issuing a Scheduling Order to set a deadline for the Providers' responses to the four Substantive Claim Challenges filed in Case Nos. 23-0926G, 23-0701G, 23-1514GC, and 24-1269GC. *Specifically, the Board requests the Providers file responses, if any, to the Medicare Contractor's Substantive Claim Challenges* ***within twenty-one (21) days of this letter's signature date*** (*i.e.*, by Tuesday, April 9, 2024): If the Providers desire to have additional evidence or argument considered (e.g., testimony or oral argument), **the Provider must submit a request to the Board with both a description of and an explanation of the need for such additional evidence/argument (whether written or oral)**. Otherwise, following the above referenced filing deadline, the Board will proceed with issuing a ruling on the § 413.24(j) compliance issue(s) based solely on the record before it. ***Be advised that the above referenced filing deadlines are firm*** *and failure of the Providers to file a response to the Board's request* ***by the above referenced filing deadline*** *will result in the Board making its determination based on the record before it without the benefit of the Providers' input*.

The Providers in Case No. 24-1269GC were put on notice of the Substantive Claim Challenges and given an opportunity to respond. However, the Providers waited until the day before the deadline to file an objection to the Medicare Contractor's Substantive Claim Challenge in 24-1269GC and failed to otherwise address the substance of the Challenge in the event the Board did not grant their objection. In this regard, the Board's Scheduling Order made clear that the Board would make its determination on the record before it following the deadline unless the Provider requested to have additional evidence or argument considered. Here, the Board finds that the Providers in Case No. 24-1269GC are not prejudiced by the Board considering the Substantive Claim Challenge filed therein since: (1) FSS' March 1 2024 response to the consolidated EJR request put the Providers on notice that the Medicare Contractors were considering filing Substantive Claim Challenges in the other cases covered by the consolidated

EJR Request; (2) the Providers themselves alerted the Board on March 5, 2024 of a substantive claim issue in Case No. 24-1269GC that the Medicare Contractor raised on February 14, 2024 and requested guidance on whether it constitutes a valid substantive claim challenge;[92] (3) the Board did not dismiss the March 14, 2024 Substantive Claim Challenge in Case No. 24-1269GC but rather accepted it and, on March 19, 2024 (*5 days after the Challenge was filed*), issued a Scheduling Order to set a schedule for Provider responses to set the record upon which it would base its ruling on the Substantive Claim Challenges; (4) the Providers filed no objection within the next few days following FSS' March 14, 2024 filing of the Substantive Claim Challenge in Case No. 24-1269GC but rather the Provider waited 25 days to file this objection until the day before the 21-day response period closed and neither addressed the substance of the Substantive Claim Challenge nor requested additional time to respond to that substance.

The Board concurs with the Medicare Contractor and finds that, *based on the record before it*, it is undisputed that no Substantive Claim made for the Challenged Participants in Case No. 24-1269GC.

4. EJR Request on the Validity of 42 C.F.R. §§ 413.24(j) and 405.1873

While it is undisputed that each of the Challenged Participants did not protest the capital DSH issue on their cost reports, they assert that the self-disallowance regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are invalid insofar as these regulations would limit the Board's authority to order payment to providers that have not claimed a particular cost on their cost report as an allowable cost or as a protested amount. The Group Representative requested a second EJR in this particular case over the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 (in addition to the capital DSH issue discussed above).[93]

In the second EJR request, the Challenged Participants argue that the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 contravene the Board's authority set forth in 42 U.S.C. § 1395oo. They note that nowhere in the statute is there a requirement that a provider must include a claim for a specific cost on its cost report before payment related to that cost can be addressed by the Board. The Challenged Participants recount how the 2008 self-disallowance regulation was held to conflict with the plain text of 42 U.S.C. § 1395oo in *Banner Heart Hosp. v. Burwell*, 201 F. Supp. 3d 131, 140 (2016). They argue that the 2016 self-disallowance regulation at 42 C.F.R. § 413.24(j) suffers from the same defects that led the *Banner* court to invalidate the 2008 self-disallowance regulation.[94]

Regarding the Board's jurisdiction, the Providers point to 42 U.S.C. § 1395oo(f)(1), which allows a provider to obtain judicial review "of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services . . .) that it is without authority to decide the

[92] In this regard, the Board notes 42 C.F.R. § 405.1873 specifies that Board review of a provider's compliance with § 413.24(j) is triggered as follows: "If . . . 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."
[93] Provider's Response to Substantive Claim Challenges at 1, 11-16. The Medicare Contractors did not file a response to the second EJR request, and the time required to do so has now passed. *See* Board Rule 42.4.
[94] Provider's Response to Substantive Claim Challenges at 11-16.

question." The Challenged Participants note that while the validity of these regulatory provisions was not at issue when the Providers filed their appeal, the Medicare Contractor raised this issue in its substantive claim challenge, and the Board's rules entitle the Providers to respond, including in the context of an EJR filing, citing Board Rule 44.5.2. Further, the Challenged Participants argue that, because the Medicare Contractor argues that the substantive claim regulatory provisions prevent the Challenged Participants from receiving additional reimbursement for the capital DSH payment, the validity of these substantive claim regulatory provisions stems from the Challenged Participants' appeal of the capital DSH regulation and is integral to the resolution of the capital DSH issue.[95]

Per 42 C.F.R. § 405.1842(a)(1), "a provider [has] the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter." Here, the Challenged Participants' challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 is relevant to the matter at issue in these group appeals. Since there is no factual dispute regarding the Challenged Participants' lack of compliance with 42 C.F.R. § 413.24(j), the Board is able to reach consideration of the Challenged Participants' challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873. Further, since 42 C.F.R. § 405.1867 requires that the Board comply with the requirements of the statute and regulations, the Board lacks the authority to eliminate the regulatory provisions that create the self-disallowance requirements in §§ 413.24(j) and 405.1873, which is the remedy the Challenged Participants are seeking. Consequently, EJR is appropriate on this issue and the Board grants the Challenged Participants' EJR request on this challenge.[96]

D. Board's Analysis Regarding the Appealed Issue

The Providers in these cases are challenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states in effect that urban hospitals may qualify for Capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers contend that this regulation is inconsistent with the enabling statute, 42 U.S.C. § 1395ww(d)(8)(B), which concerns rural status. The Providers contend that §1395ww(d)(8)(B) specifically notes that the hospitals that have undergone a rural reclassification are rural only for "purposes of this subsection [1395ww(d)]."

Additionally, the Providers assert that the Capital DSH provisions are found at 42 U.S.C. § 1395ww(g), not § 1395ww(d), and, accordingly, the literal wording of the rural reclassification statutory provision identifies that rural status does not reach the Capital DSH calculation. Thus, the Providers maintain that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is beyond the authority granted under 42 U.S.C. § 1395ww(d)(8)(B), and the regulation must be found invalid.

The Board finds that, pursuant to 42 C.F.R. § 405.1867, it must comply all the provisions of Title XVIII of the Act and regulations issued thereunder, including the challenged regulation, 42 C.F.R. § 412.320(a)(1)(iii). Moreover, pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at

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[95] *Id.* at 16.

[96] The Board notes that this question relates to only to the Challenged Participants and, as such, does apply to the full universe of participants in these groups. The Board notes that compliance with 42 C.F.R. § 413.24(j) is substantive in nature (*i.e.*, directly impacts potential reimbursement), but does not affect the issue that is the subject of the appeal. Similar to jurisdictional review, a provider's compliance with § 413.24(j) relates to the nature of the provider's participation in the group (as set forth in 42 C.F.R. § 405.1873) and is only triggered when, pursuant to § 405.1873(a) as a procedural matter in the proceedings before the Board, a party raises their hand and questions the provider's compliance with § 413.24(j).

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.

Accordingly, the Board concludes that it lacks the authority to grant the relief sought by the Providers (*i.e.,* reverse or otherwise invalidate 42 C.F.R. § 412.320(a)(1)(iii)). Thus, the Board hereby grants the Providers' request for EJR for the issue and federal fiscal years under dispute.

E. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that all of the participants in Case Nos. 23-0926G, 23-0701G, 23-1514GC and 24-1269GC are entitled to a hearing before the Board;

2) The review process in 42 C.F.R. § 405.1873(a)-(b) has been triggered for the Challenged Participants[97] in the group and 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)

3) The review process in 42 C.F.R. § 405.1873(a)-(b) has not been triggered for the remaining Non-Challenged Participants[98] and, therefore, there are no findings regarding whether their cost reports included appropriate claims for the specific item at issue in these appeals;

4) Based upon the participants' assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), there are no findings of fact for resolution by the Board;

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

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

    a. Whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid; and

    b. For the Challenged Participants, whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid.[99]

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[97] The "Challenged Participants" is a defined term. *See supra* at bottom of page 25 to top of page 26.
[98] The "Non-Challenged Participants is a defined term. *See supra* at bottom of page 26.
[99] The Board recognizes that this question relates only to some of the participants in these groups and, as such, does not apply to all of the full groups. As a result, it would appear to run afoul of 42 C.F.R. § 405.1837(g) and potentially require bifurcation. However, the Board finds that this is not so in this case. Compliance with 42 C.F.R. § 413.24(j) is substantive in nature (*i.e.*, directly impacts potential reimbursement), but does not affect the issue that is the subject of the appeal. Similar to review under 42 C.F.R. § 405.1840 of jurisdictional or claims-filing requirements, a provider's compliance with § 413.24(j) relates to the nature of the provider's *participation* in the group (as set forth in 42 C.F.R. § 405.1873) and is only triggered when, pursuant to § 405.1873(a) *as a procedural matter in the proceedings before the*

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' EJR Request for the issue and the subject years in Case Nos. 23-0926G, 23-0701G, 23-1514GC and 24-1269GC. 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 Challenged Participants' 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. The Board's jurisdictional determination is subject to review under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. § 405.1875 and 405.1877 upon final disposition of the appeal. Since this is the only issue under dispute in these cases, the Board hereby closes the cases and removes them from the Board's docket.

Board Members Participating:

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

FOR THE BOARD:

5/6/2024

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

Enclosure: Schedules of Providers

cc: Byron Lamprecht – WPS Government Health Administrators
Dana Johnson, Palmetto GBA c/o National Government Services, Inc.
Judith Cummings, CGS Administrators
Danelle Decker, National Government Services, Inc.
Scott Berends, Esq., FSS

Board, a party raises their hand and questions the provider's compliance with § 413.24(j). As a result, the Board finds that potential bifurcation has not been triggered under § 405.1837(f). This situation is akin to the Board denying jurisdiction over one participant in a group but granting EJR relative to the rest of the group. Judicial review remains available on appeal for these discreet group participation issues regardless of whether they relate the jurisdiction or claims-filing requirements under § 405.1840 or the substantive claims requirements under § 413.24(j).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
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1701 S. Racine Avenue
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RE: ***Notice of Dismissal***
Cox Medical Centers (Provider Number 26-0040)
FYE: 09/30/2015
Case Number: 20-0730

Dear Mr. Ravindran and Mr. Berends:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 20-0730. Set forth below is the decision of the Board to dismiss the appeal challenging the Provider's Disproportionate Share Hospital ("DSH") SSI Percentage ("Provider Specific") and Medicaid Eligible Days issues.

Background

A. *Procedural History for Case No. 20-0730*

Cox Medical Centers ("Cox"), Provider No. 26-0040, for the fiscal year ended ("FYE") 09/30/15, filed a timely Individual Appeal Request on **January 24, 2020**, from a Notice of Program Reimbursement ("NPR") dated **August 6, 2019**, appealing the following issues:

1) Disproportionate Share Hospital ("DSH") SSI Percentage ("Provider Specific")
2) DSH Medicaid eligible days.[1]

On **January 30, 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

[1] On January 27, 2020, the IPPS understated standardized payment amount issue was added. The issue was simultaneously added and transferred to Case No. 19-0604G on 01/27/20 via OH CDMS.

> ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[2]

On **September 17, 2020**, Cox filed its Preliminary Position Paper. With respect to Issue 2, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover.[3] 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 position paper failed to even provide the material fact of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2015 cost report does not reflect an accurate number of Medicaid eligible days . . . ."[4]

On **January 14, 2021**, the Medicare Contractor filed its Preliminary Position Paper. With regard to Issue 2 (Medicaid Eligible Days), the Medicare Contractor's position paper noted that the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position; and the Provider had failed to respond to the Medicare Contractor's requests for that Medicaid eligible days listing.[5]

On **November 18, 2020**, the Medicare Contractor filed a Jurisdictional Challenge[6] over Issue 1, the DSH SSI Percentage ("Provider Specific") issue. On **August 10, 2023**, the Medicare Contractor filed a Motion to Dismiss Issue 2, the DSH Medicaid eligible days issue, because the Provider "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"[7] and argued that the "Provider's failure to furnish such documentation (or describe why such documentation is unavailable) is in violation of [Board] Rules 7, 25.2.1 and 25.2.2."[8]

The Provider submitted a response to the Medicare Contractor's Jurisdictional Challenge and

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[2] (Emphasis added).
[3] Provider's Preliminary Position Paper at 10 (Sept. 17, 2020).
[4] *Id.* at 8.
[5] Medicare Contractor's Preliminary Position Paper at 7-10 (Jan. 14, 2021).
[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] Medicare Contractor's Motion to Dismiss at 5 (Aug. 10, 2023).
[8] *Id.*

Motion to Dismiss on **September 22, 2023**. On **September 27, 2023**, the Medicare Contractor filed comments to the Provider's response to its Jurisdictional Challenge and Motion to Dismiss.

On **February 8, 2024**, the Provider filed its Final Position Paper. On **February 29, 2024**, the Medicare Contractor filed its Final Position Paper.

On **April 15, 2024**, the Provider requested a 180-day postponement of the May 10, 2024 hearing date. On that same date, the Medicare Contractor filed a response, opposing the Provider's postponement request.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-2592G - QRS CY 2015 DSH SSI Percentage (2) Group

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

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

The Group Issue Statement in Case No. 19-2592G, to which the Provider was directly added reads, in part:

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

[9] Provider's January 24, 2020 Appeal Request, Issue Statement at 1.

Statement of the Legal Basis

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

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

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.[10]

On September 17, 2020, the Board received the Provider's Preliminary Position Paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Provider Specific

The Provider contends that its' SSI percentage published by 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 Missouri and the Provider that does not support the SSI percentage issued by CMS.

The Provider has worked with the State of Missouri 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,

[10] Provider's September 4, 2019 Group Appeal Request, Issue Statement at 1.

> 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' admission in *Baystate Medical Center v. Leavitt*, 545 F.Supp.2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[11]

The amount in controversy listed for Issue 1 in the Provider's Individual Appeal Request is $161,794. The amount in controversy for Cox in group case 19-2592G QRS CY 2015 DSH SSI Percentage (2) Group is identical $161,794.

Medicare Contractor's Contentions

Issue 1 – DSH SSI Percentage ("Provider Specific")

The Medicare Contractor contends Issue 1 has two components: 1) SSI data accuracy and 2) SSI realignment. The Medicare Contractor argues "the SSI data accuracy portion of Issue 1 should be dismissed because it is duplicative of the issue under appeal in Group Case No. 19-2592G."[12] The Medicare Contractor notes that, with respect to the portion of Issue 1 related to SSI data accuracy, the Provider states:

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' [sic] SSI percentage published by 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.

[11] Provider's Preliminary Position Paper at 8-9.
[12] Medicare Contractor's November 18, 2020 Jurisdictional Challenge at 2.

> 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.[13]

The Medicare Contractor maintains that Cox raises the same dispute in Group Case No. 19-2592G, citing the group issue statement as quoted above.

The Medicare Contractor maintains that in both Issue 1 and the group issue in Case No. 19-2592GC, stating that "the Provider is disputing the accuracy of its SSI percentage. . . .appealing an issue from a single final determination in more than one appeal. The Board's rules are clear on this matter."[14] Board Rule 4.6.1 provides: "A provider may not appeal an issue from a single final determination in more than one appeal." The Medicare Contractor requests, consistent with previous jurisdictional decisions of the Board, that the Board dismiss the portion of issue 1 concerning SSI data accuracy.[15]

The Medicare Contractor contends, with respect to SSI realignment, this issue has been abandoned, citing the Provider's argument in its appeal, as follows:

> 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 Medicare Contractor maintains the Provider did not brief the issue of SSI realignment within its preliminary position paper. Thus, it should be considered withdrawn per Board Rule 25.3 which provides: "Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn."[16]

Further, the Medicare Contractor points out that the Provider "fails to note that its cost reporting year end is identical to the federal fiscal year end. This oversight leaves [the Medicare Contractor] questioning the right the Provider is attempting to preserve."[17] Alternatively, the Medicare Contractor asserts "[e]ven if not abandoned, the Board lacks jurisdiction over SSI realignment."[18] The Medicare Contractor maintains,

> [t]he decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.[19]

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[13] *Id.* at 4.
[14] *Id.* at 5.
[15] *Id.*
[16] *Id.* at 6.
[17] *Id.* at 5.
[18] *Id.* at 6.
[19] *Id.*

The Medicare Contractor contends there was no final determination over the SSI realignment and the appeal is premature. The Medicare Contractor maintains, "[t]o 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 [Medicare Contractor] requests that the Board dismiss this issue.[20]

Issue 2 – DSH – Medicaid Eligible Days

The Medicare Contractor argues that the Board lacks jurisdiction over the DSH – Medicaid Eligible Days issue because the issue has been abandoned:

> The MAC's Motion [to dismiss] is supported by the over 3 years which have elapsed since the appeal was filed, inclusive of the Medicaid Eligible Days issue. This passage of time, and the failure to respond to the MAC's multiple requests for documentation, belies the Provider's affirmative statements in its Preliminary Position Paper that an eligibility listing was being sent to the MAC under separate cover.[21]

The MAC sent requests on April 28, 2021, July 14, 2021, January 3, 2023 for the listing after not receiving it in the September 17, 2020 preliminary paper. After these requests, and having received no responses, FSS submitted the Motion to Dismiss on August 10, 2023.

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the Medicare Contractor's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[22] The Provider filed its response to the Medicare Contractor's November 18, 2020 Jurisdictional Challenge, for Issue 1, on September 22, 2023, almost 3 years after the response due date of December 18, 2020. 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." The Medicare Contractor filed its Motion to Dismiss issue 2 on August 10, 2023. The Provider filed its response to the Medicare Contractor's Motion to Dismiss on September 22, 2023, which is beyond the 30-day deadline of September 9, 2023.

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[20] *Id*.
[21] Medicare Contractor's August 10, 2023 Motion to Dismiss at 4.
[22] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

Decision of the Board

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

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 Group Case No. 19-2592G.

The DSH – SSI Percentage ("Provider Specific") issue in the present appeals concern "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[23] 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)."[24] The Provider further argues 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."[25]

The Provider's DSH-SSI Percentage ("Systemic Errors") issue in group Case No. 19-2592G 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. 20-0730 is duplicative of the DSH-SSI Percentage ("Systemic Errors") issue in Case Nos. 19-2592G. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6,[26] the Board dismisses this aspect of the DSH Payment-SSI Percentage ("Provider Specific") issue.

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[23] Provider's Appeal Request, Issue Statement at 1.
[24] *Id.*
[25] *Id.*
[26] 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.[27] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in individual appeals 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 Provider's Preliminary Position Paper does not further clarify Issue 1. 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, to explain the nature of any alleged "errors." and to 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.

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***

[27] 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).

> ***encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year.

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

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh. [28]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[29]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. *See* 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.

Accordingly, the Board finds that the SSI Provider Specific issue in Case No. 20-0730 and the group issue from Group Case No. 19-2592G 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

[28] Last accessed May 8, 2024.
[29] Emphasis added.

Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board dismisses this aspect of the appeal. Further, the Provider's cost reporting period is congruent with the Federal fiscal year, and thus, realignment would have no effect on reimbursement.

B. DSH Payment – Medicaid Eligible Days

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

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

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

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

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[30]

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

[30] (Bold emphasis added.)

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

> **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. The Medicare contractor must also give the provider all evidence the Medicare contractor considered in making the determination (see 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Medicare contractor believes is necessary for resolution but has not been submitted by the provider. 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.

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

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

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

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

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

- if it has 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 17, 2020, the Provider filed its preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[31] The position paper did not identify how many Medicaid eligible days remained in dispute in this case.

The Provider's complete briefing of this issue in its position paper in is as follows:

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

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

> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2015 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions. [32]

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

Notably, the Medicare Contractor sent (3) separate requests for the Provider's list of Medicaid Eligible days, on April 28, 2021, July 14, 2021, and January 3, 2023. The third, final, request was sent almost three years after the filing of its preliminary position paper. The Medicare Contractor also informed the Provider in its final request for information that the deadline to respond was February 2, 2023.[33] The Provider responded to the Medicare Contractor's request on August 22, 2023, over six months past the specified final deadline to do so. The listing provided did not respond to the Medicare Contractor's concerns noted in its Motion to Dismiss.[34] Five months later, on February 9, 2024, the Provider filed a redacted listing of Medicaid eligible days in OHCDMS as a supplement to its Final Position Paper.[35] The listing was not accompanied by any substantiating evidence. Instead, it was a bare list of purported additional days.

The Provider failed to *timely* include a list of additional Medicaid eligible days with its preliminary position paper, or to submit such list under separate cover as promised, 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 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, to which it believes it 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

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[32] Provider's Preliminary Position Paper at 7-8.
[33] Medicare Contractor's Motion to Dismiss at 2
[34] Medicare Contractor's February 29, 2024 Final Position Paper at 12.
[35] Provider's February 9, 2024 Supplement to Final Position Paper at 1-2.
[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.

any specific Medicaid eligible days at issue (much less any supporting documentation for those days).The fact that the listing was filed over six months after the deadline and a supplemental listing was filed over 5 months after that does not excuse the Provider for its failure to include the information with its preliminary position paper, nor does it excuse its failure to timely respond to the Motion to Dismiss.

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

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

* * * * *

Based on the foregoing, the Board has dismissed the two (2) remaining issues in this case – (Issues 1 and 2). As no issues remain, the Board hereby closes Case No. 20-0730 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

5/8/2024

X Kevin D. Smith, CPA

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

cc: Byron Lamprecht, WPS Government Health Administrators
Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Notice of Dismissal***
Cox Medical Centers (Provider Number 26-0040)
FYE: 09/30/2016
Case Number: 21-0234

Dear Mr. Ravindran and Mr. Berends:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 21-0234. Set forth below is the decision of the Board to dismiss the appeal challenging the Provider's Disproportionate Share Hospital ("DSH") SSI Percentage ("Provider Specific") and Medicaid Eligible Days issues.

Background

A. *Procedural History for Case No. 21-0234*

Cox Medical Centers ("Cox") (Provider Number 26-0040) filed, for its fiscal year ending ("FYE") 9/30/2016, a timely Individual Appeal Request on **November 18, 2020**, from a Notice of Program Reimbursement ("NPR") dated **May 27, 2020**, appealing the following issues:

1) Disproportionate Share Hospital ("DSH") SSI Percentage ("Provider Specific")
2) DSH Medicaid eligible days

On **November 19, 2020**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

C.F.R. § 405.1853. *See* Board Rule 25.[1]

On **August 10, 2021**, Cox filed its Preliminary Position Paper. With respect to Issue 2, the Provider suggested that a list of Medicaid eligible days at issue was imminent, promising that one was being sent under separate cover.[2] However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide the material fact of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days . . . ."[3]

On **October 27, 2021**, the Medicare Contractor filed its Preliminary Position Paper. With regard to Issue 2, 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 the Board Rules to file a fully developed position paper with all available documentation necessary to support its position. The Medicare Contractor also noted that the Provider had failed to respond to the Medicare Contractor's request for that Medicaid eligible days listing.[4]

On **October 1, 2021**, the Medicare Contractor filed a Jurisdictional Challenge[5] over Issue 1 - the DSH SSI Percentage ("Provider Specific") issue. On **October 27, 2021**, the Medicare Contractor (in its Preliminary Position Paper) requested dismissal of Issue 2 - the DSH Medicaid eligible days issue - because the Provider failed to furnish documentation in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable) and 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.[6] Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge and dismissal request. However, the Provider *failed* to file any response.

On **February 8, 2024**, Cox filed its Final Position Paper. On **February 15, 2024**, the Medicare Contractor filed its Final Position Paper.

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[1] (Emphasis added).
[2] Provider's August 10, 2021 Preliminary Position Paper at 8.
[3] *Id.*
[4] Medicare Contractor's October 27, 2021 Preliminary Position Paper at 5-6.
[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] Medicare Contractor's Preliminary Position Paper at 5-6.

On **April 15, 2024**, Cox requested a 180-day postponement of the May 10, 2024 hearing date. On that same date, the Medicare Contractor responded in opposition of the Provider's postponement request.

A. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 21-0235G - QRS CY 2016 DSH SSI Percentage (2) Group

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

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

The Group Issue Statement in Case No. 21-0235G, to which the Provider was directly added reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww

[7] Provider's November 18, 2020 Appeal Request, Issue Statement at 1.

> (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[8]

On August 10, 2021, the Board received the Provider's Preliminary Position Paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by 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 Missouri and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Missouri 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

[8] Provider's November 18, 2020 Group Appeal Request, Issue Statement at 1.

> 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' admission in *Baystate Medical Center v. Leavitt*, 545 F.Supp.2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[9]

The amount in controversy listed for Issue 1 in the Provider's Individual Appeal Request is $151,447. The amount in controversy for Cox in Group Case No. 21-0235G (QRS CY 2016 DSH SSI Percentage (2) Group) is also $151,447.

Medicare Contractor's Contentions

Issue 1 – DSH SSI Percentage ("Provider Specific")

The Medicare Contractor contends Issue 1 has two components: 1) SSI data accuracy and 2) SSI realignment. The Medicare Contractor argues the SSI data accuracy portion of Issue 1 "should be dismissed because it is duplicative of the issue under appeal in Group Case No. 21-0235G."[10] The Medicare Contractor asserts that, with respect to the portion of Issue 1 related to SSI data accuracy, the Provider states:

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' [sic] SSI percentage published by 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 and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.[11]

The Medicare Contractor maintains that Cox raises the same dispute in Group Case No. 21-0235G, and cites to the group appeal issue statement, as quoted previously in this letter.

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[9] Provider's Preliminary Position Paper at 8-9.
[10] Medicare Contractor's October 1, 2021 Jurisdictional Challenge at 1.
[11] *Id.* at 4.

The Medicare Contractor maintains that, in Issue 1 and in the group issue in Case No. 21-0235G, the Provider is disputing the accuracy of its SSI percentage. The Medicare Contractor argues,

> the Provider is appealing an issue from a single final determination in more than one appeal. . . . The Board's Rules are clear on this matter: No duplicate filings. Board Rule 4.6.1 states: 'A provider may not appeal an issue from a single final determination in more than one appeal.' Consistent with the Board's previous jurisdictional decisions the MAC respectfully requests the Board dismiss the portions of issue 1 concerning SSI data accuracy.[12]

The Medicare Contractor contends that, with respect to SSI realignment, this issue has been abandoned. The Medicare Contractor notes that the Provider states:

> 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).[13]

The Medicare Contractor maintains "the Provider did not brief this issue [SSI realignment] within its preliminary position paper, and therefore it should be considered withdrawn."[14] The Medicare Contractor cites to Board Rule 25.3 which provides: "Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn."

Further, the Medicare Contractor points out that:

> [t]he Provider fails to note that its cost reporting year end is identical to the federal fiscal year end. This oversight leaves it [the Medicare Contractor] questioning the right the Provider is attempting to preserve. . . .Even if not abandoned, the Board lacks jurisdiction over SSI realignment. The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.[15]

The Medicare Contractor contends there was no final determination over the SSI realignment and the appeal is premature. The Medicare Contractor maintains that,

> [t]o 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

[12] *Id*. at 4-5.
[13] *Id.* at 5.
[14] *Id.*
[15] *Id.* at 5-6.

> Medicare Contractor requests that the Board dismiss this issue consistent with recent decisions.[16]

Issue 2 – DSH – Medicaid Eligible Days

In its Preliminary Position Paper, the Medicare Contractor argues that the DSH – Medicaid Eligible Days issue has been abandoned. The Medicare Contractor contends:

> [t]he Provider did not submit an eligibility listing with its paper, though in its Exhibit 1 the provider states that the Eligibility Listing will be emailed separately. However, the MAC has yet to receive such listing from the Provider. PRRB Rule 23.3 requires that providers file a fully developed position paper, which includes all available documentation necessary to support the provider's position. The provider has failed to submit any form of documentation in support of additional Medicaid eligible days, including the identification of the days in question. The MAC, in an effort of good faith to resolve the issue, requested the items from the list on February 03, 2021, and more recently, for a second time, on August 11, 2021.[17]

The Medicare Contractor maintains:

> [t]he Provider has failed to respond to any of the MAC's requests for information to resolve this issue. The provider had an opportunity to do so in its statement of the issue when it filed the instant appeal, and again when it submitted its preliminary position paper. Again, the provider had 40 months between the end of the cost reporting period and the start of the Audit to gather information related to the number of Medicaid days it wanted to include on its cost report. There is no indication that Medicaid eligibility information was not available when the provider filed its cost report, let alone, before the Audit. PRRB Rule 23.3 requires that providers file a fully developed position paper, which includes all available documentation necessary to support the provider's position. As the provider has failed to submit any form of documentation in support of additional Medicaid eligible days, the provider's current position is an allegation and nothing more. Documents not included in the preliminary position paper should be excluded at hearing. The provider failed to substantiate that it is entitled to additional days within the timeframe allotted by Regulation and PRRB Rules. This issue must be dismissed.[18]

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[16] *Id*. at 2, 5-6.
[17] Medicare Contractor's Preliminary Position Paper at 5.
[18] *Id*. at 6.

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. 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, 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." The Provider has not filed a response to the MAC's October 1, 2021 request for dismissal or the arguments made for dismissal in the MAC's October 27, 2021 Preliminary Position Paper.

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.

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 Group Case No. 21-0235G.

The DSH – SSI Percentage ("Provider Specific") issue in the present appeal concern "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[19] 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.

[19] Provider's Appeal Request, Issue Statement at 1.

§ 1395ww(d)(5)(F)(i)."[20] The Provider's issue statement further states 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."[21]

The Provider's DSH-SSI Percentage ("Systemic Errors") issue in group Case No. 21-0235G 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. 21-0234 is duplicative of the DSH-SSI Percentage ("Systemic Errors") issue in Group Case No. 21-0235G. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6,[22] the Board dismisses this aspect of the DSH Payment-SSI Percentage ("Provider Specific") issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[23] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors are specific to this provider.

To this end, review of the Provider's Preliminary Position Paper does not further clarify Issue 1. The Board finds that the Provider's Preliminary Position Papers 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, to explain the nature of any alleged "errors," and to 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

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

> documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule,

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

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

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

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

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. *See* 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.

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[24] Last accessed May 8, 2024.
[25] Emphasis added.

Accordingly, the Board finds that the SSI Provider Specific issue in Case No. 21-0234 and the group issue from Group Case No. 21-0235G 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. Further, the Provider's cost reporting period is congruent with the Federal fiscal year, and thus, realignment would have no effect on reimbursement.

B. DSH Payment – Medicaid Eligible Days

The Provider did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal in either the initial appeal request 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]

Therefore, 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:

> **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.

[26] (Bold emphasis added.)

> **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. The Medicare contractor must also give the provider all evidence the Medicare contractor considered in making the determination (see 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Medicare contractor believes is necessary for resolution but has not been submitted by the provider. 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.

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

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

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

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

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

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

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

On August 10, 2021, the Provider filed its preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[27] The position paper did not identify how many Medicaid eligible days remained in dispute in this case.

The Provider's complete briefing of this issue in its Preliminary position paper in 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*

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

> *Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions. [28]

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

Notably, the Medicare Contractor sent (2) two requests for the Provider's list of Medicaid Eligible days. The first notice was sent on February 3, 2021, and the second request was sent on August 11, 2021.[29] The Provider responded to the Medicare Contractor's request on February 9, 2024, over two and half years later, by filing a redacted listing of Medicaid eligible days in OHCDMS as a supplement to its Final Position Paper.[30] The listing was not accompanied by any substantiating evidence. Instead, it was a bare list of purported additional days.

The Provider failed to *timely* include a list of additional Medicaid eligible days with its preliminary position paper, or to submit such list under separate cover as promised, 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 supporting documents or to explain why it failed to produce those documents, as required by the regulations and the Board Rules.[31]

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[28] Provider's Preliminary Position Paper at 7-8.
[29] Medicare Contractor's February 15, 2024 Final Position Paper at 17.
[30] Provider's February 9, 2024 Supplement to Final Position Paper at 1-5.
[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

The Board concurs with the Medicare Contractor that the Provider is required to identify the material facts (i.e., the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled, consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).The fact that the listing was filed over two and a half years after the deadline does not excuse the Provider for its failure to include the information with its preliminary position paper, nor does it excuse its failure to timely respond to the request for dismissal.

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

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

* * * * *

Based on the foregoing, the Board has dismissed the two (2) remaining issues in this case – (Issues 1 and 2). As no issues remain, the Board hereby closes Case No. 21-0234 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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merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

Board Members Participating:

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

For the Board:

5/8/2024

X Kevin D. Smith, CPA

Clayton J. Nix, Esq.
Chair
Signed by: Kevin D. Smith -A

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision***
Christus Lake Area Hospital (Provider Number 19-0201)
FYE: 05/31/2016
Case Number: 19-0672

Dear Mr. Ravindran and Mr. Lamprecht,

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

Background:

A. ***Procedural History for Case No. 19-0672***

On **June 14, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2016.

On **December 6, 2018**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

As the Provider is owned by Community Health Systems, Inc. (hereinafter "Community Health") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2 and 5 to Community Health groups on **July 18, 2019**. After the withdrawal of Issue 3, the remaining issues in this appeal are Issues 1 (DSH Payment/SSI Percentage (Provider Specific)) and 4 (UCC Distribution Pool).

[1] On July 18, 2019, this issue was transferred to PRRB Case No. 19-1409GC.
[2] This issue was withdrawn on April 17, 2024.
[3] On July 18, 2019, this issue was transferred to PRRB Case No. 19-1410GC.

The Medicare Contractor filed a Jurisdictional Challenge on **March 28, 2019**, regarding Issue 1 (DSH SSI Provider Specific) and Issue 4 (Uncompensated Care Distribution Pool).[4] The Provider filed a Jurisdictional Response to the Medicare Contractor's Jurisdictional Challenge on **April 24, 2019**.

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

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

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

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

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's 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

[4] The MAC also challenged Issue 5 (2 Midnight Census IPPS Payment Reduction). However, Issue 5 no longer resides in this appeal.
[5] Appeal Request, Tab 3 Appeal Issues at 1 (Dec. 6, 2018).

> accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[6]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $7,000.

On July 31, 2019, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (May 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR

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

> data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[7]

On February 14, 2024, the Provider filed its final position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Calculation of the SSI Percentage**
>
> The Provider contends that the MAC's determination of Medicare Reimbursement for DSH Payments are not in accordance with the Medicare statute 42 U.S.C. 1395ww(d)(S) [sic] (F)(i). The Provider contends that the SSI percentage calculated by [CMS] and used by the MAC to settle their Cost Report was incorrectly computed because of the following reasons:
>
> **Issue #1 Provider Specific**
>
> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination 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 [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al. v. Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[8]

[7] Provider's Preliminary Position Paper at 8-9 (Jul. 31, 2019).
[8] Provider's Final Position Paper at 8-9 (Feb. 14, 2024).

MAC's Jurisdictional Challenge

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

In its Jurisdictional Challenge, filed on March 28, 2019, the MAC argues the SSI realignment issue is premature:

> 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 of this item is premature. The Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). The Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue. The MAC requests that the PRRB dismiss this issue consistent with other jurisdictional decisions.[9]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH/SSI Percentage (Systemic Errors) issue in PRRB Case No. 19-1409GC are considered the same issue by the Board.[10]

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)."[11]

Provider's Jurisdictional Response

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

The Provider contends that Issues 1 and 2 are separate and distinct issues which represent different aspects of the SSI Percentage. The Provider claims that Issue 1 addresses "errors of omission and commission"[12] which are outside of the systemic errors described in Issue 2. Regarding Issue 1, the Provider states the SSI percentage is understated as "the Provider has specifically identified patients believed to be entitled to both Medicare Part A and SSI who were

[9] Jurisdictional Challenge at 6 (Mar. 28, 2019).
[10] *Id*. at 4-6.
[11] *Id*. at 7.
[12] Jurisdictional Response at 2 (Apr. 24, 2019).

not included in the SSI percentage…"[13] and these errors "are or may be specific to the Provider."[14] Therefore, the Provider requests that the Board find it has jurisdiction over Issue 1.[15]

Issue 4 – UCC Distribution Pool.

The Provider argues that the DSH statute does not authorize the use of an estimate for the uninsured patient percentage, and "the Secretary should be required to reconcile her initial estimate of the uninsured patient percentage with actual data…".[16] The Provider's position is that the courts can review the use of estimates for Issue 4, and therefore the Board can also review this allegation.[17] The Provider argues it is entitled to a writ of mandamus ordering the Secretary to revise its estimates,[18] and this appeal is a challenge to the regulation relied upon by the Secretary to compute the estimate for the uninsured patient percentage.[19] Specifically, the provider is challenging the "IPPS rule which incorporate the defective estimates used by the Secretary."[20]

Board Analysis and Decision

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

A. DSH Payment/SSI Percentage (Provider Specific)

The Board finds that it does not have jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue. The jurisdictional analysis for Issue No. 1 has several relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage; 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period; and 3) the Provider incorporating the arguments from *Advocate Christ*[21] into its appeal.

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[13] *Id.*
[14] *Id.*
[15] *Id*.
[16] *Id.* at 3.
[17] *Id* at 4.
[18] *Id.* at 4-5.
[19] *Id.* at 5-6.
[20] *Id.* at 6.
[21] The Provider has included the Appellants' Reply Brief in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214 (D.C. Cir.), which is on appeal from the decision in *Advocate Christ Med. Ctr. V. Azar*, 17-cv-1519 (TSC), 2022 WL 2064830, (D.D.C. June 8, 2022).

1. First and Third Aspects of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 19-1409GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[22] 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)."[23] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[24]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 19-1409GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 19-1409GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[25], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 19-1409GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[26] The Provider's reliance upon in 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

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

distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-1409GC.

To this end, the Board also reviewed the Provider's Final Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 19-1409GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Final Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Final Position Paper and include *all* exhibits.

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

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

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

[27] (Emphasis added).

> set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year.

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

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproprtionate-share-data-dsh [28]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[29]

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 19-1409GC are the same issue.[30] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

Additionally, in its Final Position Paper, the Provider stated, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3)."[31] The Board finds that this purported argument does not comply with the regulations and Board rules to *fully* develop the Provider's position in the Final Position Paper, because the Provider merely lists a case name and does not explain further what the arguments are that it would like to incorporate into its appeal.

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[32]

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[28] Last accessed May 9, 2024.
[29] Emphasis added.
[30] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Community Health CIRP group per 42 C.F.R. § 405.1837(b)(1).
[31] Provider's Final Position Paper at 8-9.
[32] (Emphasis added).

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

2. Second Aspect of Issue 1

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

B. UCC Distribution Pool

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

1. Bar on Administrative Review

The Board notes that 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation. Based on these provisions, judicial and administrative review is precluded under 42 U.S.C. §§ 1395ff and 1395oo for:

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[33]
>
> (B) Any period selected by the Secretary for such purposes.

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

2. Interpretation of Bar on Administrative Review

a. Tampa General v. Sec'y of HHS

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs*. ("*Tampa General*"),[34] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[35] 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."[36] 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.[37]

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.[38]

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*").[39] 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

[34] 830 F.3d 515 (D.C. Cir. 2016).
[35] 89 F. Supp. 3d 121 (D.D.C. 2015).
[36] 830 F.3d 515, 517.
[37] *Id.* at 519.
[38] *Id.* at 521-22.
[39] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").

way to review the Secretary's method of estimation without reviewing the estimate itself."[40] 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.[41]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[42] 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.[43] 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.[44] 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.[45] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[46]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[47]

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[40] *Id.* at 506.
[41] *Id.* at 507.
[42] 514 F. Supp. 249 (D.D.C. 2021).
[43] *Id.* at 255-56.
[44] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[45] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.
[46] *Id.*
[47] *Id.* at 262-64.

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[48] 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.[49] 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.[50]

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.[51] 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*").[52] 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.[53] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the providers' claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."[54] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[55] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in

[48] *Id.* at 265.
[49] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[50] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[51] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[52] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[53] *Id*. at *4.
[54] *Id.* at *9.
[55] 139 S. Ct. 1804 (2019).

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***."[56]

The Board finds that the same findings are applicable to the Provider's challenge to their FFY 2016 UCC payments. The Providers here are challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2016. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 19-1409GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. Also, the Board dismisses the UCC Distribution Pool issue as the Board does not have jurisdiction because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation. As no issues remain pending, the Board hereby closes Case No. 19-0672 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

5/9/2024

X Kevin D. Smith, CPA

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

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

[56] *Ascension* at *8 (bold italics emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Notice of Dismissal and Denial of EJR Request***
Case No. 24-1519GC – Hospital Sisters Health FFY 2024 ATRA Unwinding CIRP Grp
Case No. 24-1512GC – Northwestern Medicine FFY 2024 ATRA Unwinding CIRP Grp

Dear Ms. Marsden:

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced common issue related party ("CIRP") group appeals and the Request for Expedited Judicial Review ("EJR") filed on March 1, 2024. The decision of the Board to deny the Request for EJR and dismiss the appeal for lack of substantive jurisdiction is set forth below.

I. Issue in Dispute:

The Providers challenge their FFY 2024 IPPS payments on the grounds that those payments were (and continue to be) improperly reduced due to the failure to eliminate the adjustments under paragraph 7(b)(1)(B) of the TMA Abstinence Education, and QI Programs Extension Act of 2007, Pub. L. No. 110–90, 121 Stat. 984, 986-87, as amended ("TMA"), such that a negative 0.9412 percent adjustment continues past FFY 2023. This negative 0.9412 percent adjustment to IPPS rates is the net result of all adjustments under section 7(b)(1)(B) of the TMA that were continued rather than eliminated in the FFY 2024 IPPS Final Rule.[1]

II. Statutory and Regulatory Background:

In the federal year ("FY") 2008 inpatient prospective payment system ("IPPS") final rule,[2] the Secretary[3] adopted the Medicare severity diagnosis-related group ("MS–DRG") patient classification system for the IPPS, effective October 1, 2007, to better recognize severity of illness in Medicare payment rates for acute care hospitals. The adoption of the MS–DRG system resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008. The Secretary believed that, by increasing the number of MS–DRGs and more fully taking in to account patient severity of illness in Medicare payment rates for acute care hospitals, MS–DRGs would encourage hospitals to improve their documentation and coding of patient diagnoses.[4]

[1] *E.g.*, PRRB Case 24-1512GC Statement of the Issue at 1 (Feb. 23, 2024).
[2] 72 Fed. Reg. 47130, 47140-47189 (Aug. 22, 2007).
[3] of the Department of Health and Human Services.
[4] 81 Fed. Reg. 56762, 56780 (Aug. 22, 2016).

In the FY 2008 IPPS final rule, the Secretary indicated that the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for additional documentation and coding. In that final rule, the Secretary exercised the authority under section 42 U.S.C. § 1395ww(d)(3)(A)(vi), which authorizes the Secretary to maintain budget neutrality by adjusting the national standardized amount, to eliminate the estimated effect of changes in coding or classification that do not reflect real changes in case-mix. CMS actuaries estimated that maintaining budget neutrality required an adjustment of -4.8 percent to the national standardized amount. The Secretary provided for phasing in this -4.8 percent adjustment over 3 years. Specifically, the Secretary established prospective documentation and coding adjustments of -1.2 percent for FY 2008, -1.8 percent for FY 2009, and -1.8 percent for FY 2010.[5]

On September 29, 2007, Congress enacted the TMA [Transitional Medical Assistance], Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007 ("TMA").[6] TMA § 7(a) reduced the documentation and coding adjustment made as a result of the MS–DRG system that the Secretary adopted in the FY 2008 IPPS final rule to -0.6 percent for FY 2008 and -0.9 percent for FY 2009.[7]

The Secretary implemented a series of adjustments required under TMA §§ 7(b)(1)(A) and 7(b)(1)(B) based on a retrospective review of FY 2008 and FY 2009 claims data. The Secretary completed these adjustments in FY 2013. However, the Secretary commented in the FY 2013 IPPS final rule that delaying full implementation of the adjustment required under TMA § 7(b)(1)(A) until FY 2013 had resulted in payments in FY 2010 through FY 2012 being overstated, and that these overpayments could not be recovered.[8]

Congress revisited TMA § 7(b)(1)(B) as part of the American Taxpayer Relief Act of 2012 ("ATRA").[9] Specifically, ATRA § 631 amended TMA § 7(b)(1)(B) to add clause (ii) which required the Secretary to make a recoupment adjustment or adjustments totaling $11 billion for discharges occurring during FYs 2014 to 2017. Per the revisions made by ATRA § 631(b), this adjustment "represents the amount of the increase in aggregate payments from fiscal years 2008 through 2013 for which an adjustment was not previously applied" (*i.e.*, represents the amount of the increase in aggregate payments as a result of not completing the prospective adjustment authorized under TMA § 7(b)(1)(A) until FY 2013).[10] As discussed above, this delay in implementing TMA § 7(b)(1) resulted in overstated payment rates in FYs 2010, 2011, and 2012 and the resulting overpayments could not have been recovered under the original TMA § 7(b).

The adjustment required under ATRA § 631 was a one-time recoupment of a prior overpayment, not a permanent reduction to payment rates. Therefore, the Secretary "anticipated that any adjustment made to reduce payment rates in one year would eventually be offset by a positive adjustment in FY 2018, once the necessary amount of overpayment was recovered."[11]

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[5] *See* 82 Fed. Reg. 37990, 38008 (Aug. 17, 2017).
[6] Pub. L. 110–90, 121 Stat. 984 (2007).
[7] *Id.* at 986.
[8] *See* 82 Fed. Reg. at 38008.
[9] Pub. L. 112-240, 126 Stat. 2313 (2013).
[10] *Id.* at 2353.
[11] 82 Fed. Reg. at 38008.

However, Congress again stepped in to revise TMA § 7(b)(1)(B). First, in § 414 of the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), Congress revised TMA § 7(b)(1)(B) to add clause (iii) which replaced the single positive adjustment the Secretary intended to make in FY 2018 with a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023.[12] Second, in § 15005 of the 21st Century Cures Act ("21-CCA"),[13] Congress amended the MACRA revision in TMA § 7(b)(1)(B)(iii) by reducing the adjustment for FY 2018 from 0.5 percentage points to 0.4588 percentage points.[14]

The Secretary's "actuaries estimated that a -9.3 percentage point adjustment to the standardized amount would be necessary if CMS were to fully recover the $11 billion recoupment required by [ATRA § 631] in FY 2014." Consistent with the policies that the Secretary has adopted in many similar situations, the Secretary implemented a phased in approach. For the first year, FY 2014, he implemented a -0.8 percentage point recoupment adjustment to the standardized amount. The Secretary declined, at that time, to set specific adjustments for FYs 2015, 2016, or 2017 "[a]s estimates of any future adjustments are subject to variations in total savings[.]"[15] However, he did estimate that, if adjustments of -0.8 percentage point were implemented in FYs 2014, 2015, 2016, and 2017, using standard inflation factors, then the requisite $11 billion would be recouped by the end of the statutory 4-year timeline.[16]

Consistent with the approach discussed in the FY 2014 rulemaking for recouping the $11 billion required by ATRA § 631, in the FY 2015 IPPS/LTCH PPS final rule[17] and the FY 2016 IPPS/LTCH PPS final rule,[18] the Secretary implemented additional -0.8 percentage point recoupment adjustments to the standardized amount in FY 2015 and FY 2016, respectively. The Secretary estimated that these adjustments, combined with leaving the prior -0.8 percentage point adjustments in place, would recover up to $2 billion in FY 2015 and another $3 billion in FY 2016. When combined with the approximately $1 billion adjustment made in FY 2014, the Secretary estimated that approximately $5 to $6 billion would be left to recover under ATRA § 631 by the end of FY 2016.

In the FY 2017 IPPS/LTCH PPS proposed rule,[19] due to lower than previously estimated inpatient spending, the Secretary determined that an adjustment of -0.8 percentage point in FY 2017 would not recoup the $11 billion under ATRA § 631. For the FY 2017 IPPS/LTCH PPS Final Rule,[20] the Secretary's actuaries estimated that, to the nearest tenth of a percentage point, the FY 2017 documentation and coding adjustment factor that would recoup as closely as possible $11 billion from FY 2014 through FY 2017 without exceeding this amount is -1.5 percentage points. Based on those updated estimates by the Office of the Actuary, the Secretary made a -1.5 percentage point adjustment for FY 2017 as the final adjustment required under ATRA § 631.[21]

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[12] Pub. L. 114–10, § 414, 129 Stat. 87, 162-163 (2015).
[13] Pub. L. 114–255, 130 Stat. 1033 (2016).
[14] *Id.* at 1319-1320. *See also* 82 Fed. Reg. at 38008.
[15] 82 Fed. Reg. at 38008.
[16] *Id.*
[17] 79 Fed. Reg. 49853, 49874 (Aug. 22, 2014).
[19] 80 Fed. Reg. 49326, 49345 (Aug. 17, 2015).
[19] 81 Fed. Reg. 24946, 24966 (Apr. 27, 2016)
[20] 81 Fed. Reg. 56761 (Aug. 22, 2016).
[21] *Id.* at 56785.

Once the recoupment required under ATRA § 631 was complete, the Secretary anticipated making a single positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631. However, MACRA § 414 (which was enacted on April 16, 2015) replaced the single positive adjustment the Secretary intended to make in FY 2018 with a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. In the FY 2017 rulemaking, the Secretary indicated that he would address the adjustments for FY 2018 and later fiscal years in future rulemaking. As noted previously, 21-CCA § 15005, which was enacted on December 13, 2016, amended TMA § 7(b)(1)(B) (as amended by ATRA § 631 and MACRA § 414) to reduce the adjustment for FY 2018 from a 0.5 percentage point to a 0.4588 percentage point. The Secretary believes the directive under 21-CCA § 15005 is clear and, as a result, in the FY 2018 IPPS/LTCH PPS proposed rule for FY 2018, the Secretary proposed to implement the required +0.4588 percentage point as a permanent adjustment to the standardized amount.[22]

A. The Final IPPS Rule for FY 2018

In response to the +0.4588 percentage point adjustment, several commenters reiterated their disagreement with the -1.5 percentage point adjustment that CMS made for FY 2017 under ATRA § 631, which exceeded the estimated adjustment of approximately -0.8 percentage point described in the FY 2014 IPPS/LTCH PPS rulemaking. Commenters contended that, as a result, hospitals would be left with a larger permanent cut than Congress intended following the enactment of MACRA. They asserted that CMS' proposal to apply a 0.4588 percent positive adjustment for FY 2018 misinterprets the relevant statutory authority, and urged the Secretary to align with their view of Congress' intent by restoring an additional +0.7 percentage point adjustment to the standardized amount in FY 2018 (*i.e.*, the difference between the -1.5 percentage point adjustment made in FY 2017 and the initial estimate of -0.8 percentage point discussed in the FY 2014 IPPS/LTCH PPS rulemaking). The commenters also urged the Secretary to use his discretion under 42 U.S.C. § 1395ww(d)(5)(I) to increase the FY 2018 adjustment by 0.7 percentage point. Other commenters requested that, despite current law, CMS ensure that adjustments totaling the full 3.9 percentage points withheld under ATRA § 631 be returned.[23]

The Secretary responded by stating that, as discussed in the FY 2017 IPPS/LTCH PPS Final Rule,[24] CMS had completed the $11 billion recoupment required under ATRA § 631. The Secretary also continued to disagree with commenters who asserted that MACRA § 414 was intended to augment or limit the separate obligation under the ATRA to fully offset $11 billion by FY 2017.[25] Moreover, the Secretary pointed out in the FY 2018 IPPS/LTCH PPS proposed rule, he believed that the directive regarding the applicable adjustment for FY 2018 is clear. While the Secretary had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 requires that he not make the single positive adjustment he intended to make in FY 2018 but instead make a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. The Secretary pointed out that, as noted by the commenters and discussed in the FY 2017 IPPS/LTCH PPS Final Rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore

[22] 82 Fed. Reg. at 38009.
[23] *Id.*
[24] 81 Fed. Reg. 56783-85.
[25] *Id.* at 56784.

even the 3.2 percentage point adjustment originally estimated in the FY 2014 IPPS/LTCH PPS final rule.[26] Finally, the Secretary noted that 21-CCA § 15005 further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point and that this change was enacted on December 13, 2016, ***after*** CMS had proposed and finalized the -1.5 percentage point adjustment as the final adjustment required under ATRA § 631 in the FY 2017 rulemaking. The Secretary finalized the +0.4588 percentage point adjustment to the standardized amount for FY 2018, as required under 21-CCA § 15005.[27]

B. The FY 2019 Adjustment to the Standardized Amount

In the Final Inpatient PPS Rule for FY 2019,[28] the Secretary finalized a +0.5 percentage point adjustment to the standardized amount for FY 2019, as required under MACRA § 414.

In the IPPS Final Rule, several commenters argued that the Secretary misinterpreted the Congressional directives regarding the level of positive adjustment required for FY 2018 and FY 2019. The commenters contended that, while the positive adjustments required under MACRA § 414 would only total 3.0 percentage points by FY 2023, the levels of these adjustments were determined using an estimated positive ''3.2 percent baseline'' adjustment that otherwise would have been made in FY 2018. The commenters believed that, because CMS implemented an adjustment of -1.5 percentage points instead of the expected -0.8 percentage points in FY 2017, totaling -3.9 percentage points overall, the Secretary has imposed a permanent -0.7 percentage point negative adjustment beyond its statutory authority, contravening what the commenters contend was Congress' clear instructions and intent. The commenters requested that the Secretary reverse his previous position and implement additional 0.7 percentage point adjustments for both FY 2018 and FY 2019. Some of the commenters requested that the Secretary use his statutory discretion to ensure that all 3.9 percentage points in negative adjustment be restored. In addition, some of the commenters acknowledged that CMS may be bound by law but expressed opposition to the permanent reductions and requested that the Secretary refrain from making any additional coding adjustments in the future.[29]

The Secretary responded by stating that, as discussed in the FY 2019 IPPS/LTCH PPS proposed rule, he believed MACRA § 414 and 21-CCA § 15005 clearly set forth the levels of positive adjustments for FYs 2018 through 2023. He was not convinced that the adjustments prescribed by MACRA were predicated on a specific ''baseline'' adjustment level. While he had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 required that a 0.5 percentage point positive adjustment be implemented for each of FYs 2018 through 2023, rather than the single positive adjustment he had anticipated making in FY 2018. As discussed in the FY 2017 IPPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the 3.2 percentage points adjustment originally estimated in the FY 2014 IPPS final rule.[30] Moreover, as discussed in the FY 2018 IPPS Final Rule, 21-CCA § 15005 further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point and this

[26] 78 Fed. Reg. 50496, 50515 (Aug. 19, 2013).
[27] 82 Fed. Reg. at 38009.
[28] 83 Fed. Reg. 41144 (Aug. 17, 2018).
[29] *Id.* at 41157.
[30] 78 Fed. Reg.at 50515.

adjustment was enacted on December 13, 2016, ***after*** the Secretary had proposed and finalized the final negative -1.5 percentage points adjustment required under ATRA § 631. The Secretary does not believe that Congress enacted these adjustments with the intent that there would be an additional +0.7 percentage point adjustment in FY 2018 to compensate for the higher than expected final ATRA adjustment made in FY 2017.[31]

C. The FY 2020 to FY 2023 Adjustments to the Standardized Amount

In IPPS Final Rules for FYs 2020 through FY 2023, the Secretary adopted only a +.5 percent adjustment. In this regard, the Secretary stated the following in the preamble to the FY 2020 IPPS Final Rule:

> In the FY 2020 IPPS/LTCH PPS proposed rule (84 FR 19170 through 19171) consistent with the requirements of section 414 of the MACRA, we proposed to implement a 0.5 percentage point positive adjustment to the standardized amount for FY 2020. We indicated that this would constitute a permanent adjustment to payment rates. We stated in the proposed rule that we plan to propose future adjustments required under section 414 of the MACRA for FYs 2021 through 2023 in future rulemaking.
>
> ****
>
> As we discussed in the FY 2020 IPPS/LTCH PPS proposed rule (84 FR 19170 through 19171), and in response to similar comments in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41157), we believe section 414 of the MACRA and section 15005 of the 21st Century Cures Act set forth the levels of positive adjustments for FYs 2018 through 2023. We are not convinced that the adjustments prescribed by MACRA were predicated on a specific adjustment level estimated or implemented by CMS in previous rulemaking. While we had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under section 631 of the ATRA, section 414 of the MACRA required that we implement a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023, and not the single positive adjustment we intended to make in FY 2018. As discussed in the FY 2017 IPPS/LTCH PPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, section 414 of the MACRA would not fully restore even the 3.2 percentage point adjustment originally estimated by CMS in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50515). Moreover, as discussed in the FY 2018 IPPS/LTCH PPS final rule, Public Law 114-255, which further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point, was enacted on December 13, 2016, after CMS had proposed and finalized the final negative -1.5 percentage point adjustment required under

[31] 83 Fed. Reg. at 41157.

> section 631 of the ATRA. We see no evidence that Congress enacted these adjustments with the intent that CMS would make an additional +0.7 percentage point adjustment in FY 2018 to compensate for the higher than expected final ATRA adjustment made in FY 2017, nor are we persuaded that it would be appropriate to use the Secretary's exceptions and adjustments authority under section 1886(d)(5)(I) of the Act to adjust payments in FY 2020 to restore any additional amount of the original 3.9 percentage point reduction, given Congress' prescriptive adjustment levels under section 414 of the MACRA and section 15005 of the 21st Century Cures Act.
>
> After consideration of the public comments we received, we are finalizing our proposal to implement a 0.5 percentage point adjustment to the standardized amount for FY 2020.[32]

The Secretary issued similar statements for FYs 2021[33] and 2022,[34] and the final rules for both FYs both adopted a +.5 percent adjustment. In the IPPS Final Rule FY 2023, the Secretary implemented the final, 0.4588 percentage point positive adjustment to the standardized amount:

> Consistent with the requirements of section 414 of the MACRA, we proposed to implement a 0.5 percentage point positive adjustment to the standardized amount for FY 2023. We stated that this would constitute a permanent adjustment to payment rates. We also stated that this proposed 0.5 percentage point positive adjustment is the final adjustment prescribed by section 414 of the MACRA. Along with the 0.4588 percentage point positive adjustment for FY 2018, and the 0.5 percentage point positive adjustments for FY 2019, FY 2020, FY 2021, and FY 2022, this final adjustment will result in combined positive adjustment of 2.9588 percentage points (or the sum of the adjustments for FYs 2018 through 2023) to the standardized amount.
>
> We received no public comments on the proposed adjustment for FY 2023 and are finalizing our proposal to implement a 0.5 percentage point positive adjustment to the standardized amount for FY 2023. As indicated, this finalized 0.5 percentage point positive adjustment for FY 2023 is the final adjustment prescribed by section 414 of the MACRA.[35]

[32] 84 Fed. Reg. 42044, 42057 (Aug. 16, 2019).
[33] 85 Fed. Reg. 58432, 58444-45 (Sept. 18, 2020).
[34] 86 Fed. Reg. 44774, 44795 (Aug. 13, 2021).
[35] 87 Fed. Reg. 48780, 48800 (Aug. 10 ,2022).

III. Providers' Request for Hearing:

The Providers frame their appeal as follows:

> The Providers challenge their FFY 2024 IPPS payments on the grounds that those payments were (and continue to be) improperly reduced due to the failure to eliminate the adjustments under paragraph 7(b)(1)(B) of the TMA Abstinence Education, and QI Programs Extension Act of 2007, Pub. L. No. 110–90, 121 Stat. 984, 986-87, as amended ("TMA"), such that a negative 0.9412% adjustment continues past FFY 2023. This negative 0.9412% adjustment to IPPS rates is the net result of all adjustments under section 7(b)(1)(B) of the TMA that were continued rather than eliminated in the FFY 2024 IPPS Final Rule.[36]

The Providers claim their FFY 2024 payments are incorrectly low because CMS did not reverse certain adjustments under the TMA for FFY 2024.[37] They argue that § 7(b)(4) of the TMA prohibits adjustments made under § 7(b)(1)(B) for a specific year from being included in determining subsequent years' standardized amounts. They claim that certain adjustments have been made under § 7(b)(1)(B)(ii) and (iii) but carried forward in violation of § 7(b)(4).[38] Specifically, the Providers claim that a positive 0.9412% adjustment for FFY 2024 is necessary to eliminate adjustments made under § 7(b)(1)(B) of the TMA.[39]

The Providers also argue that there is no preclusion of administrative review over this issue:

> [T]here is no statutory bar to administrative or judicial review of the continued application of an adjustment under section 7(b)(1)(B) of the TMA beyond the FFYs specified in section 7(b)(4) of the TMA. Section 7(b)(5) of the TMA precludes administrative or judicial review of determinations and adjustments made under section 7(b). But it does not preclude review of CMS' continued application of adjustments initially applied under section 7(b)(1)(B) beyond FFY 2023. Rather, the continuation of an adjustment under section 7(b)(1)(B) beyond FFY 2023 is expressly prohibited under sections 7(b)(4) and 7(b)(2) of the TMA. To be clear, this appeal does not challenge the calculation or application of any adjustment for FFY 2010, 2011, 2012, or FFY 2014 and the succeeding fiscal years through FFY 2023. Instead, this appeal challenges the failure to eliminate these adjustments for FFY 2024 such that they continue to be applied in FFY 2024 and subsequent fiscal years. Section 7(b)(5) of Pub. L. 110–90, therefore, does not preclude administrative or

[36] *E.g.*, PRRB Case 24-1512GC Statement of the Issue at 1 (Feb. 23, 2024).
[37] *Id.* at 2.
[38] *Id.* at 2-3.
[39] *Id.* at 3.

judicial review of this appeal, and the PRRB properly has jurisdiction in this appeal.[40]

IV. Providers' Request for Expedited Judicial Review:

The Providers filed a request for Expedited Judicial Review ("EJR") on March 1, 2024. They note that the Board granted EJR in group appeals with the same designated representative for TMA adjustments and their impact on FFY 2018 and FFY 2019 payments.[41] They also note that the Providers in the FFY 2018 group appeals thereafter unsuccessfully sought judicial review in federal court,[42] as discussed in further detail, *infra*.

In its Statement of Issue Under Appeal, the Request for EJR repeats the arguments made in the initial request for hearing.[43] The Providers also argue that the Board has jurisdiction over the group appeals. Each has an amount in controversy of at least $50,000 and they were all timely filed following the publication of IPPS rates in the annual IPPS Final Rule, which constitutes a final determination that may be appealed to the Board under this authority.[44] The Providers also make a brief claim that "there is no statute precluding judicial or Board review of the issues presented[.]"[45] They go on to repeat the same arguments from the initial request for hearing as to why TMA § 7(b)(5) does not preclude Board review of this issue.[46]

Since the Board is required to apply the standardized amounts being challenged, the Providers claim it lacks the authority to decide the questions presented. As a result, and since the Board has jurisdiction over the appeals, the Providers request the Board grant EJR.

V. Medicare Contractor's Position:

The Medicare Contractor's designated representative, Federal Specialized Services ("FSS"), filed a response to the Request for EJR on March 8, 2024 indicating that it would be filing Jurisdictional Challenges in cases 24-1519GC, 24-1554G and 24-1512GC.

The Medicare Contractor filed a "Rule 22 Jurisdictional Review" letter in Case 24-1519GC on March 6, 2024 (which was prior to FSS' notification that a challenge would be forthcoming), and FSS filed a Jurisdictional Challenge in on March 13. Similarly, in Case 24-1512GC, the Medicare Contractor filed a "Rule 22 Jurisdictional Review" letter on March 7, as well as a separate notice that a formal Jurisdictional Challenge would be forthcoming. However, no Jurisdictional or Substantive Claim Challenge was ever filed by FSS in Case 24-1512GC. Finally, in Case 24-1554GC, the Medicare Contractor filed an "Initial Jurisdictional Review of Group Appeal" letter which did not note any impediments, and FSS has not filed any Jurisdictional or Substantive Claim challenges.

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[40] *Id.* at 5.
[41] Consolidated Request for Expedited Judicial Review at 2 (Mar. 1, 2024) ("Request for EJR").
[42] *Id.* at n.3.
[43] *Id.* at 2-4.
[44] *Id.* at 5 (citing *Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986)).
[45] *Id.*
[46] *Id.* at 5-6 (*accord supra* n.40 and accompanying text).

Based on the foregoing, the Board issued a Request for Information ("RFI") and Scheduling Order (pursuant to Board Rule 44.6) requesting that the Providers file responses to the challenges in cases 24-1519GC and 24-1512GC.

A. Case 24-1519GC

The Medicare Contractor filed a "Rule 22 Jurisdictional Review" letter in Case No. 24-1519GC on March 6, 2024, and FSS filed a Jurisdictional Challenge in on March 13, 2024.

The Rule 22 Jurisdictional Review letter claimed that there are issues related to two Providers. First, HSHS Good Shepherd Hospital's (Prov. No. 14-0019) last cost report ended August 17, 2023, which predates the FFY 2024 period being appealed in Case No. 24-1519GC. Second, St. Anthony's Memorial Hospital (Prov. No. 14-0032) is a participant in Case No. 24-1519GC, as well as Case No. 24-1554G. The March 13 Jurisdictional Challenge made the same two arguments.

On March 28, the Providers' Representative withdrew HSHS Good Shepherd Hospital from Case No. 24-1519GC. The Board also issued a separate decision in Case No. 24-1554G dismissing St. Anthony's Memorial Hospital (Prov. No. 14-0032) from that case. Based on these developments, the Medicare Contractor rescinded its Jurisdictional Challenge in Case No. 24-1519GC on April 5, 2024.

B. Case 24-1512GC

In Case No. 24-1512GC, the Medicare Contractor filed a "Rule 22 Jurisdictional Review" letter on March 7, 2024. That letter identified a jurisdictional impediment for Centegra Northern Illinois Medical Center (Prov. No 14-0116) ("Centegra"), namely that the Provider was pursuing the same issue in an individual appeal under Case No. 24-1553.

On April 12, 2024, the Providers' Representative filed a Response to the Board's RFI, in which the Board requested that the Providers file responses to the challenges in Cases Nos. 24-1519GC and 24-1512GC. The Response noted that, "[o]n March 8, 2024, the provider representative for the individual appeal [under Case No. 24-1553, *i.e.*, James Ravindran of Quality Reimbursement Services, Inc. ("QRS")] became aware of the Group Appeal [under Case No. 24-1512GC]."[47] In support, the Provider's Representative included as an exhibit a letter from QRS dated April 8, 2024 in which QRS explained that the individual appeal "was mistakenly filed based on a prior year engagement and [Notice of Representation]." The Board notes that QRS withdrew the individual appeal (Case No. 24-1553) on March 11, 2024 without any qualification or explanation. As a result, QRS' April 8, 2024 explanation is a *post-hoc* explanation for its withdrawal.

In the Board's RFI, it did note that, pursuant to Board Rule 4.6.3: "Once an issue is dismissed or withdrawn, the provider may not appeal or pursue that issue in any other case." The Providers insist this Rule should be read to prevent a provider from filing a new appeal (a second time) once the Board has dismissed, or the provider has withdrawn, an issue or case. They correctly note that Centegra was required to pursue the ATRA Unwinding Issue for FFY 2024, if at all, in the CIRP

[47] Providers' Response to Board RFI at 2 (April 12, 2024).

group case since it is under common ownership or control with the Providers in Case No. 24-1512GC.[48]

Centegra's participation in this case is discussed in more detail in section VI. F. (Centegra Participation) of this Notice of Dismissal and Denial of EJR Request.

VI. Board's Decision Regarding the EJR Request:

A. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers are permitted to appeal from a published Federal Register;
- The matter at issue involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- the amount in controversy is, in the aggregate, $50,000 or more.[49]

The Providers have all appealed from the Federal Register, a valid final determination, within the required timeframe and each case has an amount in controversy that exceeds $50,000. The cases also involve a single interpretation of law that is common to each Provider in each group. The Jurisdictional Challenge in Case No. 24-1519GC was withdrawn and the Jurisdictional Challenge in Case No. 24-1512GC is now moot.

Section 5 of the TMA, however, specifically precludes administrative or judicial review of adjustments made thereunder:

> (5) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1878 of the Social Security Act (42 U.S.C. 1395oo) or otherwise of any determination or adjustments made under this subsection.

As noted above, the Providers sought EJR in group appeals with the same designated representative for TMA adjustments and their impact on FFY 2018 and FFY 2019 payments,[50] but were unsuccessful in their pursuit for relief for the FFY 2018 appeals.[51] That case reinforces that the Board is precluded from reviewing the issue appealed in these cases, and is discussed in further detail, below.

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[48] *Id*.
[49] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[50] Request for EJR at 2.
[51] *Id.* at n.3.

B. Fresno Community Hosp. & Med. Ctr. v. Azar[52]

In *Fresno v. Azar*, hundreds of hospitals ("Plaintiffs") argued "that an adjustment of at least +1.1588% was required in order for the Secretary not to continue unlawfully a prior -0.7% recoupment adjustment made in fiscal year 2017."[53] The Secretary moved to dismiss the claims in the Complaint, *arguing that Congress has* ***prohibited*** *review of the Secretary's determinations and adjustments made under § 7(b) of the TMA*.[54] The U.S. District Court for the District of Columbia ("D.C. District Court") agreed with regard to three of five counts, also finding that the claims did not fit within the narrow *ultra vires* exception to Congress' bar on judicial review. Two claims survived the Motion to Dismiss as they pertained to the Secretary's failure to exercise his "exceptions and adjustments" discretion under 42 U.S.C. § 1395ww(d)(5)(I), not adjustments under TMA § 7(b).[55]

The five counts brought by the Providers in *Fresno v. Azar* were as follows:

1. The Secretary's failure to restore the additional -0.7% ATRA reduction in 2018 adjustment was unlawful based on the Administrative Procedure Act ("APA"), the Medicare Act, and other statutes;
2. The Secretary violated the APA, the Medicare Act, and other statutes by failing to explain his reasons for not offsetting the additional -0.7% recoupment adjustment in 2018 through his "exceptions and adjustments" discretion;
3. The Secretary violated the APA, Medicare Act, and other statutes by failing to adequately address commenters' questions and requests concerning the use of the Secretary's "exceptions and adjustments" discretion in implementing the 2018 adjustment;
4. The Plaintiffs requested that the Court mandamus the Secretary to restore the additional -0.7% adjustment which was made in 2017; and
5. Under the All Writs Act, the Plaintiffs argued that they were entitled to an offsetting positive adjustment of +0/7% for fiscal year 2018.[56]

The Plaintiffs made three arguments in support of these claims and that they were not precluded from review. First, that they were not seeking to review the +0.4588% positive adjustment for FY 2018 but rather the wrongful continuation of a -0.7% recoupment adjustment into FY 2018. Second, that the court could review the +0.4588% positive adjustment and the continuation of the -0.7% recoupment adjustment because it was plainly unlawful. Third, and finally, that even if other claims are precluded from review, the claims challenging the Secretary's failure to exercise his "exceptions and adjustments" discretion are not barred by the preclusion statute.

Regarding the first argument that the Plaintiffs' challenge was not to the +0.4588% positive adjustment for FY 2018 but rather the wrongful continuation of a -0.7% recoupment adjustment,

[52] 370 F.Supp.3d 139 (D.D.C. 2019) ("*Fresno v. Azar*").
[53] *Id.* at 142.
[54] *Id.*
[55] *Id.* at 143.
[56] *Id.* at 148.

the D.C. District Court disagreed and noted that "crafty pleading" and "clever phrasing" could not avoid the bar on judicial review.[57] It reasoned:

> Plaintiffs' assertion that the Secretary improperly determined that TMA § 7(b)(2) permitted him to continue a -0.7% recoupment adjustment into fiscal year 2018 still challenges a determination or adjustment made under TMA § 7(b). Accordingly, judicial review is barred.
>
> ****
>
> In order to grant Plaintiffs' requested relief, the Court would need to order the Secretary to make a different adjustment for 2018 than the one that he decided was required. To order the Secretary to make a different adjustment than the one he intended would necessarily require the Court to review an adjustment made under TMA § 7(b), which is prohibited by the preclusion statute. *See* TMA § 7(b)(5). Accordingly, Plaintiffs' claims fall under the clear language of the TMA's preclusion statute.[58]

The Plaintiffs also claimed that continuing the -0.7% recoupment adjustment into FY 2017 violated TMA § 7(b)(2), which states that an adjustment made under § 7(b)(1)(B) for discharges in a year cannot be included in the determination of standardized amounts for subsequent years. Since the FY 2017 recoupment adjustment was -1.5% instead of -0.8%, the implementation of a +0.4588 adjustment as mandated by Congress fell short when failing to take into account the excess -0.7%. Thus, since the adjustment was unlawful, the Plaintiffs claimed the preclusion provision did not apply.[59]

The D.C. District Court disagreed, finding that TMA § 7(b)(5) precluded review of *any* determination or adjustment made under § 7(b), not just "proper" ones.[60] More importantly, this argument would completely subsume the *ultra vires* doctrine, which specifically deals with adjustments made "in violation" of a law giving agencies authority:

> Accordingly, Plaintiffs' argument that the Secretary's +0.4588% adjustment violated TMA § 7(b)(2) by leaving in place a recoupment adjustment from 2017 does not overcome the TMA's preclusion statute. Instead, Plaintiffs' argument should be addressed under the ultra vires doctrine[.][61]

The Court then turned to the Plaintiffs' second argument, that the continuation of the -0.7% recoupment adjustment was plainly unlawful – or that the Secretary had acted *ultra vires*:

> Even if the preclusion statute applies to Plaintiffs' claims, the Court may still be able to review those claims under the ultra vires

[57] *Id.* at 149.
[58] *Id.* at 150.
[59] *Id.*
[60] *Id.*
[61] *Id.* at 152.

> doctrine. Congress has not and cannot limit judicial review to correct a patently unlawful agency action. Under the ultra vires doctrine, an agency action is open to judicial review, even in the face of an applicable preclusion statute, when it "patently misconstrues a statute, disregards a specific and unambiguous statutory directive, or violates a specific command of a statute."[62]

The Court acknowledged the Plaintiffs' argument: the +0.4588% adjustment required by TMA § 7(b)(1)(B)(iii) for FY 2018 was predicated on the 2014 to 2017 recoupment adjustments totaling only -3.2%, but there had been an additional -0.7% recoupment adjustment in 2017. The FY 2018 +0.4588% adjustment did not "remove" the FY 2017 -0.7% recoupment adjustment, which violated TMA § 7(b)(2) by allowing adjustments from prior years to be included in adjustments for subsequent years. Since the adjustment violates TMA § 7(b)(2), the Plaintiffs reasoned that it is "plainly unlawful" or *ultra vires* and subject to judicial review, despite the preclusion provision at TMA § 7(b)(5).[63]

The Court disagreed, noting that TMA § 7(b)(1)(B)(iii) *explicitly* required the Secretary to make the +0.4588% adjustment, and *only* that adjustment, for FY 2018. It also explained that this very specific mandate was enacted later in time than the general prohibition on continuing recoupment adjustments found in TMA § 7(b)(2). The Court concluded:

> The Secretary's decision to follow the explicit Congressional mandate to implement a +0.4588% adjustment and "not make the adjustment . . . that would otherwise apply" in 2018, which Congress passed with full knowledge of the greater-than-previously-estimated 2017 recoupment adjustment, was not an ultra vires act.[64]

Thus, the D.C. District Court found that the preclusion of administrative or judicial review applied to counts 1, 4, and 5 of the Providers' Complaint. Counts 2 and 3, however, concerned whether the "Secretary failed to adequately explain the rationale for[, and failing to address commenters' questions and requests regarding,] not applying his 'exceptions and adjustments' discretion under 42 U.S.C. § 1395ww(d)(5)(I) to make an additional +0.7% adjustment in FU 2018, offsetting the FY 2017 -0.7% recoupment adjustment."[65] *The Court noted it could not review a claim that was "inextricably intertwined" with barred claims*.[66] The Secretary argued that he did not use his "exceptions and adjustments" discretion because he determined a +0.7% adjustment was prohibited under TMA § 7(b)(1)(B)(iii).[67] However, the Court found:

> It is not clear from the 2018 final rule, or from any other source provided by Defendant, that the Secretary considered whether or not to grant a +0.7% adjustment under the his [*sic*] "exceptions and

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[62] *Id.* (citations omitted).
[63] *Id.* at 153.
[64] *Id.*
[65] *Id.* at 156-157.
[66] *Id.* at 157.
[67] *Id.*

> adjustments" discretionary authority, despite comments urging him to do so.[68]

The Court acknowledged that perhaps the Secretary declined to exercise his discretionary authority *because he considered it to be prohibited under the TMA, thus making Counts 2 and 3 "inextricably intertwined" with the other, precluded claims*. However, the court found that the Secretary failed to prove that and, as a result, it had jurisdiction over these two, specific claims.[69]

C. Fresno Community Hosp. & Med. Ctr. v. Cochran[70]

The Plaintiffs appealed to the U.S. Circuit Court for the District of Columbia ("D.C. Circuit") which found that TMA § 7(b)(5) defeats the presumption favoring review of agency action, so the only question was whether the challenged action was "the sort shielded from review."[71] It made the same finding as the D.C. District Court: that labeling the challenge as a continued inclusion or failure to reverse a -0.7% adjustment is still, in reality, *a challenge to an "adjustment"* ***which is barred by TMA § 7(b)(5)***.[72]

The D.C. Circuit next considered the Plaintiffs' argument that the -0.6% adjustment should be set aside as *ultra vires*, noting that they had the burden of showing "that the Secretary flouted a clear, specific, statutory command."[73] The Plaintiffs made the same argument as before the D.C. District Court: TMA § 7(b)(2) bars the Secretary from allowing any recoupment adjustment to continue into a subsequent year, and by carrying over the -0.7% adjustment into FY 2018, the Secretary violated an explicit statutory prohibition.[74] The D.C. Circuit Court disagreed, noting that the Plaintiffs did not object to *other* adjustments being carried over in prior fiscal years. Ultimately, the D.C. Circuit found that TMA § 7(b)(2) did not actually forbid the Secretary from carrying over adjustments and *affirmed the D.C. District Court's decision*.

D. Expedited Judicial Review

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

E. Preclusion of Board Jurisdiction

As noted above and in both *Fresno v. Azar* and *Fresno v. Cochran*, TMA § 7(b)(5) generally prohibits administrative and judicial review of any determinations or adjustments made pursuant

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[68] *Id.* at 158.
[69] *Id.*
[70] 987 F.3d 158 (D.C. Cir. 2021) ("*Fresno v. Cochran*").
[71] *Id.* at 161 (quoting *Amgen Inc. v. Smith*, 357 F.3d 103, 113 (D.C. Cir. 2004).
[72] *Id.* at 161-162.
[73] *Id.* at 162 (citing *Nyunt v. Chairman, Broad Bd. Of Govs*., 589 F.3d, 449 (D.C. Cir. 2009)).
[74] *Id.*

to the TMA. The Providers in these appeals "challenge their FFY 2024 IPPS payments on the grounds that those payments were (and continue to be) improperly reduced due to the **failure to eliminate the adjustments under paragraph 7(b)(1)(B) of the TMA**. . . ."[75] They also claim that TMA § 7(b)(5) "does not preclude review of CMS' **continued application of adjustments initially applied** under section 7(b)(1)(B) beyond FFY 2023."[76]

The Courts directly addressed these arguments in both *Fresno v. Azar* and *Fresno v. Cochran* and found that the distinction between challenging an adjustment and challenging the failure to eliminate an adjustment amounts to nothing more than "crafty pleading" and "clever phrasing" that cannot avoid the bar on judicial review.[77]

The only claims that survived in *Fresno v. Azar* were those alleging the Secretary should have applied his "exceptions and adjustments" discretion under 42 U.S.C. § 1395ww(d)(5)(I) to make an additional +0.7% adjustment in 2018. The Providers in this group appeal have not cited 42 U.S.C. § 1395ww(d)(5)(I) or discussed the Secretary's "exceptions and adjustments" discretion in any capacity. Board Rule 7.2.1 (Nov. 2021) requires that, for each issue raised in an appeal request, a Provider must submit a concise issue statement describing, *inter alia*, the controlling authority, why the adjustment is incorrect, and the basis for jurisdiction before the Board. The Providers failed to make this argument in their requests for hearing or Request for EJR and, as such, the Board will not address or consider it as part of the appeal.

Based on the foregoing, the Board finds that it lacks substantive jurisdiction to review the issue appealed in Case Numbers 24-1419GC and 24-1512GC and is therefore dismissing these two CIRP cases (and all the participants therein) and denying their respective Requests for EJR for the same reason. 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.

F. Centegra Participation

Finally, as set forth herein, the Board is dismissing Case No. 24-1512GC for lack of jurisdiction, and this dismissal encompasses *Centegra Northern Illinois Medical Center (Prov. No 14-0116)* as a participant in that CIRP group. The Board is not ***separately*** dismissing Centegra from that CIRP group as explained below.

In filing the appeal on February 23, 2024 on behalf of Centegra appealing ***only*** one issue, the ATRA issue for FFY 2024 (Case No. 24-1553), Mr. Ravindran of QRS certified: "I certify that I am authorized to submit an appeal on behalf of the listed provider."[78] However, that certification clearly was ***false*** as the letter of representation attached to that appeal was dated ***four years earlier*** (*i.e.*, February 12, 2020) and pertained to a federal fiscal year ***four years earlier*** (*i.e.*, FFY 2020).

QRS later withdrew the Centegra individual appeal (Case No. 24-1553) on March 11, 2024 without any qualification or explanation. While QRS did not qualify the withdrawal, the Board is

[75] *E.g.*, PRRB Case 24-1499GC Statement of the Issue at 1 (Feb. 14, 2024) (emphasis added).
[76] *Id.* at 5.
[77] *Fresno v. Azar* at 149.
[78] *See* Board Rule 6.5, 12.10. *See also* 42 C.F.R. § 405.1881.

accepting QRS' belated explanation that it was *not authorized to file the appeal* after reviewing the record in Case No. 24-1553. The Board's decision to not dismiss Centegra from Case No. 24-1512GC as a duplicate appeal[79] is based solely on the fact that QRS was ***not authorized*** to file the individual provider appeal under Case No. 24-1553 and, ***as such, the filing was null and void in the first instance***.

The Board notes that QRS' ***unauthorized filing of the appeal under Case No. 24-1553*** *is not an isolated incident. Under separate cover, the Board is dismissing multiple ATRA appeals that QRS was not authorized to file and, therefore, null and void in the first instance. The Board has carbon copied Mr. Ravindran of QRS and hereby* ***admonishes QRS for its flagrant violation of Board Rules by filing an unauthorized appeal and admonishes Mr. Ravindran of QRS for his false certification***.

Board Members Participating:

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

FOR THE BOARD:

5/10/2024

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

cc: Pamela VanArsdale, National Government Services, Inc. (J-6)
Wilson Leong, FSS
James Ravindran, Quality Reimbursement Services, Inc.

[79] Notwithstanding, as set forth herein, the Board is dismissing Case No. 24-1512GC for lack of jurisdiction and this dismissal encompasses Centegra as a participant in that CIRP group.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran
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RE: ***Board Decision*** **– SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**

Weatherford Regional Medical Center (Provider Number 45-0203)
FYE: 09/30/2017
Case Number: 22-0812

Dear Mr. Ravindran and Mr. Lamprecht,

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

Background:

A. ***Procedural History for Case No. 22-0812***

On **August 26, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2017.

On **February 17, 2022**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

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

The Provider is commonly owned/controlled by Community Health Systems, Inc. (hereinafter "Community Health") and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **September 8, 2022**, the Provider transferred Issues 2, 4 and 5 to Community Health groups. As a result, there are two (2) remaining issues in this appeal: Issue 1 (DSH Payment/SSI Percentage (Provider Specific)) and Issue 3 (DSH Payment – Medicaid Eligible Days).

On **February 18, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

On **October 5, 2022**, the Provider timely filed its preliminary position paper.

On **January 24, 2023**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 3.

On **January 27, 2023**, the Medicare Contractor timely filed its preliminary position paper.

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

On **March 14, 2023**, the Provider's representative filed a Jurisdictional response on March 14, 2023.

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

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

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

[4] (Emphasis added).

> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[5]

The group issue statement in Case No. 20-0997GC, CHS CY 2017 DSH SSI Percentage CIRP Group, to which the Provider transferred Issue 2 reads, in part:

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

[5] Issue Statement at 1 (Feb. 17, 2022).

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

On October 5, 2022, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Texas and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Texas and has learned that similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[7]

C. Description of Issue 3 in the Appeal Request

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

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

[6] Group Issue Statement, Case No. 20-0997GC.
[7] Provider's Preliminary Position Paper at 8-9 (Oct. 5, 2022).

Statement of the Legal Basis

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

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

Audit Adjustment Number(s): 5,28,29,S-D

Estimated Reimbursement Amount: $27,711[8]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the Jewish Hospital case[9] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[10]

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue. First, the MAC argues that: "[T]he Provider has abandoned the issue of SSI realignment and, therefore, it should be considered withdrawn. The Provider did not brief this issue within its preliminary position paper."[11] The MAC also argues the appeal is premature:

The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital

[8] Appeal Request at Issue 3.
[9] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[10] Provider's Preliminary Position Paper at 7.
[11] Jurisdictional Challenge at 7 (Jan. 24, 2023).

> 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.[12]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH SSI Percentage issue in PRRB Case No. 20-0997GC are considered the same issue by the Board.[13]

Finally, the MAC argues "the Provider did not file a **complete** preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3."[14] The MAC posits that the Provider "failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its Preliminary Position Paper."[15]

Issue 3 – DSH Payment – Medicaid Eligible Days

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

> The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.
>
> Within its Provider's preliminary position paper, the Provider makes the broad allegation, ". . . the Provider contends that the total number of days reflected in its' [sic] 2017 cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid

[12] *Id*.
[13] *Id*. at 4-6.
[14] *Id*. at 8.
[15] *Id*. at 9.

> Percentage calculation at issue. The Provider merely repeats their appeal request.[16]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[17] Further, Board Rule 5.5.1 requires that Board deadlines continue to be met irrespective of a change in the case representation. The Provider's response to the MAC's Jurisdictional Challenge was not timely. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Therefore, the Board will not consider the arguments made in the Provider's March 14th, 2023 filing.

Board Analysis and Decision:

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

A. DSH Payment/SSI Percentage (Provider Specific)

The jurisdictional analysis for Issue 1 has 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. As set forth below, the Board should dismiss both aspects of Issue 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 PRRB Case No. 20-0997GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[18] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare

[16] *Id*. at 11.
[17] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[18] Issue Statement at 1.

Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[19] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[20]

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 the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-0997GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[21], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 20-0997GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[22] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-0997GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-0997GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (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

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[19] *Id.*
[20] *Id.*
[21] PRRB Rules v. 3.1 (Nov. 2021).
[22] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[23]

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule,

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

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

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[23] (Emphasis added).

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

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

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 20-0997GC are the same issue.[26] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal. Further, the Provider's cost reporting period is congruent with the Federal fiscal year and, therefore, realignment would have no effect on reimbursement.

B. DSH Payment – Medicaid Eligible Days

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

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

[24] Last accessed May 10, 2024.
[25] Emphasis added.
[26] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Community Health CIRP group per 42 C.F.R. § 405.1837(b)(1).

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[27]

Board Rule 7.3.1.2 states:

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

In this case, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

As of this writing, the Provider has still not submitted a listing of Medicaid Eligible Days. There has been no explanation for the delay in the submission. The Board finds the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it could not timely produce those documents, as required by the regulations and the Board Rules.[28]

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[29]

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[27] Provider's Preliminary Position Paper at 8.
[28] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.
[29] (Emphasis added).

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

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

Similarly, with regard to position papers,[30] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[31] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

Similarly, consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[32]

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

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

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

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that

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

> the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

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

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

The Board concurs with the Medicare Contractor that the Provider is required to timely identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled, consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[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. Based on the record before the Board, the Board finds that the Provider has failed to timely provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what caused the delay, in accordance with Board Rule 25.2.2. Indeed, based on these facts, plus the Provider's failure to timely respond to either the Medicare Contractor's request for the listing and the Medicare Contractor's Jurisdictional Challenge on this issue, the Board assumes that the Provider has abandoned this issue.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25 related to timely identifying the days in dispute and the submission of documentary evidence required to support its claims or to describe why said evidence is unavailable.[34]

Accordingly, the Board dismisses the DSH Payment – Medicaid Eligible Days issue.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 20-0997GC and 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

[33] (Emphasis added).
[34] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.

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. 22-0812 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

5/10/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision*** **– SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**

Novant Health Thomasville Medical Center (Provider Number 34-0085)
FYE: 12/31/2018
Case Number: 23-1164

Dear Mr. Ravindran and Ms. Johnson,

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

Background:

A. ***Procedural History for Case No. 23-1164***

On **September 20, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2018.

On **March 17, 2023**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained seven (7) issues:

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

[1] On October 31, 2023, this issue was transferred to PRRB Case No. 23-1677GC.
[2] On October 31, 2023, this issue was transferred to PRRB Case No. 23-1678GC.
[3] On October 31, 2023, this issue was transferred to PRRB Case No. 23-1695GC.

6. DSH Payment – Medicaid Fraction – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[4]
7. Standardized Payment Amount[5]

As the Provider is commonly owned/controlled by Novant Health and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **August 8 and October 31, 2023**, the Provider transferred Issues 3, 4, 5, 6 and 7 to Novant Health groups. There are two (2) remaining issues in the appeal: Issue 1 (DSH Payment/SSI Percentage (Provider Specific)) and Issue 2 (DSH Payment – Medicaid Eligible Days).

On **March 20, 2023**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

On **November 13, 2023**, the Provider timely filed its preliminary position paper.

On **February 12, 2024**, the Medicare Contractor timely filed its preliminary position paper.

On **February 16, 2024**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 2.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 23-1677GC

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

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

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[4] On October 31, 2023, this issue was transferred to PRRB Case No. 23-1695GC. Subsequently, due to a bifurcation action by the Board on January 30, 2024, this issue was transferred to PRRB Case No. 24-0965GC.
[5] On August 8, 2023, this issue was transferred to PRRB Case No. 23-0412GC.
[6] (Emphasis added).

> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[7]

The group issue statement in Case No. 23-1677GC, Novant Health CY 2018 DSH SSI Unduly Narrow Definition of SSI Entitlement CIRP Group, to which the Provider transferred Issue 3 reads, in part:

> **Statement of the Issue:**
>
> The Provider(s) protest(s) CMS's policy of excluding unpaid SSI days from the numerator of the Medicare fraction. Despite CMS's seemingly contrary policy of treating unpaid Part A days as days entitled to benefits under Part A, CMS requires that a beneficiary be paid SSI benefits (or "covered" by SSI) during the period of his or her hospital stay in order for such days to be considered "entitled to supplemental security income benefits" and included in the numerator of the SSI fraction.
>
> CMS does not include days in the numerator of the SSI fraction when individuals were eligible for SSI but did not receive a SSI payment during their hospitalization for such reasons as failure of the beneficiary to have a valid address, representative payee problems, Medicaid paying for more than 50 percent of the cost of care in a medical facility, or the period of hospitalization is during the first month of eligibility before a cash payment is made. None of these reasons affect the patient's indigency.
>
> CMS's policy of applying different interpretations to the same term, "entitled," used in the same sentence of the statute is the epitome of arbitrary and capricious agency action and must be reversed. *See Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 20 n.1 (D.C. Cir. 2011) (Kavanaugh, J. concurring) ("HHS thus interprets the word 'entitled' differently within the same sentence of the statute. The only thing that unifies the Government's inconsistent definitions of this term is its apparent policy of paying out as little money as possible. I appreciate the desire for frugality, but not in derogation of law."); *see also Walter O. Boswell Mem'l*

[7] Issue Statement at 1 (Mar. 17, 2023).

> *Hosp. v. Heckler*, 749 F.2d 788, 799 (D.C. Cir. 1984) ("It would be arbitrary and capricious for [the Secretary] to bring varying interpretations of the statute to bear, depending upon whether the result helps or hurts Medicare's balance sheets. . . .").
>
> In rulemaking, commenters specifically requested that CMS include other payment codes that identified "entitled" individuals, but the Secretary nonetheless adopted a policy of including only codes that identify people receiving actual SSI cash payment. Id. For example, commenters requested that codes S06 (suspended payment because recipients' whereabouts are unknown based on "undeliverable checks, mail, reports of change or change of address") and S07 ("checks returned for reasons that are unclear or for reasons other than address or a representative payee problem") be included. CMS refused the suggestion.
>
> Because CMS's treatment of unpaid Part A days as "days entitled to benefits under part A" was upheld by the Supreme Court in *Becerra v. Empire Health Found., for Valley Hosp. Med. Ctr.*, 597 S.Ct. June 24, 2022 WL 227680 (2022), CMS must apply the same interpretation of the word "entitled" in the context of "entitled to supplemental security income benefits." By doing so, CMS will necessarily have to widen the number of SSI status codes it treats as being "entitled to SSI benefits" to encompass not just the three codes CMS currently includes, but all codes that reflect *eligibility* for SSI benefits.[8]

On November 13, 2023, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Issue #1: Provider Specific**
>
> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the

[8] Group Issue Statement, Case No. 23-1677GC.

> provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[9]

C. Description of Issue 2 in the Appeal Request

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

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

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

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[9] Provider's Preliminary Position Paper at 8-9 (Nov. 13, 2023).
[10] Appeal Request at Issue 2.
[11] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).

payment adjustment.[12] The Provider then, for the first time in this appeal, states it is seeking reimbursement for section 1115 waiver days as a part of the Medicaid eligible day issue. Specifically, the Provider states:

> [M]edicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days) are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).[13]

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue. First, the MAC argues that the Provider has abandoned the SSI realignment sub-issue: "[T]he Provider has abandoned the issue of SSI realignment and, therefore, it should be considered withdrawn. The Provider did not brief this issue within its Preliminary Position Paper."[14] The MAC also argues the appeal is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[15]

[12] Provider's Preliminary Position Paper at 9.
[13] *Id.* at 9-10.
[14] Jurisdictional Challenge at 6 (Feb. 16, 2024).
[15] *Id*. at 6-7.

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH/SSI Unduly Narrow Definition of SSI Entitlement issue in PRRB Case No. 23-1677GC are considered the same issue by the Board.[16]

Finally, the MAC argues "the Provider did not file a **complete** preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3."[17] The MAC posits that the Provider "failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper."[18]

Issue 2 – DSH Payment – Medicaid Eligible Days

The MAC contends that the Provider is attempting to untimely and improperly add the issue of Section 1115 waiver days as a sub-issue via its preliminary position paper, filed on November 13, 2023.[19] The MAC asserts that "[p]rior to the preliminary position paper, the Provider had not raised the issue of section 1115 waiver days within this appeal. The Provider's attempt to add the Section 1115 waiver days issue falls well-beyond the deadline to add a new issue to the appeal."[20] The MAC argues that the Provider's attempt to informally add the Section 1115 waiver days issue within its preliminary position paper is improper and untimely, citing 42 C.F.R. § 405.1835(e), which governs when specific Medicare payment issues may be added to the original hearing request, including a timeframe of no later than 60 days after the expiration of the applicable 180-day deadline to file an appeal.[21]

The MAC contends that the section 1115 waiver days issue is one component of the DSH issue and that the section 1115 waiver days issue is a separate and distinct issue from Medicaid eligible days issue and must be identified and appealed separately.[22]

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

> The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents that are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.

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[16] *Id*. at 4-6.
[17] *Id*. at 7 (Emphasis added).
[18] *Id*. at 9.
[19] *Id*. at 13.
[20] *Id.* at 14.
[21] *Id*. at 13.
[22] *Id*. at 14.

> Within the Provider's preliminary position paper, the Provider makes the broad allegation, ". . . the Provider contends that the total number of days reflected in its 2018 cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats their appeal request.[23]

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

Board Analysis and Decision:

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

A. DSH Payment/SSI Percentage (Provider Specific)

The jurisdictional analysis for Issue 1 has several relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period; and 3) the Provider incorporating the arguments from *Advocate Christ*[25] into its appeal. As set forth below, the Board should dismiss all aspects of Issue 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

[23] *Id*. at 11-12.
[24] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[25] The Provider has included the Appellants' Reply Brief in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214 (D.C. Cir.), which is on appeal from the decision in *Advocate Christ Med. Ctr. V. Azar*, 17-cv-1519 (TSC), 2022 WL 2064830, (D.D.C. June 8, 2022).

duplicative of the DSH/SSI Unduly Narrow Definition of SSI Entitlement issue that was transferred to Group Case No. 23-1677GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[26] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[27] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[28]

The Provider's DSH/SSI Unduly Narrow Definition of SSI Entitlement issue in group Case No. 23-1677GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage and the DSH SSI Percentage is improper due to a number of factors. Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Unduly Narrow Definition of SSI Entitlement issue in Case No. 23-1677GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6,[29] the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 23-1677GC, 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.[30] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 23-1677GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 23-1677GC, but instead refers to systemic *Baystate* data matching

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[26] Issue Statement at 1.
[27] *Id.*
[28] *Id.*
[29] PRRB Rules v. 3.1 (Nov. 2021).
[30] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

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

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[31]

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

[31] (Emphasis added).

> set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year.

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

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh. [32]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[33]

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 23-1677GC are the same issue.[34] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

Additionally, in its Preliminary Position Paper, the Provider stated, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3)."[35] The Board finds that this purported argument does not comply with the regulations and Board rules to *fully* develop the Provider's position in the Preliminary Position Paper, because the Provider merely lists a case name and does not explain further what the arguments are that it would like to incorporate into its appeal.

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[36]

---

[32] Last accessed May 10, 2024.
[33] Emphasis added.
[34] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Novant Health CIRP group per 42 C.F.R. § 405.1837(b)(1).
[35] Provider's Preliminary Position Paper at 8-9.
[36] (Emphasis added).

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

2. Second Aspect of Issue 1

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

1. *Section 1115 Waiver Days*

The Board finds that the 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 March of 2023 and the regulations required the following:

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

> determined differently for each disputed item…[37]

Board Rule 7.2.1 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 relevant adjustment(s), including the adjustment number(s),
> - the controlling authority (e.g., specific regulation, Federal Register issuance, manual provision, or Ruling),
> - why the adjustment(s) is incorrect,
> - how the payment should be determined differently,
> - the reimbursement effect, and
> - the basis for jurisdiction before the Board.

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

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include, but are not limited to:
>
> …
>
> - ***Section 1115 waiver days (program/waiver specific)[38]***

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

[37] 42 C.F.R. § 405.1835(b).
[38] (Bold and italic emphasis added).
[39] *See* 73 Fed. Reg. 30190 (May 23, 2008).

> . . .
>
> (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.[40] 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 beneficiaries enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction.[20] In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

[40] 65 FR 47054, 47087 (Aug. 1, 2000).

> **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*

According to its Appeal Request, the Provider asserts that all Medicaid Eligible Days were not included in the calculations of the DSH calculation. The Provider failed to include a list of additional Medicaid eligible days they expect to be included in their Medicaid percentage and DSH computations, with their appeal request.

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[41]

Board Rule 7.3.1.2 states:

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

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

[41] Provider's Preliminary Position Paper at 10.

supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[42]

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[43]

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

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

Similarly, with regard to position papers,[44] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[45] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

Similarly, consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;

[42] *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.
[43] (Emphasis added).
[44] The minimum requirements for Final Position Paper narratives and exhibits sre the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[45] (Emphasis added).

> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[46]

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

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

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

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

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

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

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled, consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[47] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the

[46] (Emphasis added).
[47] (Emphasis added).

Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. Indeed, without any days identified in the position paper filing, the Board assumes that there are no days or amount in dispute for this issue.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or to describe why said evidence is unavailable.[48]

Accordingly, the DSH Payment – Medicaid Eligible Days issue is dismissed.

****

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. 23-1677GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses 1115 waiver day issue as the Provider failed to appeal this issue in their initial appeal request. Additionally, the Board dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue, in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 23-1164 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

5/10/2024

X Kevin D. Smith, CPA

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

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

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

RE: ***Dismissal of Unauthorized Participants & Duplicate Participant; and Scheduling Order***
QRS FFY 2024 ATRA IPPS Payment Reduction Group
PRRB Case No. 24-1379G

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the "Board") has reviewed the above-captioned *optional* group after having noted discrepancies in the Representative letters for various providers in the group involving the group representative, James Ravindran of Quality Reimbursement Services, Inc. ("QRS"). The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

On **February 20, 2024**, QRS filed a group appeal request to establish Case No. 24-1379G entitled "QRS FFY 2024 ATRA IPPS Payment Reduction Group". The appeal was based on the FY 2024 IPPS Final Rule published in the Federal Register on August 28, 2023.[1] The group is not yet designated to be fully formed and currently includes twenty-three (23) participants who joined via direct-add requests.[2] The time to add participants to the group by appealing from the August 28, 2023 has tolled as the one hundred eighty (180) day period to appeal that final rule expired on Monday, February 26, 2024 as discussed *infra*.

For the following nine (9) participants, QRS included Representative letters with their direct-add requests that ***failed*** to authorize QRS to represent them on the ATRA issue ***for the year under appeal in the group*** (*i.e.,* FFY 2024).[3] Indeed, seven (7) of these inapplicable Representative letters were dated *2019* (over four (4) years earlier) and clearly could ***not*** have been executed in anticipation of the FFY 2024 ATRA issue:

[1] 88 Fed. Reg. 58640 (Aug. 28, 2023).
[2] Between March 7, 2024 and March 19, 2024, QRS withdrew Olympic Medical Center, Bristol Hospital, and University Hospital from the group.
[3] There also was an issue involving Participant No. 22, Regional Health Rapid City Hospital (Prov. No. 43-0077) since the original letter of representation that QRS filed for this participant was dated November 18, 2019 and related only to FFY 2020 (and not FFY 2024). However, on February 26, 2024, (the deadline for filing an appeal from the Final Rule), QRS corrected its error by filing a supplemental letter dated February 24, 2024 confirming QRS is authorized to represent it for FFY 2024. As the letter was executed and then filed with the Board before the filing deadline (as well as before the March 1, 2024 RFI discussed *infra*), there is no question regarding QRS' representation of this participant.

- **Participant No. 16**, Bristol Hospital (Prov. No. 07-0029) – Representative letter dated March 8, 2023 for only FFYs 2012 through 2023.[4]
- **Participant No. 18**, Parkview Medical Center (Prov. No. 06-0020) – Representative letter dated November 13, 2019 for only FFY 2020.
- **Participant No. 19**, Bethesda Hospital East (Prov. No. 10-0002) – Representative letter dated January 17, 2019 for only FFY 2019.
- **Participant No. 20**, Jupiter Medical Center (Prov. No. 10-0253) – Representative letter dated September 17, 2019 for only FFY 2020.
- **Participant No. 21**, University Hospital (Prov. No. 11-0028) – Representative letter dated September 19, 2019 for only FFY 2020.[5]
- **Participant No. 23**, University of Utah Hospitals and Clinics (Prov. No. 46-0009) – Representative letter dated September 19, 2019 for only FFY 2020.
- **Participant No. 24**, Olympic Medical Center (Prov. No. 50-0072) – Representative letter dated September 18, 2019 for only FFY 2020.[6,7]
- **Participant No. 25**, Halifax Medical Center (Prov. No. 10-0017) – Representative letter dated February 14, 2019 for only FFY 2019.
- **Participant No. 26**, John D. Archbold Memorial Hospital (Prov. No. 11-0038) – Representative letter dated February 2, 2018 for only FFY 2018.

On **March 1, 2024**, the Board issued a request to QRS that it file correct/proper letters of representation for the various providers in the subjection optional group within fifteen (15) days.

On **March 7** and **March 11, 2024**, QRS ***withdrew*** Participant No. 24, Olympic Medical Center (Prov. No. 50-0072) ***and*** Participant No. 16, Bristol Hospital (Prov. No. 07-0029), respectively.

On **March 13, 2024**, QRS filed a Group Supplement with the "corrected" Representative letter for Participant No. 23, University of Utah Hospitals and Clinics (Prov. No. 46-0009). While the Representative letter pertains to FFY 2024, it was executed on March 5, 2024, well after both original February 23, 2024 request to add this participant to the group *and* the February 26, 2024 deadline for filing appeals from the FFY 2024 final rule (as discussed *supra*).

At 4:19 pm, on **March 15, 2024**, ***the date of the deadline set in the Board's Request for Corrected Representative Letters***, QRS requested the Board grant a fifteen (15)-day extension, noting that it had already addressed two participants by filing new representation letters[8] and

[4] Bristol Hospital was withdrawn from the group on March 11, 2024.
[5] University Hospital was withdrawn from the group on March 19, 2024.
[6] The original upload titled "Representative Letter Document" filed with Olympic Medical Center's February 23, 2024 "Direct Add" was a calculation of the reimbursement impact. QRS filed a Representative Letter a few minutes later using the Group Supplement button in OH CDMS. The Representative Letter referenced FFY 2020.
[7] Olympic Medical Center was withdrawn from the group on March 7, 2024.
[8] One of those is discussed in *supra* note 4 and the other pertained to Participant No. 23, University of Utah Hospitals & Clinics, as discussed *supra*.

withdrawing two (2) participants. As a result of the two (2) withdrawals, the extension would apply to only eight (8) participants – Participant Nos. 18, 19, 20, 21, 22, 23, 25, and 26.

On **March 19, 2024**, *four* (*4) days after the March 15th deadline had passed*, QRS uploaded a new representative letter for Participant No. 19, Bethesda Hospital (Prov. No. 10-0002) using the Group Supplement button in OH CDMS. While the Representative letter pertains to FFY 2024, it was executed on March 14, 2024, well after both the original February 23, 2024 request to add this participant to the group *and* the February 26, 2024 deadline for filing appeals from the FFY 2024 final rule (as discussed *supra*).

On **March 19, 2024**, QRS ***withdrew*** Participant No. 21, University Hospital (Prov. No. 11-0028) from the group.

On **March 26, 2024**, the Board responded to QRS' request for Additional Time to Provide Corrected Representation Letters. The Board denied the extension, noting that "[A] letter of authorization is required to be included with the appeal request to confirm that the representative is in fact authorized to file the appeal for the relevant providers in the first instance. Here, QRS did not include proper letters of representation but rather the letters that are dated several years ago and pertain to appeals filed with the Board for other earlier FFYs." The Board advised that the appeal was being reviewed and a ruling would be issued under separate cover regarding QRS' authorization and regarding whether the Board has substantive jurisdiction over this group.

Board Rules:

42 C.F.R. § 405.1883 addresses the authority of a representative and states in pertinent part:

> A representative appointed by a provider . . . may accept or give on behalf of the provider or other party any request or notice relative to any proceeding before a hearing officer or the Board. A representative shall be entitled to present evidence and allegations as to facts and law in any proceeding affecting the party he represents and to obtain information with respect to a request for a contractor hearing or a Board hearing made in accordance with § 405.1811, § 405.1835, or § 405.1837 to the same extent as the party he represents.

Pursuant to its authority under 42 C.F.R. § 405.1868(a), the Board issued rules to implement 42 C.F.R. § 405.1883. Board Rule 5.1 specifies that a provider may appoint a representative including external organization to act as its case representative at any proceedings before the Board:

> A party may be represented by legal counsel or by any other person appointed to act as its case representative at any proceedings before the Board. All actions taken by the case representative are considered to be those of the provider and notice of any action or

> decision sent to the case representative has the same effect as if it had been sent to the provider itself.
>
> The case representative is the individual with whom the Board maintains contact. The case representative may be an external party (*e.g.*, attorney or consultant) or an internal party (*e.g.*, employee or officer of the provider or its parent organization), but there may be only one case representative per appeal (*see* Rule 4.6 prohibiting duplicate appeals). The Board will not accept an appeal or other correspondence from any external organization that is not the case representative's organization.

To this end, Board Rule 5.3 specifies that "[t]he Board will address notice only to the official case representative."

Board Rule 5.4 address Representation Letters:

> A representation letter is required whether designating an external or internal case representative. If the provider is not commonly owned or controlled when the representation letter is being executed, then the letter designating the case representative must be on the provider's letterhead and be signed by an authorizing official of the provider organization. *If the provider is commonly owned or controlled when the representation letter is being executed, then the letter designating the case representative must be on letterhead that identifies the parent corporation (whether it's the provider's letterhead or the parent corporation's letterhead) and must be signed by an authorizing official of the provider or parent organization*.
>
> In addition, the representation letter must reflect the provider's name, number, and fiscal year under appeal. The letter must not be issue specific unless it is for participation in a group appeal in which there is only one issue permitted to be raised. Finally, the representation letter must contain the following contact information regarding the case representative:
>
> - name,
> - organization,
> - address,
> - telephone number, and
> - email address.
>
> If the provider wishes to change its case representative, it must submit an updated letter to the Board and a copy to the Medicare contractor and Appeals Support Contractor . . . .

When filing an individual appeal for a provider or directly adding a provider to a group, the representative must certify that it is authorized to make the filing on behalf of the provider and include a copy of the representation letter evidencing that authorization in the first instance.[9] Requiring representation letters to be properly executed for the fiscal year at issue ***in advance of filing an appeal*** protects providers and health chains from potentially coercive or abusive representation situations, whether in the context of an individual or group appeal.

Board Determination:

A. Dismissal of Unauthorized Participants

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 the date of receipt of the final determination.

Specifically, 42 C.F.R. § 405.1835(a)(3)[10] 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.[11] In this case, the FY 2024 IPPS Final Rule (*i.e.*, the final determination appealed) was published in the Federal Register on August 28, 2023.[12] As the 180th day fell on Saturday, February 24, 2024, the deadline for filing an appeal was the next business day, Monday, February 26, 2024.[13] In waiting to form this group appeal on February 20, 2024 and then file the direct add requests for additional participants on February 23, and February 24, 2024 (only several days prior to the filing deadline), QRS effectively left no margin for error.

Based on the August 28, 2023 determination under appeal, the filing deadline in Case No. 24-1379G expired on Monday, February 26, 2024. Therefore, the Board is ***deeming Case No. 24-1379G to be fully formed as of this letter's signature date,*** as any participant that was, or would be, added or transferred to the *optional* group after February 26, 2024 would be considered a late filing if such an appeal were based on the determination under appeal.

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[9] *See* Board Rules 5, 6.1.1, 6.5, 12.8, 12.10, Model Form A, Model Form E.

[10] 42 C.F.R. § 405.1837(a)(1) specifies that participants in a group must "satisfy[y] individually the requirements for a Board Hearing under § 405.1835(a) or § 405.1835(c), except for the $10,000 amount in controversy requirement in § 405.1835(a)(2) or § 405.1835(c)(3)." One of the requirements in § 405.1835(a)(3) is that "the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final . . . Secretary determination."

[11] When filing from a Federal Register determination, there is no 5-day mail presumption as the date of publication is considered the receipt date.

[12] Here, a provider's date of receipt of a final rule is the date it is published in the Federal Register. The statutes governing the Board (44 U.S.C. § 1507 as applied through the requirements of 42 C.F.R. § 401.101 and the Administrative Procedures Act ("APA")) are clear on their face: the date of publication of the Federal Register is the date the Providers are deemed to have notice of the FY 2024 IPPS Final Rule. To this end, Board Rule 4.3.2 specifies that "[t]he date of receipt of a Federal Register Notice is the date the Federal Register is published" and that "[t]he appeal period begins on the date of publication and ends 180 days from that date."

[13] Based on the Federal Rules of Procedure, if the last day of the period is a Saturday, Sunday, holiday, or court closure, the period continues to run until the next day that is not a Saturday, Sunday, holiday, or court closure.

In that regard, the Board finds that those participants for which QRS submitted incorrect Representative letters that clearly did not authorize QRS to file the instant appeal on their behalf (*i.e., as identified in the Board's March 1, 2024 Request for Corrected Representative letters, and on pages 1 and 2 herein*), were actually ***improperly*** added to the group because, at the time, QRS was not authorized to represent them for the FFY 2024 ATRA IPPS Payment Reduction issue under appeal.[14] Although the Board requested that QRS cure the deficiency by providing correct/proper Representative letters, QRS was only able to *properly* do so for one (1) participant, Participant No. 22, Regional Health Rapid City Hospital (Prov. No. 43-0077).[15]

The Board dismisses the following 6 participants from Case No. 24-1379G because QRS was not authorized to file the direct add appeal request for these participants and, as such, the direct add appeal request for these participants was null and void in the first instance:

- **Participant No. 18**, Parkview Medical Center (Prov. No. 06-0020) – letter dated November 13, 2019 for FFY 2020.
- **Participant No. 19**, Bethesda Hospital East (Prov. No. 10-0002) – letter dated January 17, 2019 for only FFY 2019.
- **Participant No. 20**, Jupiter Medical Center (Prov. No. 10-0253) – letter dated September 17, 2019 for only FFY 2020.
- **Participant No. 23**, University of Utah Hospitals and Clinics (Prov. No. 46-0009) – letter dated September 19, 2019 for FFY 2020.
- **Participant No. 25**, Halifax Medical Center (Prov. No. 10-0017) – letter dated February 14, 2019 for only FFY 2019.
- **Participant No. 26**, John D. Archbold Memorial Hospital (Prov. No. 11-0038) – letter dated February 2, 2018 for only FFY 2018.

Indeed, as shown above, ***all*** of the representation letters for these 6 participants were executed, ***more than 4 years ago***, in either 2018 or 2019, and all of the representation letters related to either FFYs 2018, 2019, or 2020, ***more than 4 years prior to*** FFY 2024, the federal fiscal year at issue for the above providers. As such, it is clear that QRS was not authorized to file direct-add appeal requests on behalf of the above participants and, as part of each of those filings, falsely certifying that QRS was authorized to submit an appeal on behalf of the listed provider(s).

The Board recognizes that corrected Representative Letters authorizing QRS to appeal the ATRA IPPS Payment Reduction issue for FFY 2024 for both University of Utah Hospitals and Clinics[16] and Bethesda Hospital East[17] were filed. However, both authorization letters are dated *well after the expiration of the appeal period* which, again, expired on February 26, 2024. Accordingly, QRS was not authorized to file the appeal on behalf of either University of Utah Hospitals and

[14] The Board again recognizes that three (3) of the providers noted in its March 1, 2024 Request were subsequently withdrawn (specifically, Bristol Hospital, University Hospital and Olympic Medical Center).
[15] *See supra* note 3.
[16] Representation letter is dated March 5, 2024.
[17] Representative letter dated March 14, 2024.

Clinics or Bethesda Hospital East at the time the appeals were filed. As such, it does not change the finding that, at the time QRS filed the direct add appeal request for these two (2) participants it was *not* authorized to make those filings and falsely certified in each of those filings that QRS was authorized to submit an appeal of on behalf of the listed provider.

Based on the above findings, the Board admonishes QRS for its flagrant violation of Board Rules 6.5 (Certifications for Individual Appeals) and 12.10 (Certifications for Group Appeals) by filing unauthorized appeals for nine (9) participants[18] (the above-referenced six (6) as well as the three (3) withdrawn participants[19]) *and for Mr. Ravindran of QRS for – with regard to these same providers –* ***falsely certifying:*** *"I certify that I am authorized to submit an appeal on behalf of the listed provider." The Board further reminds QRS that representation letters must be properly executed for the fiscal year at issue* ***in advance of filing an appeal and*** *QRS should carefully review its authorization letters* ***prior to certifying that it is authorized to file an appeal****. Again, the requirement for* ***prior authorization*** *protects providers and health chains from potentially coercive or abusive representation situations, whether in the context of an individual or group appeal. In giving this admonishment, the Board notes that it was not an isolated incident[20] and, as such, QRS should be well aware of this requirement. Accordingly, the Board directs QRS to come into compliance with this requirement. Continued violation of this requirement may result in additional remedial action by the Board.*

B. Dismissal of Duplicate CIRP Participant and Scheduling Order

With respect to the remaining participants,[21] the Board has identified two (2) participants that are commonly owned ***or*** *controlled* and are subject to the mandatory CIRP group requirements at 42 C.F.R. § 405.1837(b)(1).

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[18] Parkview Med. Ctr. (Prov. No. 06-0020); Bethesda Hosp. East (Prov. No. 10-0002); Jupiter Med. Ctr. (Prov. No. 10-0253); Univ. of Utah Hosps. & Clinics (Prov. No. 46-0009); Halifax Med. Ctr. (Prov. No. 10-0017); and John D. Archbold Mem'l Hosp. (Prov. No. 11-0038).

[19] Bristol Hosp. (Prov. No. 07-0029); Olympic Med. Ctr. (Prov. No. 50-0072); and Univ. Hosp. (Prov. No. 11-0028).

[20] Indeed, on May 10, 2024, the Board issued a FY 2024 ATRA EJR determination in Case No. 24-1512GC and admonished QRS for separately filing an individual provider appeal to establish a prohibited duplicate FY 2024 ATRA appeal under Case No. 24-1553 on behalf of a participant even though QRS was not authorized to file that appeal (EJR decision to be posted for May 2024 at: https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/list-prrb-jurisdictional-decisions). In addition, the Board identified the following examples of unauthorized representation issues in the following QRS cases in which QRS was the representative: **Case No. 16-0605GC** (as discussed in EJR determination for this case dated Nov. 30, 2020 (available at: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-11-1-2020-through-11-30-2020.pdf (last access May 9, 2024))); **Case Nos. 13-2350GC and 13-2351GC** (as discussed in Board Reconsideration Letter for those cases dated June 30, 2022 (available at: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-6-1-2022-through-6-30-2022.pdf (last accessed May 8, 2024))); **Case No. 17-0554GC** (as discussed in the Board EJR Denial & Dismissal Letter dated July 12, 2022 (available at: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-7-1-2022-through-7-31-2022.pdf (last accessed May 8, 2024))); **Case No. 13-1419G** (as discussed in Board Closure Letter dated June 10, 2022 under lead Case No. 09-1903GC (available at: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-6-1-2022-through-6-30-2022.pdf (last accessed May 8, 2024))); **Case Nos. 15-1580GC, 15-1581GC, 15-3027GC, 15-3030GC, 16-2357GC, 16-2358GC, 17-2275GC, and 17-2278GC** (as discussed in the Board Closure Letter dated June 8 2023 under Lead Case No. 21-0008GC (available at: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-6-1-2023-through-6-30-2023.pdf (last accessed May 8, 2024))).

[21] The Board notes that it would have similar CIRP compliance issues regarding Bethesda Hosp. East (Prov. No. 10-0002) which is part of Baptist Health S. Fl. if it had not been dismissed herein since Baptist Health S. Fl. consists of at least five (5) *other* providers based on a FFY 2024 CIRP filed and now pending for that health system.

1. MercyOne Waterloo Medical Center

MercyOne Waterloo Medical Center (Prov. No. 16-0067) (participant #9 on the Schedule of Providers extract in OH CDMS), is part of Trinity Health based out of Michigan and is ***already*** a participant in the Trinity Health CIRP group under Case No. 24-1461GC in which Toyon Associates, Inc. is the designated representative and the thirty-nine (39) participants therein. ***Accordingly, the Board dismisses MercyOne Waterloo Medical Center from Case No. 24-1379G, the QRS FFY 2024 ATRA IPPS Payment Reduction Group.***

In dismissing MercyOne Waterloo Medical Center, the Board notes that the representation letter that QRS filed for this participant was signed by Tim Huber, Vice President of Finance at MercyOne Waterloo Medical Center. However, contrary to Board Rule 5.4, the representation letter did *not* identify Trinity Health as the parent organization. Specifically, Board Rule 5.4 states, in pertinent part, that: "[i]f the provider is commonly owned or controlled when the representation letter is being executed, then the letter designating the case representative ***must be on letterhead that identifies the parent corporation*** (whether it's the provider's letterhead or the parent corporation's letterhead) and must be signed by an authorizing official of the provider or parent organization.

The Board further notes that for Case No. 24-1461GC, Stuart Kilpinen, SVP, Payer Strategy & Product Development for Trinity Health signed the representation letter for Case No. 24-1461GC. However, as neither Mr. Kilpinen nor Mr. Huber are in OH CMDS, the Board as part of its remedial action has carbon copied Edward Coyle, the Director of Third Party Reimbursement for Trinity Health who is handling multiple CIRP group appeals on behalf of Trinity Health. The Board has also carbon copied Toyon as it is the representative for Case No. 24-1461GC.

The Board directs the parent organization, Trinity Health and QRS' attention to 42 C.F.R. § 405.1837*, which indicates that related providers appealing a common issue for the same calendar year are required to pursue that issue in* ***only*** *one CIRP group appeal*.[22] *Similarly, Board Rule 4.6, also specifically prohibits "Duplicate Filings":*

> **4.6 No Duplicate Filings**
>
> **4.6.1 Same Issue from One Determination**
>
> A provider may not appeal an issue from a single final determination in more than one appeal.
>
> **4.6.2 Same Issue from Multiple Determinations**
>
> Appeals of the same issue from distinct determinations must be pursued in a single appeal. For example, a provider may not appeal an

[22] *See* 42 C.F.R. § 405.1837(b)(i) (stating "*Two or more providers under common ownership or control that wish to appeal* to the Board *a specific matter at issue* that involves a question . . . that is common to the providers, and *that arises in cost reporting periods that end in the same calendar year*, and for which the amount in controversy is $50,000 or more in the aggregate, ***must*** *bring the appeal as a group appeal*." (emphasis added)); 42 C.F.R. § 405.1837(b)(3) (stating "With respect to group appeals brought under paragraph (b)(1) of this section, ... *Any group appeal filed by a single provider* ***must be joined*** *by related providers on common issues in accordance with paragraphs (b)(1) and (e) of this section.* (emphasis added)).

> issue from a Medicare contractor's failure to issue a timely Notice of Program Reimbursement ("NPR") and then appeal the same issue from the NPR in separate appeals. Provider Reimbursement Review Board Rules Version 2.0 9 Issue
>
> **4.6.3 Previously Dismissed or Withdrawn**
>
> Once an issue is dismissed or withdrawn, the issue may not be appealed in any other case.

*The Board **admonishes** Trinity Health for authorizing QRS to pursue an issue, in this instance, the FY 2024 ATRA issue, that it had previously authorized Toyon to pursue and for which proper appeals were and remain pending.*

2. Rapid Health Rapid City Hospital

The Board has identified another situation where a participant is commonly owned or controlled. Specifically, Rapid Health Rapid City Hospital (Prov. No. 43-0077) (Participant 22 on the Schedule of Providers extract in OH CDMS), is part of Monument Health per the letterhead used for the Representation Letter. Based on a review of the Board's docket, Monument Health appears to have multiple hospital locations.[23]

Accordingly, the ***Board orders QRS to complete the following actions within thirty (30) days of this letter's signature date***:

1. Confirm whether Rapid Health Rapid City Hospital (Prov. No. 43-0077) is commonly owned ***or*** *controlled* by Monument Health and, if so:

    a. Confirm whether any other providers from Monument Health are currently, or will in the future, pursue the same issue for the same period (whether by an appeal of the FY 2024 final rule or by NPR); and

    b. If so, identify those providers and confirm that a CIRP group has been formed to allow the Board to perform a group-to-group transfer of Rapid Health Rapid City Hospital to the new CIRP group.[24]

2. Review the remaining participants in this optional group and confirm whether there any other participants that have any other related providers (whether related by ownership ***or*** *control*) and, if so, which would necessitate a CIRP group, as is required by regulation.

Following receipt of QRS' response, the Board will take appropriate action. Failure of QRS to timely file a response may result in remedial action by the Board.

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[23] Prior CIRP group cases for Monument Health suggest that Regional Health Rapid City Hospital and Regional Health Spearfish Hospital were part of Monument Health in 2021. For FFY 2024, there may be other providers in the Monument Health organization.

[24] The representative for the newly-formed CIRP group will be the representative designated by Monument Health (whether that is QRS or another organization selected by Monument Health).

* * * * *

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*. As noted in the Board's March 26, 2024 notification, a ruling with regard to whether the Board has substantive jurisdiction over the issue under appeal in this group for the remaining participants will be issued under separate cover.

Board Members:
Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.

For the Board:

5/13/2024

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-5)
Stuart Kilpinen c/o Edward Coyle, Trinity Health
Tim Huber, MercyOne Covenant Medical Center, c/o Edward Coyle Trinity Health
Lisa Ellis, Toyon Associates, Inc. (Rep. for Trinity Health CIRP under Case No. 24-1461GC)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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Michael Redmond
Novitas Solutions c/o GuideWell Source
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RE: ***Dismissal of Issues 1 & 7 and*** **Denial of Hearing Postponement**
Baylor All Saints Medical Center (Prov. No. 45-0137)
FYE 09/30/2012
Case No. 17-2021

Dear Messrs. Ravindran and Redmond,

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in the above-referenced appeal involving Baylor All Saints Medical Center ("Provider") for its fiscal year ending September 30, 2012 ("FY 2012"). The Provider's designated representative is James Ravindran of Quality Reimbursement Services, Inc. ("QRS"). Set forth below is the Board's decision to **deny** the hearing postponement request and **dismiss** Issues 1 and 7 in their entirety. In denying the postponement, the Board notes that neither party filed a Witness List.

I. Procedural Background:

A. *Procedural History for Case No. 17-2021*

On **February 10, 2017**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2012.

On **August 10, 2017**, the Provider filed its individual appeal request appealing its FY 2012 NPR. The Individual Appeal contained the following nine (9) issues related to the disproportionate share hospital ("DSH") payment:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI (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 ("MSP"), and No-Pay Part A Days)[3]

[1] On March 23, 2018, this issue was transferred to PRRB Case No. 15-3173GC.
[2] On March 23, 2018, this issue was transferred to PRRB Case No. 15-3171GC.
[3] On March 23, 2018, this issue was transferred to PRRB Case No. 15-3167GC.

5. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days[4]
6. DSH Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days, and No-Pay Part A Days)[5]
7. DSH Payment – Medicaid Eligible Days
8. DSH Payment – Medicare Managed Care Part C Days[6]
9. DSH Payment – Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days, and No-Pay Part A Days)[7]

For Issue 7, the Appeal request included an "Estimated Impact" of $54,874 based on an estimated 150 "additional Secondary Medicaid eligible Days."

As the Provider is owned by Baylor Scott & White Health ("BS&W Health"), it is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1) and must pursue any issue common to BS&W Health in a CIRP group. Accordingly, on **March 23, 2018,** the Provider transferred Issues 2, 3, 4, 5, 6, 8 and 9 to BS&W Health CIRP groups. The remaining issues in this appeal are Issues 1 (DSH Payment/SSI Percentage (Provider Specific)) and 7 (DSH Payment – Medicaid Eligible Days).

On **March 27, 2018**, the Provider timely filed its preliminary position paper.[8] Significantly, the Provider's filing did not identify the number of Medicaid eligible days in dispute for FY 2012 and did not provide a listing of Medicaid eligible days in dispute, *notwithstanding the fact that the fiscal year at issue had been closed for roughly 5½ years*. Rather, it states *without explanation* that "**ELIGIBILITY LISTING** NOT INCLUDED – TO BE EMAILED SEPARATELY."[9]

On **April 6, 2018**, the Medicare Contractor filed its 1st Jurisdictional Challenge, requesting the dismissal of Issues 1 and 7.[10] On **May 7, 2018**, the Provider timely filed a response to the Jurisdictional Challenge.[11]

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[4] On March 23, 2018, this issue was transferred to PRRB Case No. 15-3172GC.
[5] On March 23, 2018, this issue was transferred to PRRB Case No. 15-3170GC.
[6] On March 23, 2018, this issue was transferred to PRRB Case No. 15-3172GC.
[7] On March 23, 2018, this issue was transferred to PRRB Case No. 15-3170GC.
[8] Consistent with the Board Rules in effect, the Provider only filed the cover page of the preliminary position paper with the Board and exchanged the complete copy with the Medicare Contractor. A full copy of the Provider's preliminary position paper is in the record as Exhibit C-2 to the MAC 2nd Jurisdictional Challenge filed on January 18, 2024. NOTE—the content of the position paper is governed by Board Rule 25 (Jul. 2015) and 42 C.F.R. § 405.1853(b)(2)-(3).
[9] Provider's Preliminary Position Paper at Exhibit 1 (full copy included as Exhibit C-2 to the Medicare Contractor's 2nd Jurisdictional Challenge).
[10] The Jurisdictional Challenge also requested the dismissal of Issues 6-9. Issues 6, 8 and 9 were subsequently transferred to CIRP group cases. A second Jurisdictional Challenge filed on Jan. 18, 2024, superseded the challenge to Issue 7. **NOTE**—42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claim-filing requirements such as timelines or filing deadlines. For example, 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) and 405.1837(c) address certain claim-filing requirements.
[11] As the 30th day fell on Sunday, May 6, 2018, the response was due the next business day, Monday, May 7, 2018.

On **July 20, 2018**, the Medicare Contractor timely filed its preliminary position paper.

On **September 28, 2022**, the Board issued a Notice of Hearing and Critical Due Dates. On **April 19, 2023**, the Board issued a corrected Notice of Hearing and Critical Due Dates. Both of these Notices, provided among other things, the ***same*** filing deadlines for the parties' final position papers. These Notices also gave the ***same*** instructions to the Provider, as follows, 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.[12]

On **April 21, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **May 18, 2023**, QRS timely filed the Provider's final position paper. Attached to the filing at Exhibit P-1 was a spreadsheet entitled "Additional ME & 1115 Waiver Days – Consolidated" listing 6,791 total days. Significantly, the list header noted that the listing was not final and had ***not*** yet been *verified* by the State: "Listing pending finalization upon receipt of State eligibility data." *As filed with the Board*, the information included in the listing was limited to the following: Account, Admit Year, Discharge Year, and Length of Stay.[13]

On **June 15, 2023**, the Medicare Contractor timely filed its final position paper.

July 19, 2023 was the filing deadline for the Provider's (Optional) Responsive Brief per the September 28, 2022 and April 19, 2023 Notices; however, the Provider apparently opted not to make the *optional* filing as no such brief was filed.

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[12] (Emphasis added).

[13] To the extent any documents containing protected health information is necessary to support a provider's position, the provider should enter it into the record under seal, but must first submit a request in writing to the Board seeking permission to submit it under seal, as explained at Board Rule 1.4: "If the parties need to include materials with patient names, numbers, or other identifying information, they must redact (*i.e.*, untraceably remove) the names and numbers and replace them with non-identifying sequential numbers. If the confidential information itself is necessary to support your position, you must file a request seeking permission from the Board to submit unredacted PHI or PII with the Board, at least ***fourteen (14) days*** prior to the document deadline. If permission is granted, the Board will instruct how the PHI or PII should be submitted (*i.e.*, in OH CDMS or in hard copy as necessary). A redacted version of the document should also be filed in OH CDMS. Any documentation submitted with unredacted PHI or PII (not submitted under seal) will be permanently removed from the record and will not be considered by the Board." (Underline emphasis added.)

On **August 30, 2023**, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission." This listing includes 3,138 section 1115 waiver days. QRS' filing did not explain why the listing of so many days was being submitted at this late date (***nearly 11 years after the fiscal year at issue had closed***) and does not indicate how this listing relates to the listing submitted with the Final Position Paper. The listing is entitled "1115 Waiver days" and again notes in the header that the listing is not final and has not been verified with the State: "Listing pending finalisation [*sic*] upon receipt of State eligibility data." The headers were for account, admit date, discharge date, and length of stay. Finally, notwithstanding the assertion that information has been redacted, there is no evidence of any data being redacted. (NOTE—as set forth below, the Board is not accepting this late-filed exhibit into the record.)

On **January 18, 2024**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of the § 1115 waiver day issue added to Issue 7, the Medicaid Eligible days issue. Board Rule 44.4.3 specifies that the Provider had 30 days to respond, *i.e.,* until Monday February 19, 2024.[14] However, the Provider *failed* to file a timely response by the **February 19, 2024 deadline**.

Instead, on **April 24, 2024** (***65 days after the February 19, 2024 filing deadline***), the Provider filed an *untimely* response to the Jurisdictional Challenge.

B. Description of Issue 1 in the Appeal Request and the Provider's Transfer of Issue 2 to Case No. 15-3173GC

In their August 10, 2017 Individual Appeal Request, Provider summarizes Issue 1 (its DSH Payment/SSI Percentage (Provider Specific) issue) as follows:

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

[14] As the 30th day fell on Saturday, February 17, 2024, the filing deadline was moved to the next business day, Monday, February 19, 2024.

> 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*.
>
> Audit Adjustment Number(s). 7,11,30,31,33,5 1,52,S-D See Tab 4.
> Estimated Reimbursement Amount: $87,000. See Tab 5.[15]

Significantly, the above *italicized* paragraph in Issue 1 is clearly a ***legal*** issue that would be common to ***all*** BS&W Health providers and, indeed, restated *verbatim* in Issue 2 which was transferred to a BS&W CIRP group.

Issue 2 is entitled "[DSH]/[SSI]" and was described as follows in the appeal request:

> **Statement of the Issue:**
>
> Whether the Medicare/SSI fraction used in the Medicare [DSH] 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 Le2al Basis:**
>
> The Provider contends that the Lead MAC's determination of Medicare Reimbursement for theft DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww

[15] Issue Statement at 1 (Aug. 10, 2017) (italicized emphasis added).

> (d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The Provider further contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.
>
> 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 [i.e., "Medicare Provider Analysis and Review"] 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 Audit
>
> Adjustment Number(s): 7,11,30,31,33,51 ,52,S-D. See Tab 4.
> Estimated Reimbursement Amount: $87,000. See Tab 5.

As Issue 2 contained legal issues common to BS&W Health providers, the Provider transferred Issue 2 to the BS&W Health CIRP group under Case No. 15-3173GC. The group issue statement in Case No. 15-3173GC, QRS BSWH 2012 DSH SSI Percentage CIRP Group, to which the Provider transferred Issue 2, parallels Issue 2 and reads:

Statement of the Issue:

Whether the Secretary properly calculated the Provider's [DSH]/ [SSI] percentage.

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

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

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days,
6. Failure to adhere to required notice and comment rulemaking procedures.[16]

On March 27, 2018, the Provider timely filed its preliminary position paper:

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from teh4 State of Texas and the Provider does not support the SSI percentage issued by CMS.

The Provider has worked with the State of Texas 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.

[16] Group Issue Statement, Case No. 15-3173GC.

> The Provider is seeking the Medicare Part A or [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 entitl3ed to a correction of these errors of omission to its' [*sic*] 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.

On May 18, 2023, the Provider filed its final position paper and its argument for Issue 1 was largely the same as that included in its preliminary position paper, *except that it* ***abandoned*** *its argument that "SSI entitlement of individuals can be ascertained from [Texas] State [entitlement] records*."[17] The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or [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).[18]

Finally, the Provider's individual appeal request lists the ***same*** amount in controversy of $87,000 for both Issues 1 and 2.

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[17] (Emphasis added.)
[18] Provider's Final Position Paper at 8-9 (May 18, 2023).

C. Description of Issue 7 (the Medicaid eligible days issue) in the Appeal Request

According to its Appeal Request, the Provider asserts that, in Issue 7, all Medicaid eligible days were not included in the calculations of the DSH calculations. The Provider's appeal request describes Issue 7 as:

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 7,11,30,31,33,51,52, S-D *See* Tab 4.
> Estimated Reimbursement Amount: $55,000 *See* Tab 5.[19]

Significantly, the support at Tab 5, documents that the "Estimated Impact" of $54,874 is based on an estimated 150 "additional ***Secondary*** Medicaid eligible Days."[20]

In the Provider's preliminary position paper (full copy attached as Exhibit C-2 to the Medicare Contractor's 2nd Jurisdictional Challenge), the Provider makes the generic contention: "*Based on the **provided** Listing* of Medicaid Eligible day, the Provider contends that the total number of days reflected in its' [*sic*] 202 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and pertinent Federal Court decision." However, ***no*** so such "Eligibility Listing For FYE September 30, 2012" was "*provided*" at Exhibit 1 with the position paper filing. Rather, Exhibit 1 states "**ELIGIBILITY LISTING** NOT INCLUDED – TO BE EMAILED SEPARATELY." Significantly, the position paper also does ***not*** mention or discuss § 1115 waiver days.

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[19] Appeal Request at Issue 3.
[20] (Emphasis added.)

In its May 18, 2023 Final Position Paper, the Provider supports it Medicaid eligible days issue by arguing that, pursuant to the Jewish Hospital case[21] 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.[22] The Provider then, *for the first time in this appeal* (more than 5½ years after the appeal was filed), states it is seeking reimbursement for § 1115 waiver days as a part of the Medicaid eligible day issue. *However, it does so only in passing* ***as parentheticals***. Specifically, the Provider gives the following argument in its final position paper:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106 (b) (4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs*., 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v Shalala*, 83 F. 3d 1041 (8th Cir. 1996), aff'g 912 F.Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).
>
> [CMS] (. . . formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] [*sic*] are to be

[21] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[22] Provider's Final Position Paper at 7.

> included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).
>
> Based on the provided redacted Listing of Medicaid Eligible days, the Provider contends that the total number of days reflected in its' [*sic*] 2012 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Court decisions.[23]

Significantly, *by only referring to § 1115 waiver days in passing as part of parentheticals*, the Provider's final position paper does not identify what specific state § 1115 waiver program(s) are at issue, much less how such program(s) would or would not qualify under 42 C.F.R. § 412.106(b)(4) for inclusion in the numerator of the DSH Medicaid fraction. Indeed, all of the case law and ruling cited in the final position paper ***predates*** the Secretary's addition of certain § 1115 waiver days to the numerator of the Medicaid fraction in 2000, as discussed *infra,* and clearly do *not* address inclusion of any § 1115 waiver days in the DSH adjustment calcluation. The final position paper also continues to list the "Estimated Medicare Reimbursement Effect" for Issue 7 as $54,874 and again attaches as Exhibit P-2 the original "Estimated Impact" supporting that number based on an estimated 150 "additional Secondary Medicaid eligible Days."

Further, attached to the Provider's final position paper filing at Exhibit P-1 is a listing entitled "Additional ME & 1115 Waiver Days – Consolidated." Significantly, the header on the listing confirms that the eligibility of the patients underlying these days has ***not*** been verified with the State: "Listing pending finalization upon receipt of State eligibility data." The listing details 6,791 days based on data under column headers showing the "account," "admit" date, "discharge" date, and "LOS" or length of stay where a portion of the account number and then the month and day of the admit and discharge dates appear to be redacted. Given the fact that the days at issue occurred more than 11 years ago, it would not be surprising if such verification cannot be performed as the Provider failed to promptly develop its case following the close of FY 2012 and the filing of its appeal on August 10, 2017. However, the Provider's position paper did not provide any information its efforts to obtain this verification and supporting documentation as required under Board Rule 25.2 and 42 C.F.R. § 405.1853(b)(2)-(3).

On August 30, 2023, the Provider files what it identifies as a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission." However, it is ***not*** a supplement because it does not provide any argument and does not qualify as one under Board Rule 27.3:

> **27.3 Revised or Supplemental Final Position Papers**
>
> A party may also file a revised or supplemental position paper;

[23] *Id.* at 7-8 (underline emphasis added).

> however, *this filing should not present new positions, arguments or evidence <u>except on written agreement between the parties</u>*. Notwithstanding, the Board encourages revised or supplemental position papers when they promote administrative efficiency and further narrow the parties' positions or provide legal development (such as new case law) that has occurred since the final position paper was filed. *Prior to filing such papers, the parties should contact each other to discuss the anticipated substance of such papers and anticipated objections*. If a revised or supplemental position paper is filed to further refine or narrow the issues, the opposing party may file a rebuttal or reserve such rebuttal for hearing.[24]

Rather, it appears to simply be a new exhibit governed by Board Rule 35.3 because the cover letter states that it is "uploading a redacted copy of the additional Medicaid Eligible Days listing fore the record in of the case" and attached thereto was a listing entitled "1115 Waiver Days." Significantly, the header on the listing *again* confirms that the eligibility of the patients underlying these days has not been verified with the State: "Listing pending finalization upon receipt of State eligibility data." The listing details (according to the MAC)[25] details 3,138 days based on data under column headers showing the on "account," "admit" date, "discharge" date and "LOS" or length of stay. This time only a portion of the account number appears redacted while the complete/full admit and discharge dates are unredacted. Significantly, consistent with Board Rule 25.2.2 and 35.3, the Provider fails to explain why the Exhibit was ***being filed*** late outside the position paper process. As set forth below, the Board is *not* accepting this late-filed exhibit into the record for this case.

D. MAC's Contentions in its Jurisdictional Challenges

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

In its 1st Jurisdictional Challenge filed on April 6, 2018, the MAC argues that the Board lacks jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue for several reasons. First, the MAC argues that the appeal is premature:

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

[24] (Italics and underline emphasis added.)
[25] The listing does not include an aggregate number at the end. The MAC in its 2nd Jurisdictional Challenge states that the August 30, 2023 listing contains 3,138 § 1115 waiver days.

> The Provider's appeal of this item is premature. The Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). The Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue. The MAC requests that the PRRB dismiss this issue consistent with recent jurisdictional decisions.[26]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH/SSI Percentage (Systemic Errors) issue that was transferred to PRRB Case No. 15-3173GC are considered the same issue by the Board.[27]

Issue 7 – DSH Payment – Medicaid Eligible Days

In its 1st Jurisdictional Challenge filed on April 6, 2018, the MAC contends that the Provider failed to claim or protest the Medicaid eligible days issue (Issue 7) even though it was required to do so under 42 C.F.R. § 405.1835(a)(1(i)-)(ii) (as amended in 2008). In its 2nd Jurisdictional Challenge, the MAC suggests that this original challenge does not require a ruling.[28]

In its 2nd Jurisdictional Challenge filed January 18, 2024, the MAC recounts how neither the appeal request nor the preliminary position paper provided a listing of Medicaid eligible days at issue. As a consequence, the Medicare Contractor formally requested it be provided the listing of Medicaid eligible days on 3 separate occasions:

1. December 28, 2018
2. April 3, 2019
3. January 9, 2023

A copy of the January 9, 2023 email correspondence is attached to the Medicare Contractor's final position paper as Exhibits C-5. This exhibit also documents another request dated February 6, 2023. The Provider did not respond to these requests, but did included with its May 18, 2023 final position paper a listing of 6,791 "Additional ME and 1115 Waiver Days – Consolidated." Finally, the Medicare Contractor notes that on August 30, 2023, the Provider filed a listing of 3,138 § 1115 waiver days.

The Medicare Contractor contends that the Provider is attempting to untimely and improperly add the issue of § 1115 waiver days as a sub-issue via its final position paper, filed on May 18, 2023.[29] The MAC asserts that prior to the final position paper, the Provider had not formally added the dispute to the appeal, nor had it otherwise raised the issue of § 1115 waiver days.[30] The

[26] First Jurisdictional Challenge at 4 (Apr. 6, 2018).
[27] *Id*. at 3.
[28] Second Jurisdictional Challenge at 1 (Jan. 18, 2024) (stating: "On April 6, 2018, the MAC had filed a jurisdictional challenge with the Board challenging issues 1 and Issues 6-9. Although the Board has not yet ruled on this challenge, only issue 1 still requires a ruling. The challenges that relate to the other issues have been resolved either through a transfer of the issue to a group case, or CMS instruction.").
[2929] *Id.* at 4-5.
[30] *Id*. at 5.

MAC contends that the Provider's attempt to add the issue within its preliminary position paper is improper and untimely, citing 42 C.F.R. § 405.1835(e), which governs when specific Medicare payment issues may be added to the original hearing request, including a timeframe of no later than 60 days after the expiration of the applicable 180-day deadline to file an appeal.[31]

The MAC further contends that the § 1115 waiver days issue is one component of the DSH issue. The MAC argues that the § 1115 waiver days issue is a separate and distinct issue from Medicaid eligible days issue and must be identified and appealed separately.[32]

E. Provider's Responses to the Jurisdictional Challenges

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

In its May 7, 2018 response to the 1st Jurisdictional Challenge, the Provider asserts that Issue 1 (the SSI Provider Specific Issue) is separate and distinct from Issue 2 (the SSI Systemic issue). The Provider contends that it is "not addressing the errors which result from CMS' improper data matching process but is addressing *the **various** errors of omission and commission* that do not fit into the 'systemic errors' category and that "[i]n Baystate, the Board also considered whether, independent of these systemic errors, whether Baystate's SSI fractions were understated due to the number of days included in the SSI ratio."[33] The Provider further claims that it "has analyzed Medicare Part A records and has been able to identify, patients believed to be entitled to both Medicare Part A and SSI" and that it "has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio."[34] However, the Provider does not provide any examples or supporting documentation to support these broad assertions. Notwithstanding, the Provider asserts that these unsupported assertions are sufficient for the Board to distinguish Issue 1 from Issue 2 and find jurisdiction over Issue 1.

The Provider's explanation its position its itself *contradictory*. First, the Provider asserts that it "has **specifically identified patients** believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS, due to errors that are or may be specific to the Provider, but in any case, are not the systemic errors that have been previously identified in the *Baystate* litigation."[35] However, in the next sentence the Provider suggests no such patients have been identified: "*Once these patients **are identified***, the Provider contends that it will be entitled to a correction of these errors of omission to its SSI percentage." Again, the Provider did not provide any examples or documentation on any of the patients "*specifically identified* . . . [and] believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage . . . due to errors that are or may be specific to the Provider . . . ."[36]

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[31] *Id*. at 4.
[32] *Id*. at 6-7.
[33] Provider's Response to 1st Jurisdictional Challenge at 2 (May 7, 2018) (emphasis added and citation omitted).
[34] *Id.*
[35] *Id.* (bold and underline emphasis added and citation omitted).
[36] *Id.* (emphasis added).

Issue 7 – DSH Payment – Medicaid Eligible Days

The Provider's May 7, 2018 response to the 1st Jurisdictional Challenge was timely (as noted above) argued the fact that the MAC specifically adjusted the Provider's DSH, is sufficient for the Board to have jurisdiction over all aspects of the DSH calculation, including Medicaid eligible days because the "presentment requirement" in 42 C.F.R. § 405.1835(a)(i)-(ii) as amended in 2008 is valid. The Provider did not address ***why*** the *estimated* 150 "additional ***Secondary*** Medicaid eligible Days"[37] underlying Issue 7 (the Medicaid eligible days issue)[38] were not included in or claimed on the as-filed cost report at issue.

The Provider's response to the 2nd Jurisdictional Challenge was filed on April 24, 2024 – ***65 days after the filing deadline as described below***. According to Board rules in place at the time of this Jurisdictional Challenge, Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[39] In in the interim period, the Provider filed a Request for Postponement ***of the Hearing***, with no request to extend other deadlines. The Board's January 29, 2024 Notice of Rescheduled Hearing contained no extension of deadlines. Board Rule 44.4.3 specifies:

> Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record.

The Provider's response was filed on April 24, 2024, ***65 days after the 30-day response period closed on Monday, February 19, 2024***. Moreover, the response does not explain why it was filed late and, as such, fails to establish good cause for the 65-day late filing. *Because the response was not untimely and lacked good cause*, ***the Board declines to consider it in its decision***.

In the *belated* April 24, 2024 response, QRS argues that "the regulations at 42 C.F.R. § 405.1835 contain requirements for appealing an 'issue' and a time limit on adding an 'issue' – not on clarifying a 'sub-issues' or (to use the MAC's terminology) 'components' of an issue"[40] and, in support, cites to the June 25, 2004 proposed rule at 69 Fed. Reg. 35716 and the May 23, 2008 final rule at 73 Fed. Reg. 30190. QRS goes on to allege that the July 1, 2015 PRRB Rules in effect at the time the Provider filed its appeal request need only comply with the following instruction in Board Rule 7.1 and that Board Rule 8 is inconsistent with 42 C.F.R. § 405.1835:

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[37] (Emphasis added.) The Provider attached the ***same*** "Estimated Impact" of $54,874 for Issue 7 was attached to the Provider's appeal request, its preliminary position paper, and its final position paper. That "Estimated Impact" states that it is based on 150 "additional ***Secondary*** Medicaid eligible Days." (Emphasis added.)

[38] The "Estimated Impact" for Issue 7 that was included with the appeal request is based on an estimated 150 additional Medicaid eligible days with a reimbursement impact of $

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

[40] Provider's Response to Second Jurisdictional Challenge at 1-2 (Apr. 24, 2024).

Give a concise issue statement describing:

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

QRS asserts that the MAC is incorrect in asserting that is final position paper did no brief the merits of the § 1115 waiver days issue "extensively" and contends that its final position paper also "identifies the waiver program applicable to the Provider as the Texas Healthcare Transformation and Quality Improvement Program."

Finally, QRS asserts that the MAC is required "by specific command of MCS to accept and audit the Provider's section 1115 waiver days" and that "CMS has issued instruction that require the inclusion of section 1115 waiver days in providers' Medicaid fraction" consistent with the instructions in CMS Change Request 12669, Transmittal No. 11912 (March 16, 2023). In summary, the Provider asks the Board to not dismiss the Medicaid eligible days issue or the § 1115 waiver days issue.

II. Board Analysis and Decision:

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

A. Denial of Postponement of the Hearing & Failure to Designate Witnesses

As a preliminary procedural matter, the Board declines to postpone the hearing for this matter as the Provider's April 24, 2024 postponement request has not provided any sufficient basis for the postponement of the hearing.

First, as set forth in the Provider's April 24, 2024 postponement request, the Medicare Contractor opposes the hearing postponement request and has declined to enter into any administrative resolution.

Second, the evidentiary record in this case is complete. Under Board Rules 25.2, 27.2 and 35.3, any exhibits supporting the Provider's position were required to be included in the position paper process and, in connection with Issue 7, the Provider never properly identified any unavailable or missing documents in its position paper filing in compliance with Board Rule 25.2. For example, in its final position paper, the Provider states that the Listing of "Additional ME and 1115 Waiver Days – Consolidated" has not yet had the eligibility of the underlying patients verified with the State in compliance with its burden of proof under 42 C.F.R. § 412.106(b)(4)(iv) and HCFA Ruling 97-2. However, the Provider failed to comply with Board Rule 25.2 to: (1) explain why the state verification of eligibility was not furnished in its final position paper filing, (2) state the efforts it has made to obtain that verification documentation; and (3) explain when such supporting

verification documentation will be complete and be available. Such an explanation is more than reasonable since this FY 2012 case has been pending for over 6½ years and it has been more than 11½ years since the Provider's FY 2012 closed. Finally, the Board notes that neither party filed a Witness List to designate any witnesses for this hearing and that the deadline for filing a Witness List has well passed under Board Rule 28[41] and the Hearing Notices for this case.

More specifically, any postponement would be unwarranted since it is clear that the Provider has wholly failed to develop the merits of this case for the 2 remaining issues – Issue 1 and Issue 7. As explained below, the Board is: (1) dismissing Issue 1 as a prohibited duplicate of Issue 2 which was transferred to a CIRP group; and (2) dismissing the newly-added § 1115 waiver days sub-issue from Issue 7 as it was not part of the original appeal request and not timely added. Similarly, with respect to the original appealed Issue 7 concerning traditional Medicaid eligible days, the Provider wholly failed to develop the merits of its case and the associated evidentiary record for Issue 7 in its position paper filings notwithstanding the Provider's burden of proof under 42 C.F.R. §§ 412.106(b)(iv), 405.1853(b)(2)-(3), and 405.1871(a)(1)(iii) and Board Rules 25 and 27.

Finally, even if the Board had been inclined to grant a postponement, the Board would *not* permit the Provider to subsequently file a Witness List because the time to file a Witness list had already expired ***prior to the Provider's April 24, 2024 postponement request*** and the Board declines to permit a postponement being used to allow the Provider to file a *belated, untimely* Witness List given the procedural history and age of this case. Similarly, *at this late date*, the Board would not permit the Provider to add any additional exhibits or documentary evidence since: (1) this FY 2012 case has been pending for over 6½ years and the Provider's FY 2012 closed more than 11½ years ago; and (2) any relevant evidence should have been submitted as part of the position paper process as discussed *infra*.

B. DSH Payment/SSI Percentage (Provider Specific)

The analysis for Issue 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. As set forth below, the Board dismisses both aspects of Issue 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 Issue 2 (the DSH – SSI Percentage (Systemic Errors) issue) that was transferred to the CIRP group under Case No. 15-3173GC since Issue 2 was a common issue subject to the CIRP group requirements under 42 C.F.R. § 405.1837(b)(1).

[41] Board Rule 28 specifies that Witness lists must be filed 30 days prior to the hearing date.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[42] 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)."[43] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[44]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 15-3173GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Indeed, one paragraph as noted in Issue 1 above is verbatim the same paragraph in Issue 2 and addresses a legal issue that is otherwise common to BS&W Health and subject to the mandatory CIRP group requirements under 42 C.F.R. § 405.1837(b)(1). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 15-3173GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.5,[45] the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 15-3173GC, 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.[46] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 15-3173GC.

To this end, the Board also reviewed the Provider's Final Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 15-3173GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Final Position Paper failed to comply with the Board Rule 25 governing the content of

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[42] Issue Statement at 1.
[43] *Id.*
[44] *Id.*
[45] PRRB Rules v. 1.3 (Jul. 2015).
[46] 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 Med. 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).

position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Final Position Paper and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2[47] to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2 Position Paper Exhibits**
>
> **25.2.2 Unavailable and Omitted Documents:**
>
> If documents necessary to support your position are still unavailable, then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[48]

[47] v. 3.1 (Nov. 2021).
[48] Last accessed May 11, 2024.

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[49]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 15-3173GC. The Board recognizes that the Provider's final position paper included as Exhibit P-3 a copy of the "Reply Brief" filed by the Appellants in the *Advocate Christ* case. However, the final position paper is fatally flawed in that it simply tries to incorporate the arguments made by the Providers in the *Advocate Christ* litigation in a one-sentence reference without explaining how or why its applicable to the instant case. In particular, the Provider fails explain in its final position paper how that the arguments made by the Appellants in the *Advocate Christ* case are *only* provider specific and not systemic. In this respect, Issue 2 encompassed the "Availability of MEDPAR and SSA Records" and "Paid days vs. Eligible days" issues (*i.e*., the Advocate Christ issues) and was transferred as a common issue to Case No. 15-3173GC. Indeed, the *Advocate Christ* issues have been pursued as a common issue subject to the CIRP group rules which under Board Rules was required to be transferred to a CIRP ***prior to*** filing preliminary position papers and otherwise improperly duplicates the CIRP in which the Provider should be participating.[50]

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 15-3173GC are the same issue.[51] 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 SSI Percentage - Provider Specific issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare

[49] (Emphasis added.)
[50] Indeed, the *Advocate Christ* case itself originates from groups pursuing a common legal issue that was appealed from PRRB Dec. Nos. 2017-D11 (Mar. 27, 2017) and 2017-D12 (Mar. 28, 2017) to federal court.
[51] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a BS&W Health CIRP group per 42 C.F.R. § 405.1837(b)(1).

Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board dismisses this aspect of the appeal.

C. Issue 7 -- DSH Payment – Medicaid Eligible Days

Upon review the Board dismisses Issue 7 *in its entirety,* including the newly-added § 1115 waiver days issue and the original Medicaid eligible days issue because: (1) the § 1115 waiver days issue is not properly part of this appeal since it was not included in the appeal request consistent with 42 C.F.R. § 405.1835(a)-(b) and Board Rules 7 and 8 (Jul. 2015) and was not timely added pursuant to 42 C.F.R. § 405.1835(e); and (2) the Provider failed to properly develop the merits of both the original Medicaid eligible days and the improperly-added § 1115 waiver days issue in its preliminary position paper (as well as its final position paper) as required under 42 C.F.R. §§ 412.106(b)(4)(iv)[52] and 405.1853(b)(2)-(3), Board Rules 25 and 27, and the instructions in the Notices setting the deadlines for the position paper filings.

1. *Dismissal of the Newly-Added § 1115 Waiver Days Issue*

The Board finds that the § 1115 waiver days issue is not a part of this appeal as it was not *properly* part of Issue 7 and was *not* timely added to the appeal. The Provider failed to include § 1115 Waiver days as a cost issue in its appeal request (whether as part of Issue 7 or any other issue[53]) and failed to timely and properly add this additional issue to the appeal. While the Provider appealed Medicaid eligible days in Issue 7, this issue is separate and distinct from the § 1115 Waiver days as recognized by multiple Board, Administrator and Court decisions[54] (many of which were issued prior to the Provider's October 13, 2017 deadline for adding issues to this appeal[55]). Moreover, even if the § 1115 waiver days issue were properly part of this appeal (which it was not), the Provider failed to properly develop the merits of the § 1115 waiver days issue in its preliminary

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[52] Note this regulatory provision was previously located at 42 C.F.R. § 412.106(b)(4)(iii) but was redesignated as subparagraph (iv) as a result of the FY 2024 IPPS Final Rule, 88 Fed. Reg. 58640, 59332 (Aug. 28, 2023).

[53] The Board notes that Issues 2, 3, 4, 5, 6, 8 and 9 were all transferred to CIRP groups on March 23, 2018 prior to the Provider filing its preliminary position paper on March 28, 2018. As such, to the extent the 1115 wavier day issue could have been part of any of those issues, it was transferred out of the individual appeal. That leave only issues 1 and 7. As discussed infra, Issue 1 only pertained to the SSI fraction and, as such, could not encompass the § 1115 waiver days issue.

[54] *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. Ci;r. 2020).

[55] The NPR at issue was issued on February 10, 2017 and the Provider had until Monday, August 14, 2017 to file this appeal. Thus, the deadline to add issues is 60 days beyond that date, *i.e*., by Friday, October 13, 2017.

position paper (as well as its final position paper) as required under 42 C.F.R. §§ 412.106(b)(4)(iv)[56] and 405.1853(b)(2)-(3), Board Rules 25 and 27, and the instructions in the Notices setting the deadlines for the position paper filings. This would be an independent basis to dismiss the § 1115 waiver days issue. Finally, there are unresolved jurisdictional issues under 42 C.F.R. § 405.1835(a)(1)(i)-(ii) (2012) as clarified by CMS Ruling 1727-R that would serve as yet another independent basis for dismissal (*e.g.*, why the Provider could not otherwise claim or protest any of the ***several thousand*** § 1115 waiver days on the as-filed cost report).

The appeal was filed with the Board in August of 2017 and the regulations required the following for the "content" of the Provider's appeal request:

> (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.
>
> (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 intermediary's or Secretary determination under appeal.
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final contractor or Secretary determination under appeal, including an account of all of the following:
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
>
> (iii) If the provider self-disallows a specific item (as specified in §413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for

[56] Note this regulatory provision was previously located at 42 C.F.R. § 412.106(b)(4)(iii) but was redesignated as subparagraph (iv) as a result of the FY 2024 IPPS Final Rule, 88 Fed. Reg. 58640, 59332 (Aug. 28, 2023).

> 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.[57]

Board Rule 7[58] elaborated on this regulatory requirement instructing providers:

> **Rule 7 – Issue Statement and Claim of Dissatisfaction**
>
> For <u>each</u> issue under appeal, give a brief summary of the determination being appealed and the basis for dissatisfaction (*See* Rule 8 for special instructions regarding multi-component disputes.)
>
> **7.1 – NPR or Revised NPR Adjustments**
>
> **A. Identification of Issue**
>
> Give a concise issue statement describing:
> - the adjustment, including the adjustment number,
> - why the adjustment is incorrect, and
> - how the payment should be determined differently.
>
> ****
>
> **B. No Access to Data**
>
> If the Provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.
>
> **7.2 – Self-Disallowed Items**
>
> **A. Authority Requires Disallowance**
>
> If the Provider claims that the item being appealed was not claimed on the cost report because a regulation, manual, ruling, or some other legal authority predetermined that the item would not be allowed, the following information must be submitted:
>
> - a concise issue statement describing the self-disallowed item

[57] (Italics emphasis in original and bold and underline emphasis added).
[58] v. 1.3 (Jul. 2015).

> • the reimbursement or payment sought for the item, and
> • the authority that predetermined that the claim would be disallowed. *[March 2013]*
>
> **B. No Access to Data**
>
> If the Provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.
>
> **C. Protest**
>
> Effective for cost reporting periods ending on or after December 31, 2008, items not being claimed under subsection A above must be adjusted through the protested cost report process. The Provider must follow the applicable procedures for filing a cost report under protest as contained in CMS Pub. 15-2, Section 115. *See* 42 C.F.R. § 405.1835(a)(1)(ii). *[March 2013]*

Board Rule 8[59] (as referenced in Board Rule 7) explains that, when framing issues for adjustments involving multiple components, providers must ***specifically*** identify *each* item in dispute, and "…each contested component must be appealed as a separate issue and described as ***narrowly*** *as possible*…".[60] 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 <u>*specifically*</u> *identify* the items in dispute, <u>*each*</u> *contested component* <u>*must*</u> be appealed as a separate issue and *described* <u>*as narrowly as possible*</u> using the applicable format outlined in Rule 7. See common examples below.
>
> **8.2 – Disproportionate Share Cases**
> (e.g., dual eligible, general assistance, charity care, HMO days, etc.)
>
> **8.3 – Bad Debts Cases** (e.g., crossover, use of collection agency, 120-day presumption, indigence determination, etc.)

[59] *Id*.
[60] (Emphasis added.)

> **8.4 – Graduate Medical Education/Indirect Medical Education** (e.g., managed care days, resident count, outside entity rotations, etc.)
>
> **8.5 – Wage Index** (e.g., wage vs. wage-related, rural floor, data corrections, etc.)[61]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect ***to limit*** the time frame in which issues may be added to appeals.[62] 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.[63]

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 (which is presumed to be 5 days after issuance per the definition of "date of receipt" in 42 C.F.R. § 405.1801(a)). Specifically, as the NPR at issue was issued on February 10, 2017 and the Provider had 185 days after that to file the appeal (i.e., until Monday, August 14, 2017), the deadline to add issues was 60 days after August 14, 2017 (*i.e*., by Friday, October 13, 2017). However, there is no evidence/filing in the record to indicate the Provider added the § 1115 Waiver days issue to the case properly or timely by the October 13, 2017 deadline since the first mention of the issue was in the Provider's May 18, 2023 final position paper, filed almost 6 years after the appeal was filed on August 10, 2017.

Accordingly, the only way in which the 1115 wavier day issue could be properly part of this appeal is if it was included in the original appeal request. The Board finds that it was not as set forth below.

First, as a preliminary matter, the Board notes that § 1115 Waiver days are *not* traditional Medicaid eligible days and that the burden of proof relative to 1115 waiver days (both factually and legally) is materially different from that for traditional Medicaid eligible days. In this regard, 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 be included in the DSH calculation and that she exercised her discretion to include only

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[61] v. 1.3 (Jul. 2015) (italics and underline emphasis added).
[62] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[63] (Bold and underline emphasis added.)

certain such days).[64] 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 § 1115 waiver days. Specifically, § 412.106(b)(4) *as it existed in 2012* (and before the revisions made in the FY 2024 IPPS Final Rule[65]) states in pertinent part:

> (2) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> (ii) **Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act**.
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.[66]

*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***

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[64] 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).").

[65] *See supra* note 52 discussing how the FY 2024 IPPS Final Rule redesignated 42 C.F.R. § 412.106(b)(4)(iii) as was redesignated as § 412.106(b)(4)(iv).

[66] (Bold emphasis added.)

Act.[67] 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[68] and not every inpatient day associated with beneficiary enrolled in such a § 1115 waiver program qualifies to be included in the numerator of the DSH Medicaid fraction.[69] In contrast, every state has a Medicaid state plan;

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[67] 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.

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

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

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

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.[70] Indeed, the final position paper only refers § 1115 waiver days *in parentheticals*, and none of the authorities cited by the Provider in its final position paper concern § 1115 waiver days but rather ***predate*** the Secertary's 2000 exercise of discretion to include only certain § 1115 waiver days in the numerator of the Medicaid DSH fraction.[71]

Notwithstanding the fact that § 1115 waiver days are handled differently from regular Medicaid eligibility under a State plan, the appeal request only *generically* references Medicaid eligible days and includes an "Estimated Impact" of only 150 days (*exponentially different than the days being claimed **without explanation** in the Provider's final position paper filed almost 6 years later*).[72] In this regard, documentation needed to verify eligibility for a § 1115 waiver day is *materially* different than that for a traditional Medicaid eligible day[73] 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.[74] Here, 42 C.F.R. § 405.1835(b) and Board Rules 7 and 8 required each separate issue to be identified. Yet, the Provider failed to do so.[75] Accordingly, the Board dismisses it from this appeal

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> 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.

[70] (Emphasis added.)

[71] The Provider's final position paper only cites to the following authorities which addressed Medicaid eligible as opposed to Medicaid paid days and clearly predate the Secretary's 2000 decision to include certain § 1115 waiver days in the numerator of the Medicaid DSH fraction: HCFA Ruling 97-2 (Feb. 1997) (available at: https://www.cms.gov/regulations-and-guidance/guidance/rulings/downloads/hcfar972.pdf (last visited May 14, 2024)); *Jewish Hosp. Inc. v. Secretary of Health and Human Servs*., 19 F.3d 270 (6th Cir. 1994); *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).

[72] The estimated 150 days in the appeal request is exponentially different than the 6,791 days claimed in the Provider's final position paper or the Supplemental Exhibit that appears to replace that listing and contains a reduced though still exponentially large amount of 3,138 § 1115 waiver days (as explained by the MAC in its 2nd Jurisdictional Challenge at 4).

[73] 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 69 and litigation in *supra* note 54.

[74] *See* litigation in *supra* note 54.

[75] 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. This is supported by the fact that the "Estimate Impact" of Issue 7 in the appeal

because Issue 7 (the DSH Medicaid Eligible Days issue) as stated in the original appeal request did not specifically include the § 1115 waiver days issue consistent with the appeal request *content* requirements at 42 C.F.R. § 405.1835(b) and Board Rules 7 and 8, and because the § 1115 waiver days was not timely added to the appeal consistent with 42 C.F.R. § 405.1835(e).[76]

Regardless, of whether the Provider *properly* included the § 1115 waiver days issue in its appeal request (which it did not), QRS failed to properly develop the merits of § 1115 waiver day issue in any of the Provider's position paper filings (whether the preliminary or final position paper filings). This is an independent basis for dismissal of the § 1115 waiver day issue. Specifically, the material facts and legal arguments need to establish the merits of the Provider's claims regarding the § 1115 waiver days issue along with the relevant supporting documentation were not properly briefed and included in either the preliminary or final position paper filings.[77]

First, the Provider's March 27, 2018 preliminary position paper does not mention or discuss the § 1115 waiver day issue, much less:

(1) Identify the material facts (*e.g.*, identify the total number of § 1115 waiver days at issue, the each of the specific days at issue, and the State § 1115 waiver program(s) at issue);

(2) Present the legal arguments in support of its position (*e.g.*, explain how the relevant State 1115 waiver program(s) identified in No. 1 above met the requirements of 42 C.F.R. § 412.106(b)(4) to have days associated with such program(s) to be included in numerator of the Medicaid program); and

(3) Include the relevant supporting document (*e.g.*, documentation verifying eligibility of the relevant patients underlying each of the § 1115 waiver days).

42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25 (Jul. 2015) required a ***fully***-developed preliminary position paper that include the legal merits and material facts of the Provider's position as well as all available supporting documents as required Board Rule 25.2 (Jul. 2015). The Board recognizes that the Provider did state in its preliminary position paper that "**ELIGIBILITY LISTING** NOT INCLUDED – TO BE EMAILED SEPARATELY"; however, the Provider failed to meet its burden under Board Rule 25.2 to fully identify those missing documents (meaning that the listing would encompass 2 different classes of days, both traditional Medicaid eligible days and § 1115 waiver days), explain why listing was unavailable, state the efforts to obtain the listing, and explain when the listing will be become available. Further Board Rule 25.2 (Jul. 2015) explained that the Provider had an obligation to "***promptly*** forward them

request is only 150 days and the failure of the Provider to explain why the ***thousands*** of § 1115 waiver days at issue were not identified until the Provider's May 18, 2023 final position paper, *more than 10 years after the fiscal year at issue had closed on September 30, 2012*. Indeed, it raises jurisdictional issues as discussed *infra*.

[76] In this regard, the Board notes that the Medicare Contractor documents that the Provider did not otherwise protest either Medicaid eligible days (much less § 1115 waiver days) on its FY 2012 as-filed cost report. *See* 1st Jurisdictional Challenge at Exhibit I-4.

[77] Similarly, a review of the Provider's preliminary position paper confirms that the Provider did not even mention (much less brief) the § 1115 waiver days issue in its preliminary position paper (copy attached as Exhibit C-2 to the 2nd Jurisdictional Challenge).

[*i.e.*, the listing] to the Board and the opposing party" once the listing became available.[78] Indeed, the Secretary has stated that 17 months following the close of a fiscal year is ample time to identify any additional Medicaid eligible days missed in the as-filed cost report.[79] Here, providing a listing more than 5 years after the preliminary position paper (i.e., on May 18, 2023 as part of the final position paper (which is also fatally flawed as discussed *infra*)) clearly does not meet that *promptly*-forward obligation. Upon this basis, the Board may dismiss the § 1115 waiver day issue due to the Provider's failure to properly brief the 11115 waiver day issue in its preliminary position paper filing consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25 (Jul. 2015).

Similarly, the Provider's final position paper failed to properly develop the § 1115 waiver days issue because it was a *perfunctory* and flawed filing and only made generic unsupported conclusory assertions regarding the § 1115 waiver day issue in the argument section for Issue 7. First, the Provider's final position paper only references § 1115 waiver days in passing *in parentheticals*, and ***fails** to identify* the specific state § 1115 waiver program(s) at issue (whether 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. Finally, the so-called listing included at Exhibit P-1 to the Provider's Final Position Paper is *fatally flawed* because it was still not final and does ***not*** include sufficient information to be auditable (*e.g.*, it did not include any patient identifying information such as patient name, date of birth, social security number, medical record number, or even specific dates of service) and, in particular made clear that it had not yet verified with the State that, for each of the days claimed, the relevant patient was eligible for the relevant § 1115 waiver program. Rather, the only information provided is: a partial Account number, the Admit year and Discharge year, and length of stay. In this regard, 42. C.F.R. § 412.106(b)(4)(iv) "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 stay*."[80] Here, the provider has failed to furnish any of the basic/threshold information needed to satisfy that burden.

The ***perfunctory*** nature of the filing is further highlighted by the fact that the Provider's final position paper fails to properly describe the amount in controversy even though that is a material fact. Instead, it continued to reference the *clearly inapplicable* original $54,874 and continued to attached the original "Estimated Impact" of $54,874 for Issue 7 based on a then-estimated 150 "additional Secondary Medicaid eligible Days." Similarly, the Provider's final position paper fails to explain why the 6,791 "Additional ME and § 1115 Waiver Days" were identified *at such a late*

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[78] (Emphasis added.)

[79] In this regard, the Board notes that the Secretary stated in the final rule published on November 13, 2015 that generally 17 months after the close of a provider's fiscal year (the filing of the cost report is due the last day of the 5th month after the close of the fiscal year) is *sufficient time* for the provider to identify any additional Medicaid eligible days missed in the as-filed cost report:

> In our experience, we believe an additional 12 months [after the filing of the cost report on the last day of the 5th month following the end of the fiscal year] is sufficient time for States to make Medicaid eligibility determinations and for hospitals to revise its number of Medicaid-eligible patient days in order to make an appropriate cost report claim for a DSH payment adjustment.

80 Fed. Reg. 70298, 70564 (Nov. 13, 2015).

[80] (Emphasis added.)

date (almost 6 years after the appeal was filed on August 10, 2017 and more than 5 years after the Provider's March 27, 2018 preliminary position paper had been filed) and why the those 6,791 days had not yet been verified with the State as being eligible for the hereto ***unspecified*** state § 1115 waiver program.

Indeed, when the "Supplemental" Exhibit was filed on August 30, 2023 with apparently a revised listing, it continued to list ***unverified*** days and did not included any additional information beyond having a complete date for admit and discharge. Consistent with its authority under 42 C.F.R. §§ 405.1868 and 405.1853(b)(2)-(3) and Board Rules 25.2 (as applied to final position papers via Board Rule 27.2) and 35.3, the Board finds the listing was untimely and **declines** to accept this late listing into the record for this case since it was filed outside the position paper process and no explanation was given consistent with Board Rule 25.2,2 why it was being filed outside this process and yet was still not final, what efforts had been expended to obtain this not-yet-final information, and when the final documentation would be obtained. The listing of the Medicaid Eligible Days was to be filed with the Provider's Preliminary Position Paper but was not without any explanation. As the Provider did not even attempt to establish good cause under Board Rule 35.3 for the late filing outside the position paper process and inconsistent with Board Rule 25.2.2, the Board has ***not*** considered (and declines to consider) the listing in its decision.

Moreover, as previously discussed, the hearing is currently scheduled for Tuesday, May 14, 2024 and the Provider designated ***no*** *witnesses* under the time allotted under Board Rule 28 and in the Notices of Hearing issued in this case. *As a result, the Provider is* ***solely*** *relying on the documentary record in this case and, as discussed above, the record is* ***wholly*** *insufficient as a threshold matter relative to the Provider's burden of proof under 42 C.F.R. § 412.106(b)(4)(iv).*

Finally, there is no indication that any § 1115 waiver days included in Exhibit P-1 as attached to the final position paper were included with the as-filed cost report and, if true, would make them an *unclaimed* cost and provide an independent basis for dismissal (*see* Board Alert 10). The fact that the Provider is claiming *a* ***materially*** *large number of days* (6,791 days) suggests that they may be an unclaimed cost for which the Board would lack jurisdiction under 42 C.F.R. § 405.1835(a)(1)(i)-(ii) (2012) as clarified by CMS Ruling 1727-R, and that the Provider failed to address the Board's jurisdiction over the § 1115 waiver days issue in its final position paper consistent with § 405.1853(b)(2) and Board Rule 25 as applicable via Board Rule 27.2 (quoted *infra*). 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 advertence from the as-filed cost report,[81] 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

[81] 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.)

Ruling 1727-R.[82] The Provider's final position paper does not discuss this jurisdictional issue even though 42 C.F.R. § 405.1853(b)(2) requires position papers to address the Board's jurisdiction over each issue. In particular, QRS fails to address whether, pursuant to CMS Ruling 1727-R, "***the provider 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***."[83] Here, the Provider in its final position paper appears to claim that the Medicare Contractor was required to include these § 1115 days in the numerator of the DSH Medicaid fraction and, thus, would appear ***not*** to qualify under CMS Ruling 1727-R for jurisdiction (*i.e.*, there would be no basis for jurisdiction under Ruling 1727-R). This is an independent basis for the Board to dismiss the § 1115 waiver days issue (*i.e.*, in addition to and independent from dismissal for failure to properly include the issue in its appeal request).

In summary, the Board finds that: (1) the § 1115 waiver days issue is a separate issue and it is not a part of this appeal because it was not properly or timely added;[84] and (2) even if it were an issue in this appeal (which it is not), the Provider effectively abandoned it by failing to develop the merits of its case in both its preliminary position paper and its final position paper and its admission that its evidence failed to satisfy the elements of its burden under § 412.106(b)(4)(iv)[85] without explaining why it has been unable to do so as required under Board Rule 25.2.2. Accordingly, for the multiple and independent bases, the Board dismisses the § 1115 waiver day issue from this appeal.

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[82] *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 06-1852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days from the appeal because no days were claimed with the as-filed cost report due to choice, error and/or inadvertence and, as such, the practical impediment standard or futility concept in the *Norwalk* and *Danbury* Board decisions under PRRB Dec. Nos. 2012-D14 and 2014-D03 is not applicable) (available at: https://www.cms.gov/regulations-andguidance/review-boards/prrbreview/downloads/jd-2017-11.pdf (last accessed Dec. 15, 2023)).

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

[84] The fact that, as a result of the *Bethesda and Forrest General* decisions, the Secretary may ***now*** (well after the appeal request was filed) have changed its stance on how ***certain*** § 1115 waiver days may or may not be included in the numerator of the Medicaid fraction does *not* otherwise alter the base requirement that the Provider must have a claim for that issue *properly* pending in an appeal in the first instance. Moreover, CMS Transmittal No. 11912 at 5 (Mar. 16, 2023) does reference the requirement that a Provider have a properly pending appeal of the issue: "jurisdictionally valid pending Section 1115 Bethesda-like appeals." As such, the Board finds that Medicare Contractors are ***not*** obligated to accept or review any and all claims for § 1115 waiver days but rather only those where a "Section 1115 Bethesda-like appeal" is *properly* pending before the Board. Indeed, this is a basic mantra of CMS included in CMS Rulings generally. *See, e.g.*, CMS Ruling 1498-R (Apr. 28, 2010) ("In accordance with the foregoing history and determination, CMS and the Medicare contractors will resolve each properly pending DSH appeal of the SSI fraction data matching process issue, by applying…."); CMS Ruling 1739-R (Aug. 17, 2020) ("First, it is CMS's Ruling that the agency and the Medicare contractors will resolve each properly pending claim in a DSH appeal in which a provider alleges that . . . ."). Regardless, that Transmittal is not directed to the Board itself or Board proceedings and, to this end, does not give any guidance or instruction *to the Board*.

[85] Instead of documenting eligibility, the Provider admits in its listing that no State verification of eligibility has been completed on the days included in the listing.

2. *Dismissal of the original Medicaid Eligible Days issue*

Upon review, the Board also dismisses the original Medicaid eligible days issue due to the failure of the Provider to properly develop the merits of the issue and material facts during the position paper process in accordance with 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iv), Board Rules 25 and 27, and the instructions included in the Board Critical Due Dates Notices setting the deadlines for the position paper filings.

According to its Appeal Request, the Provider asserts that all Medicaid Eligible Days were not included in the calculations of the DSH calculation. The Provider states Issue 7 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.[86]

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

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[87]

With regard to the filing of an individual appeal, Board Rule 7.1.B[88] states:

[86] Individual Appeal Request, Issue 7.
[87] Ex. C-2 at 16 (Jan. 18, 2024).
[88] v. 1.3 (Jul. 2015).

B. No Access to Data

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

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.B.[89]

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.[90]

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

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth <u>the relevant facts</u> 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. **<u>Exhibits regarding the merits</u>** 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.[91]

So, essentially, 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), as applied to Final Position Papers via Rule 27.2 gives the following instruction on the content of position papers:

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

Rule 25 Preliminary Position Papers[92]

> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will issue a notice setting deadlines for the first position paper generally at eight months after filing the appeal request for the provider, and twelve months for the Medicare contractor. Even though it will not be addressed in the Board's notice, the provider may file an *optional* response no later than ninety days following the due date for the Medicare contractor's preliminary position paper. Therefore, the Board requires preliminary position papers to present the ***fully*** developed positions of the parties and expects that parties will be diligent in planning and conducting any required investigation, discovery, and analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the applicable subsection.

25.1.1 Provider's Position Paper

The provider's preliminary position paper must:

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.

B. For ***each*** issue that has not been fully resolved, provide a ***fully*** developed narrative that:

- States the material facts that support the provider's claim.
- Identifies the controlling authority (e.g., statutes, regulations, policy, or case law) supporting the provider's position.
- Provides a conclusion applying the material facts to the controlling authorities.

C. Comply with Rule 25.2 addressing Exhibits.

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

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

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

Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.

25.2.3 List of Exhibits

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

25.3 Filing Requirements to Board

The Board requires the parties file a ***complete*** preliminary position paper that includes a fully developed narrative (Rule 25.1), all exhibits (Rule 25.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn.[93]

[93] (Underline emphasis added.)

The commentary to Board Rule 23.3 (Nov. 1, 2021) reinforces the requirement that the position paper must be fully developed with all exhibits:

> Because the date for adding issues will have expired and transfers are to be made prior to filing the preliminary position papers, the Board requires preliminary position papers to be fully developed and include all available documentation necessary to provide a thorough understanding of the parties' positions.

Board Rule 27 addresses final position papers, stating:

> **27.2 Content**
>
> The final position paper should address each issue remaining in the appeal. The *minimum* requirements for the position paper narrative and exhibits are the same as those outlined for preliminary position papers at Rule 25.

The Notice of Hearing and Critical Due Dates issued to the Provider to set its position paper filing deadlines included instructions on the content of those filings consistent with the above-referenced Board Rules and regulations.

Moreover, in connection with Issue 7, Medicare regulations specifically place the burden on hospitals to provide data and documentation to prove State eligibility for ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

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

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. Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization, whether it is operated for profit or on a nonprofit basis. It is a reasonable expectation on the part of any agency paying for services on a cost reimbursement basis…

Finally, Board Rule 41.2[94] permits dismissal or closure of a case on the Board's own motion:

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

Here, in this case, the Provider's March 27, 2018 preliminary position paper ***failed*** to identify the Medicaid eligible days in dispute or include a listing of such days and instead promised that a listing was being sent under separate cover. As a result, the Medicare Contractor requested, *on 4 separate occasions*, that the Provider provide a listing with the appropriate documentation of eligibility:

1. December 28, 2018
2. April 3, 2019
3. January 9, 2023
4. February 6, 2023[95]

Notwithstanding, the Provider ***failed*** to respond directly to these 4 separate requests.

When the Provider filed its final position paper on May 18, 2023, it belatedly provided a listing of 6,791 "Additional ME & 1115 Waiver Days – Consolidated" of which only an *unspecified* subset pertained to the original Medicaid eligible days issue. However, the Provider again ***failed*** to include any of the *basic/material information* required to satisfy its burden under § 412.106(b)(4)(iv). Rather, it only provided the account number (partial), Admit Year, Discharge Year, and LOS ***and***, *without explanation*, included the following header that confirms that no State

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[94] v. 3.2 (Dec. 2023).

[95] 2nd Jurisdictional Challenge at 4; Medicare Contractor's Final Position Paper at Exhibit C-5. Note the January 9, 2023 request stated: "Please submit the original Medicaid eligible listing along with the additional days list. Once the lists are received, the number of days will be traced to the latest finalized cost report. The additional list will be reviewed to ensure the days were not previously claimed and a statistical sample will be selected where the UBs and Medicaid eligibility will be requested." The February 6, 2023 request stated: "This is the final request for documentation, additional Medicaid days listing along with the original Medicaid listing. If the documentation is not received within 30 days from the date of this email, we will file a motion to dismiss as the Provider failed to satisfy the requirements of Board Rule 25.2 (Preliminary Position Paper submission) under the authority of 42 CFR 405.1868 (a)-(b)."

verification of eligibility had yet been obtained for any of the purported 6,791 days: "Listing pending finalization upon receipt of State eligibility data" (of which only a subset pertains to the original Medicaid eligible days issue and which contains 1115 waiver days dismissed above).

The Board is perplexed as to why the Provider's final position paper failed to furnish *basic/material information* on the purported 6,791 days at issue consistent with the Provider's burden under § 412.106(b)(4)(iv). The fiscal year at issue, FY 2012, has been finished for over 11 years now and, as a consequence, any State information relating to that fiscal year is now expectedly stale. The Provider cannot blindly pursue an issue for years without developing the merits of that issue and furnishing the necessary/material information and documentation (as made clear in § 412.106(b)(4)(iv)). The position paper process is designed to do just this, as set forth in 42 C.F.R. § 405.1853(b)(2)-(3), Board Rules 25 and 27, and the instructions included in the Board Notices dated September 28, 2022 and April 19, 2023.

The Board finds that the purported listing attached as Exhibit P-1 to the Provider's final position paper does not include auditable information and is fatally flawed because it does not include the basic/material information consistent with the Provider's burden of proof under § 412.106(b)(4)(iv). Specifically, the purported listing does not include any patient-specific information (redacted or unredacted) such as patient name, date of birth, medical record number, social security number, the dates of service, the hospital unit providing inpatient care,[96] and the relevant State Medicaid program eligibility code (as well as state verification of that Medicaid program eligibility code). Moreover, by including in the header for the listing that it is "pending finalization upon receipt of State eligibility data," it is clear that ***none*** *of the 6,791 days included in that listing* (of which only a subset is covered by the original Medicaid eligible days issue) had been verified for State Medicaid eligibility as of the filing of that listing, notwithstanding the Provider's burden to do so under § 412.106(b)(4)(iv).[97] Similarly, the Provider's burden of proof would necessarily include establishing that the days at issue are, in fact, *additional* days (*i.e.*, were not duplicates of any of the Medicaid eligible days already allowed in the settled cost report for FY 2013). The fact that the pertinent information and documentation needed to satisfy its burden of proof under 42 C.F.R. § 412.106(b)(4)(iv) may involve protected health information ("PHI") simply means that the provider must follow a Board process under Board Rule 1.4 to submit the relevant information under seal.[98] Here it is clear that, without State verification of eligibility, the Provider has ***not*** (and cannot) satisfy that burden of proof based on the record before the Board.

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[96] For example, excluded units as well as other units that do not provide a level of care payable under IPPS may not be included in the DSH Medicaid fraction. *See* 42 C.F.R. § 412.106(a)(1)(ii). In this regard, the Board notes that the Provider did have an IPF unit that became decertified on October 4, 2010 and the Psych subunit was ***removed*** from the FY 2012 cost report per the Feb. 2, 2017 Audit Adjustment Report for the Provider's FY 2012. MAC's Final Position Paper at Exhibit C-1 (Audit Adj. No. 6 states: "To ***remove*** *the PSYCH subunit* ***from the cost report*** since the subunit decertified on 10/04/2010." (emphasis added)).

[97] It is unclear what portion of the 6,791 days pertain to traditional Medicaid eligible days. If it materially exceeds the original estimated 150 days, then there days may be unclaimed costs and there could be jurisdictional issues under 42 C.F.R. § 405.1835(a)(i)-(ii) (2013) as clarified under CMS Ruling 1727-R. *See supra* notes 81 and 82 and accompanying text.

[98] *See supra* note 13 (discussing Board Rule 1.4 generally and submission of PHI under seal *if such confidential information is necessary to support the Provider's position*). This case clearly does not include any of the basic/material information needed, as a threshold matter at the final position paper stage, relative to the Provider's burden of proof under 42 C.F.R. § 412.106(b)(4)(iv).

Moreover, the hearing is currently scheduled for Tuesday, May 14, 2024 and the Provider designated ***no*** *witnesses* under the time allotted under Board Rule 28 and in the Notices of Hearing issued in this case. *As a result, the Provider is* ***solely*** *relying on the documentary record in this case and, as discussed above, the record is* ***wholly*** *insufficient as a threshold matter relative to the Provider's burden of proof under 42 C.F.R. § 412.106(b)(4)(iv).*

It has been ***more than 10 years*** since the cost reporting period ended and it is unreasonable that, at this late date after the completion of the position paper stage, the Provider still has not provided any of the basic/material information needed to support the purported listing of 6,791 additional days (of which only an *unspecified* portion is part of the original Medicaid eligible days issue) consistent with the Provider's burden under § 412.106(b)(4)(iv). A key aspect of this burden is verifying with the State that, for each day claimed, the relevant patient was eligible under the relevant State Medicaid plan. Yet the Provider has admitted that it has ***not*** even done that at this late stage. Again, as previously noted, the Secretary has stated that 17 months following the close of a fiscal year is ample time to identify any additional Medicaid eligible days missed in the as-filed cost report.[99] The Provider was required to set forth all material facts and submit all supporting documentation as part of the position paper process (whether in the preliminary or final position papers), but it failed to do so, notwithstanding the requirements in 42 C.F.R. §§ 405.1853(b)(2)-(3), 412.106(b)(4)(iv), and 405.1871(a)(3), Board Rules 25 and 27, and the instructions included with the Notices setting the deadlines for the filing of the preliminary and final position papers.[100] Moreover, to the extent such documentation was not available, the Provider failed to comply with Board Rule 25.2.2 to: "1. Identify the missing documents; 2. Explain why the documents remain unavailable; 3. State the efforts made to obtain the documents; and 4. Explain when the documents will be available." Again, the Provider failed to timely designate any witnesses for this hearing to provide any other evidence. Accordingly, the Board dismisses the Medicaid eligible days issue as the Provider has effectively abandoned the claim by filing perfunctory/hollow position papers relative, as a threshold matter, to the Provider's burden of proof under 42 C.F.R. § 412.106(b)(4)(iv) and its obligation to develop the merits of the original Issue 7 and include all the relevant documents in support of its position as part of the position paper process, as required by 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iv), Board Rules 25 and 27, and the instructions in the Notices setting the position paper filing deadlines.

In summary, based on the above findings, the Board concludes that, while the Provider has supplied a purported listing of 6,791 days *with its final position paper* (of which only an *unspecified* portion pertains to the original Medicaid eligible days issue), that purported listing at the final position paper stage in this proceeding is *wholly* insufficient as a threshold matter relative to the Provider's burden of proof under 42 C.F.R. § 412.106(b)(4)(iv) and that the Provider has failed to comply with its obligation to develop the merits of the original Issue 7 and include all the relevant documents in support of its position as part of the position paper process, as required by 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iv), Board Rules 25 and 27, and the instructions in the Notices setting the position paper filing deadlines. Accordingly, pursuant to its authority under 42 C.F.R. § 405.1868(b), the Board dismisses the Medicaid eligible days issue due

[99] *See supra* note 79 and accompanying text.
[100] Similarly, any Board review would need to confirm that the days at issue were not already included in the settled cost report for FY 2012.

to the fact that the Provider has failed to sufficiently develop the merits and material facts of its case on this issue in its position paper filings, consistent with its burden under § 412.106(b)(4)(iv) and generally under § 405.1853(b)(2)-(3), Board Rules 25 and 27, and the instructions in the Board Notices dated April 3, 2017, November 21, 2022, and April 19, 2023.

* * * * *

In summary, the Board declines to postpone the hearing. The Board further dismisses Issue 1 (the DSH Payment/SSI Percentage (Provider Specific) issue) *in its entirety* from this appeal as it is duplicative of the issue in Case No. 15-3173GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses Issue 7 (the DSH Payment - Medicaid Eligible Days issue) *in its entirety* because: (1) the § 1115 waiver days issue is not properly part of Issue 7 (or this appeal in general) since it was not included in the appeal request consistent with 42 C.F.R. § 405.1835(a)-(b) and Board Rules 7 and 8 (Jul. 2015) and was not timely added pursuant to 42 C.F.R. § 405.1835(e); and (2) the Provider failed to properly develop the merits of both the original Medicaid eligible days and the improperly-added § 1115 waiver days issue in its preliminary position paper (as well as its final position paper) as required under 42 C.F.R. §§ 412.106(b)(4)(iv)[101] and 405.1853(b)(2)-(3), Board Rules 25 and 27, and the instructions in the Notices setting the deadlines for the position paper filings.

As no issues remain pending, the Board hereby closes Case No. 17-2021 and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

5/13/2024

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

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

[101] Note this regulatory provision was previously located at 42 C.F.R. § 412.106(b)(4)(iii) but was redesignated as subparagraph (iv) as a result of the FY 2024 IPPS Final Rule, 88 Fed. Reg. 58640, 59332 (Aug. 28, 2023).

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***
Lea Regional Medical Center (Provider Number 32-0065)
FYE: 12/31/2016
Case Number: 19-2775

Dear Mr. Summar:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-2775. Set forth below is the decision of the Board to dismiss the two (2) remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) and Uncompensated Care ("UCC") payments.

Background

A. *Procedural History for Case No. 19-2775*

On **March 5, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2016. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **August 28, 2019**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

[1] On March 20, 2020, this issue was transferred to PRRB Case No. 19-1409GC.
[2] On February 26, 2024, the Provider withdrew this issue from the appeal.
[3] On March 20, 2020, this issue was transferred to PRRB Case No. 19-1410GC.

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **March 20, 2020**, the Provider transferred Issues 2 and 5 to CHS groups.
On February 26, 2024, the Provider withdrew Issue 3 from the appeal. As a result of the case transfers and withdrawn issues, there are two remaining issues in this appeal: Issue 1, DSH – SSI Percentage (Provider Specific), and Issue 4, UCC Distribution Pool.

On **September 27, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

On **April 22, 2020**, the Provider timely filed its preliminary position paper.

On **April 27, 2021**, the Medicare Contractor timely filed a Jurisdictional Challenge[5] with the Board over Issues 1 and 4 requesting that the Board dismiss these issues. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **February 22, 2024**, the Provider filed its final position paper. On **March 18, 2024** the Medicare Contractor filed its final position paper.

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[4] (Emphasis added.)

[5] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as 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. 19-1409GC - CHS CY 2016 DSH SSI Percentage CIRP Group

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

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).[6]

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

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

[6] Provider's Appeal Request at 19 (Aug. 28, 2019).

Statement of the Legal Basis

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

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

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

On February 22, 2024, the Board received the Provider's final position paper in 19-2775. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Issue # 1: Provider Specific

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

The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis 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*

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

> *Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[8]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $10,000.

MAC's Contentions

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

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

> According to the Provider's appeal request, Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the portions of Issue 1 related to SSI data accuracy and individuals who are eligible for SSI but did not receive SSI payment are duplicates of Issue 2, which was transferred to Group Case No. 19-1409GC, "CHS CY 2016 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:
>
> > 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[.]

[8] Provider's Final Position Paper at 10 (Feb. 22, 2024).

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

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

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

This component of Issue 1 is repeated by the Provider, word-for-word, within Issue 2.

The MAC contends that the Provider raises the same disputes in Issue 2. The Provider describes Issue 2 as follows:

> The Provider contends that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Provider contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in

> some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The Provider further contends that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in Baystate Medical Center v. Michael O. Leavitt, 54 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 v. Total days

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

As previously noted, Issue 2 has been transferred to Group Case No. 19-1409GC. This means that the Provider is appealing an issue from a single final determination in more than one appeal. The Board's Rules are clear on this matter: No duplicate filings. Board Rule 4.6.1 states:

> A Provider may not appeal an issue from a single final determination in more than one appeal.[9]

[9] Medicare Contractor's Jurisdictional Challenge at 4-6 (Apr. 27, 2021).

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

> Issue 1 includes the Provider's appeal over SSI realignment. The Provider states:
>
> > The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).
>
> SSI realignment is still active in this appeal. Within its preliminary position paper, the Provider states:
>
> > The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (December 31). (Emphasis added).
>
> The decision to realign a hospital's SSI percentage with its fiscal year is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[10]

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)."[11]

The MAC contends:

> The issue presented here has been put before the D.C. Circuit Court in *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v.*

[10] *Id.* at 6-7.
[11] *Id.* at 7.

Sec'y of Health & Human Serv. ("Tampa General"), 830 F. 3d 515 (D.C. Cir. 2016). The court concluded that preclusion was absolute. Moreover, the Board is consistently finding that it lacks jurisdiction over the UCC DSH issue because judicial and administrative review of the calculation is barred by statute and regulation. For example, in its jurisdictional decision covering ten group appeals dated 08/02/2018, the Board cited the Court's decision in *Tampa General* and stated the following:

> Further, the D.C. Circuit Court upheld the D.C. District Court's decision that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, 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 District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General'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 Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well." The Court also rejected Tampa General'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.
>
> The Board finds that the same findings are applicable to the Provider's challenge to their 2016

> uncompensated care payments. As in *Tampa General,* the Providers here are challenging the calculation of the amount they received for uncompensated care for 2016. The Board finds that in challenging the Medicare Contractor's calculation of their uncompensated care final payment amounts, the Providers are seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board therefore finds that the Providers are challenging the underlying data relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well.

The above-mentioned decision is consistent with the many other recent Board decisions denying jurisdiction over the UCC DSH issue. The MAC respectfully requests the Board dismiss this issue from this case.[12]

Provider's Jurisdictional Response

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

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.

---

[12] *Id.* at 9-10.
[13] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

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.

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."[14] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[15] The Provider argues 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."[16]

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. 19-2775 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[17], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[18] The Provider's reliance upon referring

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

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 Final 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. The Provider also alleges that "SSI entitlement of individuals can be ascertained from State records"[19] but fails to explain how that can be done, or to explain how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2.[20] Moreover, the Board finds that the Provider's Final Position Paper failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Aug. 29, 2018), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

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

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

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule,

> [b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's

[19] Provider's Preliminary Position Paper at 8.
[20] It is also not clear whether this is a systemic issue for CHS providers in the same state subject to the CIRP rules or something that is provider specific because, if it was a common systemic issue, it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.
[21] (Italics and underline emphasis added.)

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

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

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

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[23]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 19-1409GC.

Accordingly, *based on the record before it*,[24] the Board finds that the SSI Provider Specific issue in Case No. 19-2775 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.

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[22] Last accessed May 13, 2024.
[23] Emphasis added.
[24] Again, the Board notes that the Provider failed to respond to the Jurisdictional Challenge and the Board must make its determination based on the record before it.

2. *Second Aspect of Issue 1*

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

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board dismisses this aspect of the appeal.

B. UCC Distribution Pool

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

1. Bar on Administrative Review

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

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[25]
>
> (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*"),[26] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C.

[25] 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.
[26] 830 F.3d 515 (D.C. Cir. 2016).

Circuit") upheld the D.C. District Court's decision[27] 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."[28] 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.[29]

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.[30]

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*").[31] 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."[32] 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

[27] 89 F. Supp. 3d 121 (D.D.C. 2015).
[28] 830 F.3d 515, 517.
[29] *Id.* at 519.
[30] *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*").
[31] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[32] *Id.* at 506.

"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.[33]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[34] 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.[35] 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.[36] 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.[37] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[38]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[39]

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."[40] While there is some case law to support

[33] *Id.* at 507.
[34] 514 F. Supp. 249 (D.D.C. 2021).
[35] *Id.* at 255-56.
[36] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[37] *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.
[38] *Id.*
[39] *Id.* at 262-64.
[40] *Id.* at 265.

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.[41] 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.[42]

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.[43] 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*").[44] 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.[45] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the providers claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."[46] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[47] 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***."[48]

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

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[41] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[42] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[43] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[44] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[45] *Id*. at *4.
[46] *Id.* at *9.
[47] 139 S. Ct. 1804 (2019).
[48] *Ascension* at *8 (bold italics emphasis added).

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 *DCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review.

* * * * *

Based on the foregoing, the Board has dismissed the two (2) remaining issues in this case – (Issues 1 and 4). As no issues remain, the Board hereby closes Case No. 19-2775 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

5/13/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision* – Issue 5 – the Medicaid Eligible Days Issue**
St. Cloud Regional Medical Center (Prov. No. 10-0302)
FYE 12/31/2015
Case No. 19-0152

Dear Mr. Ravindran and Mr. Pike,

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in the above-referenced appeal involving St. Cloud Regional Medical Center ("Provider") which is commonly owned by Community Health Systems ("CHS"). The Provider's designated representative is James Ravindran of Quality Reimbursement Services, Inc. ("QRS"). Set forth below is the Board decision to dismiss Issue 5, the Medicaid eligible days issue, in its entirety.

Background:

A. *Procedural History for Case No. 19-0152*

On **April 13, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2015.

On **October 15, 2018**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained two (2) issues:

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

[1] After a Jurisdictional Challenge filed on September 17, 2019, this issue was dismissed by the Board on July 2, 2020.
[2] On May 22, 2019, this issue was transferred to PRRB Case No. 18-0588GC.
[3] On May 22, 2019, this issue was transferred to PRRB Case No. 18-0589GC.
[4] On May 22, 2019, this issue was transferred to PRRB Case No. 18-0584GC.

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

The Provider transferred Issues 2, 3, 4, 6, 7, 8, and 9 to common issue related party ("CIRP") groups for CHS, and also the Board dismissed Issue 1. As a result, *the sole remaining issue* in this appeal is Issue 5 (DSH Payment – Medicaid Eligible Days). Accordingly, this decision focuses *only* on that remaining issue.

On **October 29, 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.[9]

On **June 5, 2019**, the Provider timely filed its preliminary position paper. Significantly, the Provider's preliminary position paper did not identify the number of Medicaid eligible days in dispute and did not provide a listing. Rather it stated at Exhibit 1 (attached to that filing) that the Medicaid eligibility listing was "NOT INCLUDED – BEING SENT UNDER SEPATATE COVER." However, the preliminary position paper does not explain why it was not submitted, what efforts had been made to obtain that listing and related information, or when the listing would become available. Finally, the preliminary position paper does not mention, reference or discuss any § 1115 waiver days issue.

On **September 26, 2019**, the Medicare Contractor timely filed its preliminary position paper. With respect to Issue 2, the Medicare contractor requested from the Provider all documentation necessary to resolve the issue in dispute but, to date, has not received either a listing of the Medicaid eligible days at issue or any other documentation to support the inclusion of additional Medicaid eligible days in the DSH calculation.[10]

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[5] On May 22, 2019, this issue was transferred to PRRB Case No. 18-0591GC.
[6] On May 22, 2019, this issue was transferred to PRRB Case No. 18-0585GC.
[7] On May 22, 2019, this issue was transferred to PRRB Case No. 18-0587GC.
[8] On May 22, 2019, this issue was transferred to PRRB Case No. 18-0592GC.
[9] (Emphasis added).
[10] Medicare Contractor's Preliminary Position Paper at 11-12 (Jan. 17, 2020).

On **June 2, 2023**, the Board issued a Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

> Provider's Final Position Paper – *For each remaining issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *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.[11]

On **February 22, 2024**, the Provider timely filed its final position paper prior to the February 24, 2024 filing deadline which fell on a Saturday and was extended to the next business day, Monday, **February 26, 2024**. Again, the final position paper does not identify the number of Medicaid eligible days in dispute and does not include a listing. Rather, at Exhibit P-1 (attached to that filing), the Provider states: "A listing of the additional Medicaid Eligible days being claimed is being submitted directly to the MAC. A redacted version of this same list will be uploaded to the portal shortly." However, as required under Board Rule 25.2.2, the Provider failed to explain why the listing and related supporting documentation was not available, what efforts had been made to obtain such information/documentation, and explain when such information/documentation would be available.

On **February 26, 2024**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS"). As Board Rule 5.2 makes clear that "the recent appointment of a new case representative *will also not be considered good cause for delay of any deadlines or proceedings*."

Also, on **February 27, 2024** (***one day after the final position paper filing deadline***), QRS filed an ***untimely*** "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission." This listing is entitled "1115 Waiver and Additional ME Days Consolidated." Significantly, QRS confirms that the listing has not yet been verified with the State by including the following header: "Listing pending finalization upon receipt of State eligibility data." The listing appears to total 959 days. However, QRS' filing did not explain why the listing of so many days was being submitted at this late date (***over 8 years after the fiscal year at issue had closed***). The Board declines to accept this ***untimely*** filing as it does not give any basis for its late filing and, as set forth below, it is a fatally flawed listing.

On **March 15, 2024**, the Medicare Contractor filed a jurisdictional challenge,[12] requesting the dismissal of Issue 5, in its entirety because: (1) the provider effectively abandoned the issue by

[11] (Emphasis added).
[12] **NOTE**—42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claim-filing requirements such as timelines or filing deadlines. For example, whether an appeal was timely is not a jurisdictional requirement *but*

not submitting a complete list of Medicaid eligible days at issue with either its preliminary or final position papers; and (2) the Provider improperly and untimely added a new issue to its appeal in the narrative for Issue 5 in its final position paper that was not part of the original appeal, was not timely added, and was not briefed in the preliminary position paper. Pursuant to Board Rule 44.4.3, the Provider had 30 days to file a response to the Jurisdictional Challenge and, as a result, the filing deadline for a response was Monday, **April 15, 2024**.[13]

On **March 20, 2024**, the Medicare Contractor timely filed its final position paper.

On **April 23, 2024**, QRS filed a "Redacted Medicaid Eligible Days Listing Submission." This listing was entitled "1115 Waiver Days" and the caption in OH CDMS indicates it is a "redacted . . . finalized" listing of 1115 Waiver Days. The filing appears to list 947 days and appears to replace the February 27, 2024 listing with 956 days because a partial review confirms that account numbers appear on both listings. However, *again*, failed to explain why the listing of so many days was being submitted at this late date, and describe the prior efforts to obtain that listing. Similar to the February 27, 2024 listing, the Board declines to accept this ***untimely*** listing into the record.

Wednesday, **April 24, 2024**, was the filing deadline for the parties to file a Witness List for the May 24, 2024 hearing (as explained in the Hearing Notice and Board Rule 28). However, the Provider failed to make that filing and designate any witnesses for the hearing. As a result, the Provider is relying *solely* on the evidentiary record in this case.

On **May 3, 2024** (***18 days after the deadline*** for filing a response), the Provider filed an ***untimely*** response to the Jurisdictional Challenge.

B. Description of Issue 5 in the Appeal Request

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

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory

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) and 405.1837(c) address certain claim-filing requirements.

[13] As the 30th day fell on Sunday, April 14, 2024, the deadline was automatically extended to the next business day, Monday, April 15, 2024.

> instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 4,11,13,S-D *See* Tab. 4
> Estimated Reimbursement Amount: $44,000 *See* Tab. 5[14]

Th information at Tab 5 to the appeal request documents the "Estimated Impact" for Issue 5 to be $43,881 based on an estimated 100 "additional Secondary Medicaid eligible Days."

In its preliminary position paper, the Provider arguments in support of the Medicaid eligible days issue is simply 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" of the DSH payment adjustment.[15] In support of its position, the Provider cites to HCFA Ruling 97-2 issued February 1997 and four different decisions issued *prior to that ruling* by the U.S. Circuit Courts of Appeals for the Fourth, Sixth, Eighth and Ninth Circuits between 1994 and 1996.[16] In particular, the Provider cites to the following excerpt for its contention that CMS "acquiesced in the above [Circuit Court] decisions and issued HCFA Ruling 97-2" to included Medicaid eligible days in the numerator of the DSH Medicaid fraction:

> [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.

In its final position paper, the Provider simply restates its citations to HFCA Ruling 97-2 and four different decisions issued *prior to that ruling* by the U.S. Circuit Courts of Appeals for the Fourth, Sixth, Eighth and Ninth Circuits to support its contention that all Medicaid eligible days must be included in the numerator of the DSH calculation as "acquiesced" by CMS in HCFA Ruling 97-2.

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[14] Appeal Request at Issue 5.
[15] Provider's Preliminary Position Paper at 7 (June 5, 2019).
[16] The four Circuit Court decisions cited on page 7 of the Provider's preliminary position paper were: *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994); *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); *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).

However, for the first time, the Provider includes parentheticals to say "Medicaid eligible days (including section 1115 waiver days under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days]." Significantly, the Provider does not identify what specific State § 1115 waiver program(s) are at issue, much less how those program(s) qualify under 42 C.F.R. § 412.106(b)(4) to be included in the numerator of the Medicaid fraction. Rather, the Provider makes a generic allegation that, "[w]ith respect to section 1115 waiver days, the courts have firmly rejected CMS's interpretation of its regulations, holding instead that the plain language of the statute and the regulations require inclusion in the Medicaid Fraction of the days belonging to individuals who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." In support of its position on the § 1115 waiver days issue, the Provider cites to the following three decisions: *Forrest General Hospital*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43(D.D.C. 2018); *Bethesda Health Inc., v. Azar*, 389 F. Supp. 3d 32, (D.D.C. 2019), *aff'd*, 980 F.3d 121 (D.C. Cir. 2020). The Provider also cites to CMS Chane Request 12669, Transmittal No. 11912 (Mar. 16, 2023) for the proposition that CMS has acquiesced to *Bethesda* and suggest that this interpretation "represent[s] the official policy of CMS all along."

Finally, even at this late stage, the final position paper continued to list the amount in controversy as $43,881 and continued to attach the same "Estimated Impact" calculation for that amount at Exhibit P-2 based on an estimated 100 "additional Secondary Medicaid eligible Days."

MAC's Contentions in its Jurisdictional Challenge:

The MAC contends that the Provider is attempting to untimely and improperly add the issue of Section 1115 waiver days as a sub-issue via its final position paper, filed on February 22, 2024.[17] The MAC asserts that prior to the final position paper, the Provider had not formally added the dispute to the appeal, nor had it otherwise raised the issue of section 1115 waiver days.[18] The MAC contends that the Provider's attempt to add the issue within its final position paper is improper and untimely, citing 42 C.F.R. § 405.1835(e), which governs when specific Medicare payment issues may be added to the original hearing request, including a timeframe of no later than 60 days after the expiration of the applicable 180-day deadline to file an appeal.[19]

The MAC argues that section 1115 waiver days issue is a separate and distinct issue from Medicaid eligible days issue and must be identified and appealed separately.[20]

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

> The MAC contends that the Provider was in violation of Board Rules 25.3 and 27 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its

[17] Jurisdictional Challenge at 7-8 (Mar. 15, 2024).
[18] *Id*. at 8-9.
[19] *Id*. at 7.
[20] *Id*. at 9.

> claim in its preliminary and final position papers. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.
>
> Within its Provider's preliminary position paper, the Provider makes the broad allegation, ". . . the Provider contends that the total number of days reflected in its' [sic] 2015 cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider merely repeats this assertion within its final position paper. The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats their appeal request. Moreover, the list of additional Medicaid eligible days was redacted, incomplete and insufficient to meet the requirements to initiate review.[21]

Provider's Jurisdictional Response

The Board Rules require that provider responses to a jurisdictional challenge must be filed within thirty (30) days of the date that the jurisdictional challenge was filed.[22] Here, the Provider's response to the MAC's March 15, 2024 Jurisdictional Challenge was *not* timely as it was filed after the 30-day filing deadline occurring on Monday, April 15, 2024 (as discussed *supra*). Specifically in this case, the response was filed on Friday, May 3, 2024, ***18 days after that filing deadline***.

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." *Therefore, the Board will* ***not*** *consider the arguments enclosed in that filing in making this decision*.

Analysis and Recommendation

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

[21] *Id*. at 5.
[22] Board Rule 44.4.3, v. 3.2 (Dec. 2023).

A. Denial of Hearing Postponement & Failure to Designate Witnesses

As a preliminary procedural matter, the Board declines to postpone the hearing for this matter as the Provider's April 24, 2024 postponement request has not provided any sufficient basis for the postponement of the hearing.

First, the postponement request fails to address the pending Medicare Contractor' pending motion to dismiss the remaining issue this case. As such, it is clear that there is no potential administrative resolution of this case.

Second and more importantly, the evidentiary record in this case is complete. Under Board Rules 25.2, 27.2 and 35.3, any exhibits supporting the Provider's position were required to be included in the position paper process and, in connection with Issue 5, the Board is declining to accept any of the listings submitted outside that process as discussed below. Further, there are no witnesses designated for this case. Finally, any postponement would be unwarranted since it is clear that the Provider has wholly failed to develop the merits of this case for Issue 5 as also described below.

Finally, even if the Board had been inclined to grant a postponement, the Board would *not* permit the Provider to subsequently file a Witness List because the time to file a Witness list had already expired ***prior to the Provider's May 3, 2024 postponement request*** and the Board declines to permit a postponement being used to allow the Provider to file a *belated, untimely* Witness List given the procedural history and age of this case. Similarly, *at this late date*, the Board would not permit the Provider to add any additional exhibits or documentary evidence since: (1) this FY 2015 case has been pending for over 5 years and the Provider's FY 2015 closed more than 8 years ago; and (2) any relevant evidence should have been submitted as part of the position paper process as discussed *infra*.

B. Dismissal of the § 1115 Waiver Days Issue

The Board finds that the § 1115 Waiver days issue is not a part of Issue 7 or this appeal because it was not properly part of the original appeal request and it was not timely and properly added to this appeal. The Provider failed to include § 1115 Waiver days as a cost issue in its October 15, 2018 appeal request (whether as part of Issue 5 or any other issue[23]) and failed to timely and properly add this additional issue to the appeal. While the Provider's appeal included the Medicaid eligible days issue at Issue 5, this issue is separate and distinct from the § 1115 Waiver days. as set forth in Board Rule 8 (Aug. 2018) which reflected multiple Board, Administrator and Court decisions on this issue[24] (most of which had been issued prior to the Provider's December 14, 2018 deadline for

[23] The Board notes that Issues 2, 3, 4, 6, 7, 8, and 9 were all transferred to CIRP groups on March 22, 2019 prior to the Provider filing its preliminary position paper on June 5, 2019. As such, to the extent the § 1115 wavier day issue could have been part of any of those issues, it was transferred out of the individual appeal and the § 1115 wavier day issue would have needed to have been briefed in its preliminary position paper. Finally, the Board notes that it dismissed Issue 1 in its entirety on September 17, 2019, and that issue had nothing to do with § 1115 wavier day issue since it related only to the DSH SSI fraction.

[24] *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.*,

adding issues to this appeal[25]). Moreover, even if the § 1115 waiver days issue were properly part of this appeal (which it was not), the Provider failed to properly develop the merits of the § 1115 waiver days issue in its preliminary position paper (as well as its final position paper) as required under 42 C.F.R. §§ 412.106(b)(4)(iv)[26] and 405.1853(b)(2)-(3), Board Rules 25 and 27, and the instructions in the Notices setting the deadlines for the position paper filings. This would be an independent basis to dismiss the § 1115 waiver days issue. Finally, there are unresolved jurisdictional issues under 42 C.F.R. § 405.1835(a)(1)(i)-(ii) (2012) as clarified by CMS Ruling 1727-R that would serve as yet another independent basis for dismissal (*e.g.*, why the Provider could not otherwise claim or protest any of the ***900+*** § 1115 waiver days on the as-filed cost report).

The Provider's appeal was filed with the Board on October 15, 2018 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing 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.
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final contractor or Secretary determination under appeal, including an account of all of the following:
>
> (i) why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).

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. Ci;r. 2020).

[25] The NPR at issue was issued on April 13, 2018 and the Provider had until Monday, October 15, 2018 to file this appeal. Thus, the deadline to add issues is 60 days beyond that date, *i.e*., by Friday, December 14, 2018.

[26] Note this regulatory provision was previously located at 42 C.F.R. § 412.106(b)(4)(iii) but was redesignated as subparagraph (iv) as a result of the FY 2024 IPPS Final Rule, 88 Fed. Reg. 58640, 59332 (Aug. 28, 2023).

> (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.[27]

Board Rule 7[28] elaborated on this regulatory requirement instructing providers and *specifically* cross-references Board Rule 8 for "special instructions regarding multi-component disputes":

> **Rule 7 Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction**
>
> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.
>
> ****
>
> **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:
>   - the adjustment, including the adjustment number,
>   - the controlling authority,
>   - why the adjustment is incorrect,
>   - how the payment should be determined differently,

[27] 42 C.F.R. § 405.1835(b) (bold and underline emphasis addd).
[28] v. 2 (Aug. 2018).

  - 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). . . .

7.3 Self-Disallowed Items (Applies to Cost Reporting Periods Ending On or Before 12/31/15)

7.3.1 Authority Requires Disallowance

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

- a concise 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).

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[29] (as referenced in Board Rule 7) 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*…".[30] Specifically, Board Rule 8 states:

Rule 8 – Framing Issues for Adjustments Involving Multiple Components

8.1 – General

Some issues may have multiple components. To comply with the regulatory requirement to *specifically identify* the items in dispute, *each contested component must* be appealed as a separate issue and *described as narrowly as possible* using the applicable format outlined in Rule 7. 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.

B. Bad Debts

Common examples include: crossover bad debts, collection effort, use of collection agency, 120-day presumption, and 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

[29] *Id*.
[30] (Emphasis added.)

> 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[31]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect ***to limit*** the time frame in which issues may be added 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 (which is presumed to be 5 days after issuance per the definition of "date of receipt" in 42 C.F.R. § 405.1801(a)). Specifically, as the NPR at issue was issued on April 13, 2018 and the Provider had 185 days after that to file the appeal (*i.e*., until Monday, October 15, 2018), the deadline to add issues was 60 days after October 15, 2018 (*i.e*., by Friday, December 14, 2018). However, there is no evidence in the record to indicate the Provider added the § 1115 waiver days issue to the case properly or timely.

Accordingly, the only way in which the 1115 wavier day issue could be properly part of this appeal is if it was included in the original appeal request. The Board finds that it was not as set forth below.

First, as a preliminary matter, the Board notes that § 1115 Waiver days are *not* traditional Medicaid eligible days and that the burden of proof relative to 1115 waiver days (both factually and legally) is materially different from that for traditional Medicaid eligible days. In this regard, 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 be included in the DSH calculation and that she exercised her discretion to include only certain such days).[33] Rather, they relate to Medicaid expansion program(s) and are

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[31] (Emphasis added).
[32] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[33] 65 Fed. Reg. 47054, 47087 (Aug. 1, 2000). *See also* 68 Fed. Reg. 45346, 45420 (Aug. 1, 2003) (stating: "On

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) *as it existed in 2015* (and before the revisions made in the FY 2024 IPPS Final Rule[34]) states in pertinent part:

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

*Significantly, **§ 1115 waiver programs can pertain** to not just Medicaid (Title XIX), but also **to other programs under Titles I, X, XIV, XIV or part A or D of Title IV of the Social Security Act**.*[35] Hence, an important limitation is that the § 1115 waiver program receive Title XIX

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).").

[34] *See supra* note 26 discussing how the FY 2024 IPPS Final Rule redesignated 42 C.F.R. § 412.106(b)(4)(iii) as was redesignated as § 412.106(b)(4)(iv).

[35] Section 1115 of the Social Security Act (42 U.S.C. § 1315] pertains to "experimental, pilot, or demonstration project[s] which, in the judgment of the Secretary, is likely to assist in promoting the objectives of ***title I, X, XIV,***

matching payments. Moreover, not every state Medicaid program has a qualifying § 1115 expansion program receiving Title XIX matching payments[36] and not every inpatient day associated with beneficiary enrolled in such a § 1115 waiver program qualifies to be included in the numerator of the DSH Medicaid fraction.[37] In contrast, every state has a Medicaid state plan;

XVI, or XIX, or part A or D of title IV, in a State or States." 1115(a) of the Social Security Act (emphasis added). As such, § 1115 waiver programs are not just limited to Title XIX Medicaid programs but may also relate to programs under Titles I, X, XIV, XVI, or part A or D of Title IV.

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

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

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

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

Notwithstanding the fact that § 1115 waiver days are handled differently from regular Medicaid eligibility under a State plan, the appeal request only *generically* references Medicaid eligible days and includes an "Estimated Impact" of only 100 days (*exponentially different than the 900+ days claimed on February 27, 2024* ***without explanation and after*** *the Provider's final position paper filing deadline*). In this regard, documentation needed to verify eligibility for a § 1115 waiver day is *materially* different than that for a traditional Medicaid eligible day[39] and, similarly, it is not a given that *all* § 1115 waiver days (even those under a program receiving Title XIX matching payments) necessarily would qualify under § 412.106(b)(4) as demonstrated by Board decisions and case law.[40] Here, 42 C.F.R. § 405.1835(b) and Board Rules 7 and 8 required each separate issue to be identified, and Board Rule 8 ***specifically*** *identified § 1115 waiver days is a separate and distinct issue*. Yet, the Provider failed to identify *§ 1115 waiver days* as a separate issue.[41] Accordingly, the Board dismisses it from this appeal because Issue 7 (the DSH Medicaid Eligible Days issue) as stated in the original appeal request did not specifically include the § 1115 waiver days issue consistent with the appeal request *content* requirements at 42 C.F.R. § 405.1835(b) and Board Rules 7 and 8, and because the § 1115 waiver days was not timely added to the appeal consistent with 42 C.F.R. § 405.1835(e).

Regardless, of whether the Provider *properly* included the § 1115 waiver days issue in its appeal request (which it did not), QRS failed to properly develop the merits of § 1115 waiver day issue in any of the Provider's position paper filings (whether the preliminary or final position paper filings). This is an independent basis for dismissal of the § 1115 waiver day issue. Specifically, the material facts and legal arguments need to establish the merits of the Provider's claims regarding the § 1115 waiver days issue along with the relevant supporting documentation were not properly briefed and included in either the preliminary or final position paper filings.

First, the Provider's June 5, 2019 preliminary position paper does not mention or discuss the § 1115 waiver day issue, much less:

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would not be counted as Medicaid days for purposes of determining the DSH patient percentage.

[38] (Emphasis added.)

[39] In addition to providing proof that the patient at issue was eligible for the § 1115 waiver program for each day claimed, the Provider must also establish that the particular § 1115 waiver program at issue relates to Title XIX and qualified under 42 C.F.R. § 412.106(b)(4) as demonstrated by the preamble discussion in *supra* note 37 and litigation in *supra* note 24.

[40] *See* litigation in *supra* note 24.

[41] The Board recognizes that the appeal request states that "The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation." However, the "including but not limited to" phrase only pertained to traditional Medicaid eligible days and reasons why they may not have been included in the fraction. It did not expand to include other classes of days such as general assistance, State-only days or § 1115 waiver days. A generic catchall phrase cannot be used to essentially shoehorn in the later addition of an issue on an ***untimely*** basis in contravention of Board Rules and regulations. This is made clear by Board Rule 8 (Aug. 2018) which specifically identified § 1115 waiver days as a distinct issue.

(1) Identify the material facts (*e.g.*, identify the total number of § 1115 waiver days at issue, the each of the specific days at issue, and the State § 1115 waiver program(s) at issue);

(2) Present the legal arguments in support of its position (*e.g.*, explain how the relevant State 1115 waiver program(s) identified in No. 1 above met the requirements of 42 C.F.R. § 412.106(b)(4) to have days associated with such program(s) to be included in numerator of the Medicaid program); and

(3) Include the relevant supporting document (*e.g.*, documentation verifying eligibility of the relevant patients underlying each of the § 1115 waiver days).

42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25 (Jul. 2015) required a ***fully***-developed preliminary position paper that include the legal merits and material facts of the Provider's position as well as all available supporting documents as required Board Rule 25.2 (Jul. 2015). As noted in Board Rule 8, 1115 waiver days is a separate and distinct issue. As it was not briefed in the preliminary position paper, it is "considered withdrawn" to the extent it was ever part of this appeal as made clear by Board Rule 25.3 (Aug. 2018): "Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn."

Even if it had not been effectively abandoned/withdrawn in the preliminary position paper, the Provider's final position paper failed to properly develop the § 1115 waiver days issue because it was a *perfunctory* and flawed filing and only made generic unsupported conclusory assertions regarding the § 1115 waiver day issue in the argument section for Issue 7. First, the Provider's final position paper only generically references § 1115 waiver days and ***fails*** *to identify* the specific state § 1115 waiver program(s) at issue (whether 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. Finally, the specific days § 1115 waiver days at issue were not identified with the final position paper filing, *even though the appeal had been filed more than 5 years ago and the fiscal year at issue had closed more than 8 years ago*. The position paper did not explain why that listing was not provided, what efforts had been made to obtain the listing, and when the listing would be made available.

The Board recognizes that the Provider later filed a listing of § 1115 waiver days with the Board. However, consistent with its authority under 42 C.F.R. §§ 405.1868 and 405.1853(b)(2)-(3) and Board Rules 25.2 (as applied to final position papers via Board Rule 27.2) and 35.3, the Board finds the listing was untimely and **declines** to accept this late-filed listing into the record for this case since it was filed outside the position paper process and no explanation was given consistent with Board Rule 25.2,2 why it was being filed outside this process and yet was still not final, what efforts had been expended to obtain this not-yet-final information, and when the final documentation would be obtained. Indeed, the Secretary has stated that 17 months following the close of a fiscal year is ample time to identify any additional days missed in the as-filed cost report which here would have been by June 1, 2017 (*i.e.*, ***before*** this appeal was filed).[42] Moreover, the Board notes that the late-

[42] In this regard, the Board notes that the Secretary stated in the final rule published on November 13, 2015 that generally 17 months after the close of a provider's fiscal year (the filing of the cost report is due the last day of the

filed listing filed on February 27, 2024 is *fatally flawed* because eligibility was *unverified* and no eligibility information was provided for the relevant § 1115 waiver program. 42. C.F.R. § 412.106(b)(4)(iv) make clear the Provider has the "burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and ***of verifying with the State*** *that a patient was eligible for Medicaid during each claimed patient hospital stay*."[43] Here, the Provider has failed to furnish any of the basic/threshold information needed to satisfy that burden.

Additionally, as previously discussed, the hearing is currently scheduled for Friday, May 24, 2024 and the Provider designated ***no*** *witnesses* under the time allotted under Board Rule 28 and in the Notices of Hearing issued in this case. *As a result, the Provider is* ***solely*** *relying on the documentary record in this case and, as discussed above, the record is* ***wholly*** *insufficient as a threshold matter relative to the Provider's burden of proof under 42 C.F.R. § 412.106(b)(4)(iv).*

Finally, even if the Board had accepted the late-filed listing, there is no indication that any of the late-filed 900+ § 1115 waiver days 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). The fact that the Provider is claiming *a* ***materially*** *large number of days* (+900 days) suggests that they may be an unclaimed cost for which the Board would lack jurisdiction under 42 C.F.R. § 405.1835(a)(1)(i)-(ii) (2012) as clarified by CMS Ruling 1727-R, and that the Provider failed to address the Board's jurisdiction over the § 1115 waiver days issue in its final position paper consistent with § 405.1853(b)(2) and Board Rule 25 as applicable via Board Rule 27.2 (quoted *infra*). 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 advertence from the as-filed cost report,[44] 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.[45] The Provider's final position paper does not discuss this jurisdictional issue even though 42 C.F.R. § 405.1853(b)(2) requires position papers to address the Board's jurisdiction over each issue. In

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5th month after the close of the fiscal year) is *sufficient time* for the provider to identify any additional Medicaid eligible days missed in the as-filed cost report:

> In our experience, we believe an additional 12 months [after the filing of the cost report on the last day of the 5th month following the end of the fiscal year] is sufficient time for States to make Medicaid eligibility determinations and for hospitals to revise its number of Medicaid-eligible patient days in order to make an appropriate cost report claim for a DSH payment adjustment.

80 Fed. Reg. 70298, 70564 (Nov. 13, 2015).

[43] (Emphasis added.)

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

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

[45] *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 06-1852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days because no days were claimed with the as-filed cost report due to choice, error and/or inadvertence and, as such, the practical impediment standard or futility concept in the *Norwalk* and *Danbury* decisions under PRRB Dec. Nos. 2012-D14 and 2014-D03 is not applicable (available at: https://www.cms.gov/regulations-andguidance/review-boards/prrbreview/downloads/jd-2017-11.pdf (last accessed Dec. 15, 2023)).

particular, QRS fails to address whether, pursuant to CMS Ruling 1727-R, "***the provider had a good faith belief*** *that claiming reimbursement for [the § 1115 waiver days at issue] in the cost report would be futile because [the § 1115 waiver days at issue] was subject to a regulation or other payment policy* ***that bound the Medicare contractor and left the contractor with no authority or discretion to make payment in the manner sought by the provider***."[46] Here, the Provider in its final position paper appears to claim that the Medicare Contractor was required to include these § 1115 days in the numerator of the DSH Medicaid fraction and, thus, would appear ***not*** to qualify under CMS Ruling 1727-R for jurisdiction (*i.e*., there would be no basis for jurisdiction under Ruling 1727-R). This is an independent basis for the Board to dismiss the § 1115 waiver days issue (*i.e*., in addition to and independent from dismissal for failure to properly include the issue in its appeal request).

In summary, the Board finds that: (1) the § 1115 waiver days issue is a separate issue as set forth in Board Rule 8 (Aug. 2018) and it is not a part of this appeal because it was not properly or timely added;[47] and (2) even if it were an issue in this appeal (which it is not), the Provider effectively abandoned it by failing to develop the merits of its case in both its preliminary position paper and its final position paper and its admission that its evidence failed to satisfy the elements of its burden under § 412.106(b)(4)(iv)[48] without explaining why it has been unable to do so as required under Board Rule 25.2.2. Accordingly, for the multiple and independent bases, the Board dismisses the § 1115 waiver day issue from this appeal.

C. Dismissal of the original Medicaid Eligible Days issue

According to its Appeal Request, the Provider asserts that all Medicaid Eligible Days were not included in the calculations of the DSH calculation. The Provider states Issue 5 as:

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

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

[47] The fact that, as a result of the *Bethesda and Forrest General* decisions, the Secretary may ***now*** (well after the appeal request was filed) have changed its stance on how ***certain*** § 1115 waiver days may or may not be included in the numerator of the Medicaid fraction does *not* otherwise alter the base requirement that the Provider must have a claim for that issue *properly* pending in an appeal in the first instance. Moreover, CMS Transmittal No. 11912 at 5 (Mar. 16, 2023) does reference the requirement that a Provider have a properly pending appeal of the issue: "jurisdictionally valid pending Section 1115 Bethesda-like appeals." As such, the Board finds that Medicare Contractors are ***not*** obligated to accept or review any and all claims for § 1115 waiver days but rather only those where a "Section 1115 Bethesda-like appeal" is *properly* pending before the Board. Indeed, this is a basic mantra of CMS included in CMS Rulings generally. *See, e.g*., CMS Ruling 1498-R (Apr. 28, 2010) ("In accordance with the foregoing history and determination, CMS and the Medicare contractors will resolve each properly pending DSH appeal of the SSI fraction data matching process issue, by applying…."); CMS Ruling 1739-R (Aug. 17, 2020) ("First, it is CMS's Ruling that the agency and the Medicare contractors will resolve each properly pending claim in a DSH appeal in which a provider alleges that . . . ."). Regardless, that Transmittal is not directed to the Board itself or Board proceedings and, to this end, does not give any guidance or instruction *to the Board*.

[48] Instead of documenting eligibility, the Provider admits in its listing that no State verification of eligibility has been completed on the days included in the listing.

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.[49]

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

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

Board Rule 7.3.2[51] 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.

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.[52]

The Provider did not submit a listing of Medicaid Eligible Days until February 27, 2024 outside the position paper process. As discussed above, the listing included no explanations for the delay in the submission and the Board has not accepted that late-filed listing into the record for this case. Accordingly, the Board finds the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why

[49] Individual Appeal Request, Issue 5.
[50] Provider's Preliminary Position Paper at 8.
[51] v. 2 (Aug. 2018).
[52] *Id*.

it could not timely produce those documents, as required by the regulations and the Board Rules.[53] Indeed, it is not clear that the late-filed listing even included any Medicaid eligible days as demonstrated by the fact that the "finalized" listing (which the Board also declined to accept into the record as discussed above) only pertained to § 1115 waiver days and appears to have been intended to replaced the earlier non-final listing.

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[54]

Similarly, with regard to position papers,[55] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[56] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

Similarly, consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.

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

[54] (Emphasis added).

[55] The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. *See* Board Rule 27.2.

[56] (Emphasis added).

> Once the documents become available, promptly forward them to the Board and the opposing party.[57]

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

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

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

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

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

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

The Board concurs with the Medicare Contractor that the Provider is required to timely identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[58] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to timely provide a listing or other supporting documentation for the Medicaid Eligible Days issue as part of the position paper process as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent from its position papers or what caused the

[57] (Emphasis added).
[58] (Emphasis added).

delay with Board Rule 25.2.2. Indeed, based on these facts, the Board must assume that the Provider has effectively abandoned this issue.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25 related to timely identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[59]

Accordingly, the Board dismisses the original DSH Payment – Medicaid Eligible Days issue.

****

In summary, the Board declines to postpone the hearing. The Board further dismisses Issue 5 (the DSH Payment - Medicaid Eligible Days issue) *in its entirety* because: (1) the § 1115 waiver days issue is not properly part of Issue 7 (or this appeal in general) since it was not included in the appeal request consistent with 42 C.F.R. § 405.1835(a)-(b) and Board Rules 7 and 8 (Jul. 2015) and was not timely added pursuant to 42 C.F.R. § 405.1835(e); and (2) the Provider failed to properly develop the merits of both the original Medicaid eligible days and the improperly-added § 1115 waiver days issue in its preliminary position paper (as well as its final position paper) as required under 42 C.F.R. §§ 412.106(b)(4)(iv)[60] and 405.1853(b)(2)-(3), Board Rules 25 and 27, and the instructions in the Notices setting the deadlines for the position paper filings. The Board takes administrative notice that it has made similar dismissal in other cases in which QRS was the designated representative[61] as well as cases involving CHS providers.[62] As no issues remain pending, the Board hereby closes Case No. 19-0152 and removes it from the Board's docket.

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

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[59] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.
[60] Note this regulatory provision was previously located at 42 C.F.R. § 412.106(b)(4)(iii) but was redesignated as subparagraph (iv) as a result of the FY 2024 IPPS Final Rule, 88 Fed. Reg. 58640, 59332 (Aug. 28, 2023).
[61] Examples of cases in which QRS was the designated representative and which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days at issue include, but are not limited to: Case No. 14-2674 (by Board letter dated 5/5/2022); Case No. 16-2521 (by Board letter dated 5/5/2022); Case No. 16-0054 (by Board letter dated 5/5/2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, 16-1712 (by Board letter dated 9/30/2022). Moreover, in Case Nos. 13-3022, 13-3211, 14-2506, and 14-4313, the Board's attention to the filing deficiency was brought to the Board's attention via a motion to dismiss filed by the Medicare Contractor in its position paper (on December 10, 2020, December 11, 2020, March 12, 2021, March 12, 2021 respectively).
[62] Examples of CHS individual provider cases which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0076 (dismissed by Board letter dated Dec. 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper); Case No. 22-0376 (dismissed by Board letter dated February 22, 2023 based on a MAC December 14, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

Board Members Participating:

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For the Board:

5/14/2024

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Notice of Dismissal***

CN 23-0875G	Hooper Lundy & Bookman FFY 2023 Unlawful Correction of GME 'Fellows Penalty' in Final Rule Group
CN 23-0906GC	Yale-New Haven FFY 2023 Unlawful Correction of GME 'Fellows Penalty' in Final Rule CIRP Group

Dear Ms. Carroll:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests and final determinations in Case Nos. 23-0875G and 23-0906GC. The Board's decision to dismiss these cases is set forth below.

Issue in Dispute

The Providers are appealing from the issuance of the Fiscal Year ("FY") 2023 Final Rule published in the Federal Register on August 10, 2022. The sole issue in these cases is "whether CMS's determination to adopt an amended regulation *retroactively* to FY 2001 to determine DGME FTE counts but to limit the retroactive application of the amended regulation to open cost reporting years is substantively and/or procedurally invalid."[1] The Providers' issue statements[2] describe the issue as follows:

> This appeal challenges one of the final determinations made by the Centers for Medicare and Medicaid Services ("CMS") in the HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEMS FOR ACUTE CARE HOSPITALS AND THE LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM AND POLICY CHANGES AND FISCAL YEAR 2023 RATES FINAL RULE ("FY 2023 IPPS Final Rule"), 87 Fed. Reg. 48,780, 49,066-72, 49,456, and 49,480 (Aug. 10, 2022). Specifically, in the FY 2023 IPPS Final Rule, CMS **retroactively amended** its regulation (42 C.F.R. § 413.79(c) & (d)) that dictates the method to calculate a hospital's weighted number of Full-Time Equivalent ("FTE") residents for purposes of computing

[1] (Emphasis added.)
[2] The Board's decision encompasses one (1) optional group appeal and one (1) common issue related party ("CIRP") group appeal. The issue statements are materially identical in both.

> Direct Graduate Medical Education ("DGME") payments; CMS's prior regulation was, as CMS states, "inconsistent with the statutory requirements" of the Medicare Act and had caused what is known as the "fellows penalty" and DGME underpayments since federal fiscal year ("FY") 1997. *See id.* However, d**espite purporting to apply its amended regulation retroactively to cost reporting periods starting in FY 2001, CMS refused to correct DGME underpayments for any settled cost reports.** *See id.* at 49,070.
>
> The issue in this appeal is whether CMS's determination to adopt an amended regulation retroactively to 2001 to determine DGME FTE counts but to limit the retroactive application of the amended regulation to open cost reporting years is substantively and/or procedurally invalid.
>
> The Providers contend that **CMS's determination not to apply the amended retroactive FTE count regulation to settled cost reports that were impacted by, and thus to correct for, the "fellows penalty' and DGME underpayments in contrary to the Medicare Act and the intent of the congress, arbitrary and capricious, otherwise contrary to law, and/or procedurally invalid**. *See* 5 U.S.C. § 706(2)(A) (providing that agency action shall be held unlawful and set aside where it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law"); *id.* § 706(2)(C) (same where agency action is "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right"); and *id.* § 706(2)(D) (same where agency action is "without observance of procedure required by law.") 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).
>
> The excerpts from the Federal Register relevant to this appeal are from (a) the FY 2023 IPPS Final Rule, 87 Fed. Reg. at 48,780, 49,066-72, 49,456, and 49,480 (Aug. 10, 2022), and (b) the FY 2023 IPPS Final Rule Correction Notice, 87 Fed. Reg. at 66,558, 66,561 (Nov. 4, 2022).[3]

Background

A. History of the DGME Methodology

The Medicare statute requires the Secretary[4] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or

[3] (Underline and bold emphasis added.)
[4] of the Department of Health and Human Services.

"DGME").[5] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[6]

The Medicare statute prescribes a formula for computing annual DGME payments to hospitals. The statutory formula consists of three components:

1. The hospital's number of FTE residents, or "FTE count;"
2. The hospital's average cost per resident (*i.e.* the per resident amount or "PRA"); and
3. The hospital's patient load, which is the percentage of a hospital's inpatient treatment days attributable to Medicare Part A and Part C beneficiaries.[7]

These appeals concern the first component of the DGME payment calculation—the resident FTE count.

A hospital's FTE count for DGME reimbursement is the number of residents trained at the hospital as adjusted by three statutory provisions. First, the statute, 42 U.S.C. § 1395ww(h)(4)(C), assigned different weights to residents depending on their status. The statute states that:

> (C) . . . [I]n calculating the number of full-time equivalent residents in an approved residency period---
>
> (ii) . . .for a resident who is in the resident's initial residency period . . . the weighting factor is 1.0 . . .
>
> (iv) . . .for a resident who is not in the resident's initial residency period . . . the weighting factor is .50.

Pursuant to this statutory provision, FTEs attributable to residents who are training in their initial residency period[8] ("IRP residents") are weighted at 100 percent or 1.0, while FTEs attributable to residents who are not in their initial residency period (commonly referred to as "fellows") are weighted at 50 percent or 0.5. The sum of the weighted FTEs for IRP residents and fellows in a given year is known as a hospital's "weighted FTE count." For example, under this weighting assignment, a hospital that trained 10 IRP residents and 10 fellows in a given year would have a weighted FTE count of 15.

On August 5, 1997, Congress enacted § 4623 of the Balanced Budget Act of 1997 ("BBA")[9] which added 42 U.S.C. § 1395ww(h)(4)(F) to establish a limit on the number of osteopathic and allopathic residents that a hospital can include in its FTE count for DGME payments. For cost

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[5] 42 U.S.C. § 1395ww(h).
[6] *See* S. Rep. No. 404, 89th Cong. 1st Sess. 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).
[7] 42 U.S.C. § 1395(h).
[8] "Initial residency period" is defined in the statute as the minimum number of years required for Board eligibility. 42 U.S.C. § 1395ww(h)(5)(F).
[9] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).

reporting periods beginning on or after October 1, 1997, a hospital's unweighted DGME FTE count could not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. In this regard, § 1395(h)(4)(F)(i) states:

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[10]

Further, 42 U.S.C. § 1395ww(h)(4)(G)(i) provides that residents are counted on a three-year average. Finally, 42 U.S.C. § 1395ww(h)(4)(A) directs the Secretary to "establish rules consistent with [§ 1395ww(h)(4)] for the computation of the number of full-time equivalent residents in an approved medical residency training program."

CMS implemented BBA § 4623, in part, by promulgating regulations at 42 C.F.R. § 413.86(g)(4) to implement the unweighted FTE cap.[11] Specifically, in the FY 1998 inpatient prospective payment system ("IPPS") final rule published on August 20, 1997 ("FY 1998 IPPS Final Rule"), CMS promulgated revisions to 42 C.F.R. § 413.86(g)(4) and included the following explanation in the preamble to that rule:

> *To address situations in which a hospital increases the number of FTE residents* ***over*** *the cap*, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.
>
> - *Determine the ratio of* the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, *to* the hospital's number of FTE residents without application of the cap for the cost reporting period at issue.
>
> - *Multiply the ratio determined above by* the weighted FTE count for those residents for the cost reporting period. Add the weighted count of residents in dentistry and podiatry to determine the weighted FTEs for the cost reporting period. This methodology

[10] 42 U.S.C. § 1395ww(h)(4)(F)(i) (emphasis added). Further, 42 U.S.C. § 1395ww(h)(4)(H) directs the Secretary to establish rules for determining the caps of hospitals that establish new programs after December 31, 1996.
[11] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> should be used for purposes of determining payment for cost reporting periods beginning on or after October 1, 1997. . . .
>
> For example, if the hospital's FTE count of residents in its cost reporting period ending December 31, 1996 is 100 residents before application of the initial residency weighting factors and the hospital's number of residents for its December 31, 1990 [*sic*] cost reporting period is 110 FTE residents, the ratio of residents in the two cost reporting periods equals 100/110. If the hospital's weighted FTE count is 100 FTE residents in the December 31, 1998 cost reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
>
> ****
>
> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[12]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[13] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

> *Step 1.* Determine that the hospital's total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in allopathic and osteopathic medicine do not exceed the hospital's FTE cap for these residents in accordance with § 413.86(g)(4). *If the hospital's total unweighted FTE count in a cost reporting period exceeds its cap*, the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately* in the following manner:
>
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and

[12] 62 Fed. Reg. at 46005 (emphasis added).
[13] 66 Fed. Reg. 39826 (Aug. 1, 2001).

> obstetrics and gynecology FTEs in the cost reporting period)
>
> plus
>
> (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period).
>
> Add the two products to determine the hospital's reduced cap.[14]

To codify this change, the Secretary added clause (iii) to 42 § 413.86(g)(4). In the final rule published on the August 11, 2004, CMS relocated 42 C.F.R. § 413.86(g)(4)(iii) to 42 C.F.R. § 413.79(c)(2)(iii) (2004).[15] This regulation is the focus of this appeal, and it stated the following:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonresidents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.[16]

As previously noted, this regulation addressed how to reduce a hospital's weighted FTE count for a fiscal year when the unweighted FTE count for that fiscal year exceeds the hospital's unweighted FTE cap.

On their cost reports, hospitals report the number of allopathic and osteopathic FTE residents (before applying the weighting factors mentioned above) that were actually trained at the facility in that year.[17]

In addition, the statute sets the number of FTEs a hospital can claim for reimbursement as the hospital's average FTE count between the present, prior and penultimate years. The statute states:

> [T]he total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the

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[14] *Id.* at 39894 (emphasis added).
[15] *See* 69 Fed. Reg. 48916, 49258-64. As part of the relocation, CMS modified the language slightly by removing the references to "paragraph (g)" that was in the prior version of the regulation and replacing it them with reference to "the limit described in this section."
[16] 42 C.F.R. §§ 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.
[17] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")

> average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.[18]

Therefore, a hospital's present year FTE count, after applying the weighting factors and FTE caps, was averaged with the FTE counts from the prior and penultimate years.

B. The Board's Analysis of 42 C.F.R. § 413.79(c)(2)(iii) (2004)

The Board has received a number of appeals concerning the DGME methodology for which it granted Expedited Judicial Review ("EJR").[19] Providers would typically assert that the regulation at 42 C.F.R. § 413.79(c)(2)(iii) (2004) penalized hospitals which exceeded their FTE caps. They would assert that § 413.79(c)(2)(iii) (2004) stated the following equation for calculating the weighted cap (*i.e.* "Allowable FTE Count") for a particular FY and that this formula resulted in the perceived disparate treatment between IRP residents and fellows. Specifically, in their EJR request, providers often presented the following equation used to calculate the allowable count for primary care and obstetrics and gynecology residents and separately for nonprimary care residents:

$$\mathrm{WFTE}\left(\frac{\mathrm{UCap}}{\mathrm{UFTE}}\right) = \mathrm{WCap}\,^{20}$$

Accordingly, the Board set out to confirm the Providers' assertion that § 413.79(c)(2)(iii) does in fact set forth the above equation.

The Board noted that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[21] As such, the equation would logically appear to be a method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" was consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[22] Accordingly, the Board referred to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii) (2004).

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[18] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[19] *See, e.g.,* PRRB Case 19-2489GC, EJR Determination (July 26, 2022).
[20] *Id.* at 4.
[21] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).
[22] 66 Fed. Reg. at 39894 (emphasis added).

Bearing this concept in mind, the Board reviewed the regulation closely and agreed that § 413.79(c)(2)(iii) (2004) essentially states the above equation, albeit in a slightly different form where the difference is inconsequential and it gives the same results. In its entirety, § 413.79(c)(2)(iii) (2004) stated:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[23]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[24] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[25] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[26] (*i.e.*, ratios) using variables a, b, c, and d:

$$If\ \frac{a}{b} = \frac{c}{d}\ \ then\ \mathrm{c} = \frac{a}{b}\ x\ d$$

On the first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or limit]." This phrase (the ***Unweighted FTE Cap*** is to the ***FY's Unweighted FTE Count***) expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[27]

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[23] (Emphasis added.)

[24] *See* 62 Fed. Reg. at 46005 (emphasis added).

[25] *Id.* (emphasis added). *See also* 66 Fed. Reg. at 39894 ("[F]or primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately…."* (Emphasis added.)).

[26] Two alternative ways to express the algebraic principle of equivalent functions include:
If a/b = c/d, then c = (a x d) / b ; and
If a/b = c/d, then c = (a/b) x d.

[27] Note that, in using equivalent ratios, the key is the relationship of the ratios. As such, the relation between the ratios does not change if they are flipped. For example, if these ratios are flipped, then the initial equation becomes the FY's Weighted FTE Count (variable d) over the Weighted FTE Cap (variable c) equals the FY's Unweighted

On the other side of the algebraic equation (*i.e.*, the ratio of "c /d") is the following phrase: "the hospital's weighted FTE count (before application of the limit) . . . will be reduced in the same proportion." This phrase expressed as a ratio ("c/d") is an *unknown* Weighted FTE Cap over the FY's Weighted FTE Count. In other words, the unknown Weighted FTE Cap is the resulting value of the weighted FTEs being reduced in the same proportion as the FY Unweighted FTE Count exceeds the Unweighted FTE cap. The full proportional equation is expressed as follows:

$$\frac{Unweighted\ FTE\ Cap\ (a)}{FY's\ Unweighted\ FTE\ Count\ (b)} = \frac{Weighted\ \ FTE\ Cap\ (c)}{FY's\ Weighted\ FTE\ Count\ (d)}$$

The unknown Weighted FTE Cap (variable "c") is then determined by a/b x d. In other words, the unknown Weighted FTE Cap is determined by the following formula:

$$\boldsymbol{Weighted\ FTE\ cap} = \frac{Unweighted\ \ FTE\ Cap}{Unweighted\ FTE\ Count} \times\ Weighted\ FTE\ Count$$

This formula is clearly stated in the preambles to both the FYs 1998 and 2002 IPPS Final Rules as previously quoted.

Based on the above, the Board found that 42 C.F.R. § 413.79(c)(2)(iii) (2004) did set forth the equation being challenged and, accordingly, that the providers were challenging the validity of § 413.79(c)(2)(iii) (2004). The Board also found that EJR was appropriate for the issue under dispute in the cases challenging the DGME methodology.

C. Milton S. Hershey Med. Ctr. v. Becerra and 42 C.F.R. § 413.79(c)(2)(iii) (2022)[28]

One group of providers appealed to U.S. District Court for the District of Columbia in *Hershey* to challenge the regulation setting forth the DGME methodology.[29] The Court ultimately found that CMS' "application of the regulation to calculate [the providers'] reimbursement payments was unlawful because, in calculating the weighted number of FTE residents, the regulation effectively changed the weighting factors for residents and fellows that Congress established in the Medicare statute."[30]

The Court looked to the enabling statute for the DGME payment at 42 U.S.C. § 1395ww(h)(4)(C), noting it commanded that rules promulgated by the Secretary would weight residents at 1.0 and fellows at 0.5.[31] The regulation at 42 C.F.R. § 413.79(c)(2)(iii) (2004), however, effectively reduced the weighted FTE count when a hospital exceeds its FTE cap and employs fellows. The Court found that "the text of the statute does not give the Secretary the latitude to decide . . . to change the

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FTE Count (variable b) over the Unweighted FTE Cap (variable a). The unknown variable is still "c" and you would get the same results where rule would then be: If b/a = d/c, then c = (a/b) x d.

[28] 2021 WL 1966572 (D.D.C. 2021) ("*Hershey*").

[29] *Hershey* at *1.

[30] *Id.* at *3.

[31] *Id.* at *5.

weights that Congress assigned to residents and fellows when he calculates the FTE residents for each hospital."[32] The Court also found the statute at 42 U.S.C. § 1395ww(h)(4)(C) was not ambiguous, but clear, and since the challenged regulation contradicted mandatory (*i.e.*, "shall") provisions of the statute, the regulation failed the first step in the analysis set forth in *Chevron.*[33] Thus, the Court held the DGME regulation was unlawful as applied to the providers in that case.[34]

Following the decision in *Hershey*, the Secretary issued the FY 2023 Final Rule to replace the policy at 42 C.F.R. § 413.79(c)(2)(iii) (2004) and implement a modified policy applicable to all teaching hospitals, effective as of October 1, 2021.[35] While the DGME methodology struck down in *Hershey* was first applicable to cost reports beginning October 1, 1997, the Secretary noted there did not appear to be any "open or reopenable" Notices of Program Reimbursement ("NPRs") for 1997-2001 and, as such, opted to amend the policy for cost reporting periods beginning on or after October 1, 2001.[36] The Secretary acknowledged that the policy set forth in 42 C.F.R. § 413.79(c)(2)(iii) (2004) was inconsistent with the statutory requirements of 42 U.S.C. § 1395ww(h)(4)(C). Since, however, 42 U.S.C. § 1395ww(h)(4)(A) directs the Secretary to "establish rules consistent with [§ 1395ww(h)(4)] for the computation of the number of full-time equivalent residents in an approved medical residency training program[,]" the Secretary determined retroactive rulemaking was necessary to modify the methodology for cost reporting periods beginning on or after October 1, 2001. As such, the regulation at 42 C.F.R. § 413.79(c)(2)(iii) and the related cost reporting instructions were revised to incorporate a new methodology that "would address situations for applying the FTE cap when a hospital's weighted FTE count was greater than its FTE cap, but would not reduce the weighting factor of residents that are beyond their IRP by an amount less than 0.5."[37] However, the Secretary specifically noted that, consistent with 42 C.F.R. § 405.1885(c)(2), the retroactive rule would ***not*** cover cost reporting periods for which any NPRs had already been settled.[38]

The Secretary maintained, over commenters' objections, that retroactive rulemaking was the appropriate means to implement its new DGME methodology because: (1) 42 U.S.C. § 1395ww(h)(4)(A) states that "[t]he Secretary shall establish rules *consistent with this paragraph* for the computation of the number of full-time equivalent residents in an approved medical residency training program; and (2) The Court in *Hershey* held, and the Secretary agreed, that the method for computing FTEs was not consistent with statutory requirements.[39] The Secretary also maintained that declining to open closed cost reports through this retroactive rule was consistent with 42 C.F.R. § 405.1885(c)(2), which states that a "change of legal interpretation or policy by CMS in a regulation . . . made in response to judicial precedent," is "not a basis for reopening a CMS or contractor determination."[40]

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[32] *Id.*
[33] *Chevron v. Nat. Res. Def. Council*, 467 U.S. 837 (1984).
[34] *Id.*
[35] 87 Fed. Reg. 28108, 28410-28412 (May 10, 2022).
[36] *See* 87 Fed. Reg. 48780, 49067 (Aug. 10, 2022). CMS had solicited comments alerting them of any open or openable NPRs for 1997-2001, but this discussion suggests that apparently CMS did not receive any such comments.
[37] *Id.* at 49067-49068.
[38] *Id.* at 49067, 49070.
[39] *Id.* at 49068-49069.
[40] *Id.* at 49070.

Decision of the Board

The Providers are challenging the ***refusal*** of the CMS to apply the newly revised 42 C.F.R. § 413.79(c)(2)(iii) (2022) to the fiscal years at issue.[41] They argue that the CMS' determination to *not* reopen and revise the closed cost reports at issue is contrary to law.[42] Specifically, the Providers argue that "CMS's determination not to apply the amended retroactive FTE count regulation to settled cost reports. . . is contrary to the Medicare Act and the intent of the Congress, arbitrary and capricious, otherwise contrary to law, and/or procedurally invalid."[43]

42 C.F.R. § 405.1885(c)(1)(i) provides an example of a CMS-directed reopening:

> A contractor determination . . . must be reopened and revised if CMS provides explicit notice to the contractor that the contractor determination . . . is inconsistent with the applicable law, regulations, CMS ruling, or other interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS in effect, and as CMS understood those legal provisions, at the time the determination or decision was rendered by the contractor. CMS may also direct the contractor to reopen a particular contractor determination or decision in order to implement a final agency decision (as described in §§405.1833, 405.1871(b) and 405.1875 of this subpart), a final, non-appealable court judgment §405.1877, or an agreement to settle an administrative appeal or a lawsuit, regarding the same determination or decision.

As set forth below, the Board hereby dismisses the Providers' appeals because they failed to appeal from a "final determination" as that term is used in 42 U.S.C. § 1395oo(a)(1)(A)(ii).

A. The Providers have failed to appeal a "final determination" as that term is issued in 42 U.S.C. § 1395oo(a)(1).

While a provider typically has appeal rights from the publication of a final rule in the Federal Register,[44] the policy being appealed here is not a "***final*** determination"[45] within the context of 42 U.S.C. § 1395oo(a)(1) because the policy has no reimbursement impact on cost reports at issue *that have already been settled and closed*. 42 U.S.C. § 1395oo(a) typically allows two types of appeals: directly from a Medicare Contractor's "final determination" issued in the form of a Notice of Program Reimbursement ("NPR"), or from the issuance of a notice of what will be paid under the IPPS system.[46] With regard to the latter, once a hospital's IPPS payment amounts are finally determined or set by CMS, there has been a "final determination" that is subject to an

[41] Issue Statement at 1.
[42] *Id.*
[43] *Id.*
[44] *See Washington Hosp. Ctr. v. Bowen,* 795 F.2d 139 (D.C. Cir. 1986).
[45] (Emphasis added.)
[46] *Id.* at 144-145.

appeal before the Board.[47] In these cases, the Providers' IPPS payment amounts were finally determined when their NPRs were issued in accordance with the prior DGME policy. The revised DGME policy set forth in the FY 2023 IPPS Rule has not altered or set any payment amount the Providers received or will receive. Indeed, that is the crux of the Providers' challenge: that their payment amounts have not been, and will not be, set to a different amount.

The Supreme Court addressed this very issue in its 1999 decision for *Your Home Visiting Nurse Services, Inc. v. Shalala*.[48] Specifically, the Supreme Court confirmed that the decision of the Medicare Contractor, CMS or the Secretary to not reopen a final determination is precluded from administrative and judicial review:

> Petitioner relies upon 42 U.S.C. § 1395*oo* (a)(1)(A)(i), which says that a provider may obtain a hearing before the Board with respect to a cost report if the provider "is dissatisfied with a final determination of . . . its fiscal intermediary . . . as to the amount of total program reimbursement due the provider . . . for the period covered by such report . . . ." Petitioner maintains that the refusal to reopen a reimbursement determination constitutes a separate "final determination . . . as to the amount of total program reimbursement due the provider." The Secretary, on the other hand, maintains that this phrase does not include a refusal to reopen, which is not a "final determination . . . as to the amount," but rather the *refusal* to make a new determination. The Secretary's reading of § 1395*oo* (a)(1)(A)(i) frankly seems to us the more natural—but it is in any event well

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[47] *Id.* at n.7. *See also Abbott-Northwestern Hosp. v. Leavitt*, 377 F.Supp.2d 119, 127 (D.D.C. 2005) (noting that a letter from the Secretary declining a hospital's request to revise certain payments was a "final determination" because it "did not suggest that the decision would be revisited, and it established definitely the amount" of certain payments.). In their appeal requests, the Providers cite to a 1993 decision of the Administrator pertaining to an appeal of the 1992 wage index rates published in the Federal Register. However, that decision is not supportive as made plain by the following excerpt from that decision:

> After a review of the record, the law, applicable regulations and court's decision in Washington Hospital Center, the Administrator determines that the Providers can appeal the validity of the wage index that the Secretary has established for Federal fiscal year 1992 for the District of Columbia hospitals, within 180 days of the publication of the wage index in the Federal Register. Both the Board and BPD, although finding that publication of the rates did not constitute a final determination of the Secretary, failed to cite what constituted such a determination for purposes of appeal under PPS.
>
> The controlling case law clearly holds that Congress did not intend for a PPS hospital to wait until the issuance of an NPR before it can appeal the final determination of the Secretary as to the amount of payment under subsection (b) or (d) of Section 1886 [PPS]. The publication of the wage index is the only formal notice, other than the NPR, that these Providers received regarding their DRG prospective payment rate under Section 1886(d) of the Act. Therefore, the finding that this publication is not a final determination of the Secretary conflicts with the court's reasoning in Washington Hospital Center. Based on the controlling case law, the Administrator determines that the publication of the wage index in the Federal Register constitutes a "final determination of the Secretary" for purposes of Section 1878(a)(1)(A)(ii) of the Act.

District of Columbia Hospital Association Wage Index Group Appeal, Adm'r Dec. (Jan. 15, 1993), *vacating* PRRB Juris. Dec., Case No. 92-1200G (Nov. 18, 1992) (footnotes omitted).

[48] 525 U.S. 449 (1999).

> within the bounds of reasonable interpretation, and hence entitled to deference under *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.,* 467 U.S. 837, 842 . . . (1984).
>
> The reasonableness of the Secretary's construction of the statute is further confirmed by *Califano v. Sanders,* 430 U.S. 99 . . . (1977), in which we held that § 205(g) of the Social Security Act does not authorize judicial review of the Secretary's decision not to reopen a previously adjudicated claim for benefits. In reaching this conclusion we relied, in part, upon two considerations: that the opportunity to reopen a benefit adjudication was afforded only by regulation and not by the Social Security Act itself; and that judicial review of a reopening denial would frustrate the statutory purpose of imposing a 60–day limit on judicial review of the Secretary's final decision on an initial claim for benefits. *Id.,* at 108. Similar considerations apply here. The right of a provider to seek reopening exists only by grace of the Secretary, and the statutory purpose of imposing a 180–day limit on the right to seek Board review of NPRs, see 42 U.S.C. § 1395*oo* (a)(3), would be frustrated by permitting requests to reopen to be reviewed indefinitely.
>
> Finally, we do not think that the Secretary's position is inconsistent with 42 U.S.C. § 1395x(v)(1)(A)(ii), which provides that the Secretary's cost-reimbursement regulations shall "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." Petitioner asserts that the reopening regulations, as construed by the Secretary, do not create a "suitable" procedure for making "retroactive corrective adjustments" because an intermediary's refusal to reopen a determination is not subject to administrative review. . . .
>
> This argument fails for two reasons. First, and most importantly, petitioner's construction of § 1395x(v)(1)(A)(ii) is inconsistent with our decision in *Good Samaritan Hospital v. Shalala,* 508 U.S. 402 . . . (1993), in which we held that the Secretary reasonably construed clause (ii) to refer to the year-end reconciliation of monthly payments to providers, see 42 U.S.C. § 1395g, with the total amount of program reimbursement determined by the intermediary. Although we did not specifically consider the procedure for reopening determinations *after* the year's books are closed, we think our conclusion there—that clause (ii) refers to the year-end book balancing—forecloses petitioner's contention that clause (ii) requires any particular procedure for reopening reimbursement determinations. And second, the procedures for obtaining reimbursement would not be "unsuitable"

> simply because an intermediary's refusal to reopen is not administratively reviewable. Medicare providers already have the right under § 1395*oo* (a)(3) to appeal an intermediary's reimbursement determination to the Board. Title 42 C.F.R. § 405.1885 (1997) generously gives them a second chance to get the decision changed—this time at the hands of the intermediary itself, but without the benefit of administrative review. That is a "suitable" procedure, especially in light of the traditional rule of administrative law that an agency's refusal to reopen a closed case is generally " 'committed to agency discretion by law' " and therefore exempt from judicial review. See *ICC v. Locomotive Engineers,* 482 U.S. 270, 282 . . . (1987).[49]

Accordingly, it is clear that the Providers have no basis to appeal CMS' ***refusal*** to reopen the closed or settled cost reports at issue.

Indeed, the substantive rule actually promulgated (*i.e.*, amending a regulation to implement a new DGME policy at 42 C.F.R. § 413.79(c)(2)(iii) (2022)) is not being challenged. Rather, the Providers' arguments, as a whole, challenge CMS' decision *not* to reopen certain closed or settled cost reports. Again, the Supreme Court has affirmed that the *refusal* to reopen a reimbursement determination is not a final determination for which the Board has jurisdiction to review.[50] Refusing to reopen is, more simply, a refusal to make a new determination.[51] 42 C.F.R. § 405.1885(a)(6) also specifically states that "a determination or decision to reopen or not to reopen a determination or decision is not a final determination or decision" which is subject to administrative or judicial review. Pursuant to 42 C.F.R. § 405.1867, the Board is bound by that regulation and must find that the Providers have failed to appeal a final determination over which it has jurisdiction under 42 U.S.C. § 1395oo(a)(1).

B. CMS' decision not to reopen is consistent with its regulations governing reopening of final determinations.[52]

42 C.F.R. § 405.1885(c) specifies that Medicare contractors have discretion whether to reopen final determinations that they have issued, but with one caveat. The Medicare contractor's exercise of discretion is "***subject to a directive from CMS*** to reopen ***or not reopen*** the determination . . . ."[53] With regard to the retroactive application of 42 C.F.R. § 413.79(c)(iii) (2022), CMS has specifically directed Medicare contractors *to **not** reopen and revise* closed or settled cost reports.[54]

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[49] *Id.* at 453-55. *See also Barlett Mem. Med. Ctr., Inc. v. Thompson*, 347 F.3d 828 (10th Cir. 2003); *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013); *Baptist Mem. Hosp. v. Sebelius*, 603 F.3d 57 (D.C. Cir. 2010).
[50] *Your Home Visiting Nurse Services, Inc. v. Shalala,* 525 U.S. 449, 449-450 (1999).
[51] *Id.*
[52] The Board has no authority to otherwise alter or amend the Secretary's policy finalized in the preamble to the FFY 2023 IPPS Final Rule. In this section, the Board is merely expounding on the Secretary's rationale on how the reopening regulation serves as a basis for its policy.
[53] (Emphasis added.) *See also* 42 C.F.R. § 405.1885(a)(3) ("A contractor's discretion to reopen or not reopen a matter is subject to a contrary directive from CMS to reopen or not reopen that matter.").
[54] 87 Fed. Reg. at 49067.

Reopening the cost reports in question would be "prohibited reopening[s]" under 42 C.F.R. § 405.1885(c)(2). CMS is obligated to interpret and apply the Medicare Statute.[55] Thus, consistent with this obligation, 42 C.F.R. § 405.1885(c)(2) specifically states that a "change of legal interpretation or policy by CMS in a regulation . . . *whether made in response to judicial precedent or otherwise*, is ***not*** a basis for reopening a CMS or contractor determination . . . ."[56] This is precisely the situation in these cases; CMS changed its interpretation of 42 U.S.C. § 1395ww(h)(4)(C) as set forth in its regulations "in response to judicial precedent" (*i.e.*, the *Hershey* decision).[57]

Finally, the Providers make bald allegations that CMS' actions are arbitrary and capricious and/or procedurally invalid,[58] but there is no discussion or suggestion that the notice-and-comment rulemaking for the FY 2023 Final Rule itself was deficient. CMS has opted to not reopen and revise cost reports consistent with its policy favoring finality embedded in 42 C.F.R. § 405.1885(c)(2).[59] The Providers have not made any statements or arguments to suggest how this would be deemed arbitrary.

Conclusion:

The Board hereby dismisses the two (2) appeals from the FY 2023 IPPS Final Rule filed by Hooper, Lundy & Bookman, P.C. because the Providers failed to appeal a "final determination" as that term is issued in 42 U.S.C. § 1395oo(a)(1) and a decision not to reopen is not an appealable determination per the Supreme Court decision in *Your Home*. Moreover, CMS' decision not to reopen is consistent with its regulations governing reopening of final determinations. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

5/14/2024

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

cc: Pamela VanArsdale, National Government Services, Inc. (J-6)
Danelle Decker, National Government Services, Inc. (J-K)
Wilson Leong, FSS

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[55] *See, e.g., MacKenzie Med. Supply, Inc., v. Leavitt*, 506 F.3d 341, 346 (4th Cir. 2007) (". . . the Secretary is charged with administering the Medicare Act . . . .")
[56] (Emphasis added.)
[57] 87 Fed. Reg. at 49067.
[58] Issue Statement at 1.
[59] 87 Fed. Reg. at 49070.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Board Decision* – SSI Percentage (Provider Specific) Issue**
Davis Regional Medical Center (Provider Number 34-0144)
FYE: 09/30/2015
Case Number: 19-0977

Dear Messrs. Ravindran and Lamprecht,

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

Background:

A. *Procedural History for Case No. 19-0977*

On **July 26, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2015.

On **January 3, 2019**, the Board received the Provider's individual appeal request. The Individual Appeal contained nine (9) issues:

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

[1] On July 23, 2019, this issue was transferred to PRRB Case No. 18-0588GC.
[2] On July 23, 2019, this issue was transferred to PRRB Case No. 18-0589GC.
[3] On July 23, 2019, this issue was transferred to PRRB Case No. 18-0584GC.
[4] On July 23, 2019, this issue was transferred to PRRB Case No. 18-0591GC.
[5] On July 23, 2019, this issue was transferred to PRRB Case No. 18-0585GC.

8. Uncompensated Care ("UCC") Distribution Pool[6]
9. 2 Midnight Census IPPS Payment Reduction[7]

As the Provider is owned by Community Health Systems, Inc. ("Community Health") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2, 3, 4, 6, 7, 8 and 9 to Community Health CIRP groups on **July 23, 2019**. The remaining issues in this appeal are Issues 1 (DSH Payment/SSI Percentage (Provider Specific)) and 5 (DSH Payment – Medicaid Eligible Days).

On **February 5, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[8]

On **August 20, 2019**, the Provider timely filed its preliminary position paper.

On **October 22, 2019**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1.

On **December 20, 2019**, the Medicare Contractor timely filed its preliminary position paper.

On **September 8, 2023**, the Board issued a corrected Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

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

[6] On July 23, 2019, this issue was transferred to PRRB Case No. 18-0587GC.
[7] On July 23, 2019, this issue was transferred to PRRB Case No. 18-0592GC.
[8] (Emphasis added).

> requirements. If the Provider misses its due date, the Board will dismiss the cases.[9]

On **February 28, 2024**, the Provider timely filed its final position paper.

On **March 14, 2024**, the Medicare Contractor timely filed its final position paper.

On **May 2, 2024**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-0588GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[10]

The group issue statement in Case No. 18-0588GC, QRS HMA 2015 DSH SSI Percentage CIRP Group, to which the Provider transferred Issue 2 reads:

> **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)?

[9] (Emphasis added).
[10] Issue Statement at 1 (Jan. 3, 2019).

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

The Provider(s) further contend(s) that the SSI percentages calculated by [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[11]

On **February 28, 2024**, the Provider filed its final position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

[11] Group Issue Statement, Case No. 18-0588GC.

> **Provider Specific**
>
> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[12]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $14,000.

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue for several reasons. First, the MAC argues that the appeal is premature:

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

[12] Provider's Final Position Paper at 8-9 (Feb. 28, 2024).

> 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 PRRB dismiss this issue consistent with recent jurisdictional decisions.[13]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH/SSI Percentage (Systemic Errors) issue that was transferred to PRRB Case No. 18-0588GC are considered the same issue by the Board.[14]

Provider's Jurisdictional Response

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

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

Board Analysis and Decision:

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

The jurisdictional analysis for Issue 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. As set forth below, the Board should dismiss all aspects of Issue 1.

1. First Aspect of Issue 1

The first and third aspects of Issue No. 1—both included in the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the

[13] Jurisdictional Challenge at 5 (Oct. 22, 2019).
[14] *Id*. at 3-4.
[15] Board Rule 44.4.3, v. 2 (Aug. 2018).

DSH percentage—are duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 18-0588GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[16] 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 that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[18]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 18-0588GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 18-0588GC. 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.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 18-0588GC, 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.[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 can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 18-0588GC.

To this end, the Board also reviewed the Provider's Final Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from

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[16] Issue Statement at 1.
[17] *Id.*
[18] *Id.*
[19] PRRB Rules v. 2 (Aug. 2018).
[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).

the SSI issue in Case No. 18-0588GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Final Position Paper failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Final Position Paper and include *all* exhibits.

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

> **25.2 – Position Paper Exhibits**
>
> **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.

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule,

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

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and

Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

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

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

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. 18-0588GC.

Accordingly, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue and the group issue from Group Case 18-0588GC 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 SSI Percentage - Provider Specific issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal. Further, the Provider's cost reporting period ends on 9/30, making it congruent with the Federal fiscal year. As such, realignment of the SSI percentage would have no effect on reimbursement.

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[21] Last accessed May 15, 2024.
[22] Emphasis added.

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. 18-0588GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The case remains open.

Board Members Participating:

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

For the Board:

5/15/2024

X Kevin D. Smith, CPA

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

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

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RE: ***Board Determination on Request for Reconsideration of Dismissal/Reinstatement***
Advocate Aurora Health CY 2017 Understated Standardized Amt. Predicate Fact CIRP Grp.
Case No. 20-2071GC

Dear Ms. Elias:

The Provider Reimbursement Review Board (the "Board") has reviewed the above-captioned common issue related party ("CIRP") group appeal in response to November 21, 2023 correspondence from Hall, Render, Killian, Heath & Lyman, P.C. ("Hall Render"/"Representative") in which it requests that the Board reconsider the November 21, 2023 "Dismissal for Untimely Filing." The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

On **September 15, 2020,** Hall Render filed a group appeal request to establish the subject CIRP group under Case No. 20-2071GC for the Understated Standardized Amount Predicate Fact issue. The group was formed with the direct addition of Advocate South Suburban Hospital (Prov. No. 14-0250), which was filed from receipt of its Notice of Program Reimbursement ("NPR") for FYE 12/31/2017.

On **September 15, 2020,** the Board issued a "Case Acknowledgement and Critical Due Dates Notice" ("ACCD") requiring the Representative to file its comments regarding full formation by September 15, 2021.

On **September 9, 2021**, the Representative advised the Board that the group was not yet complete as it was still waiting to add eighteen (18) providers that had outstanding NPRs. Accordingly, between **May 4, 2021** and **November 2, 2022**, these additional 18 providers were directly added to the group.

On **September 12, 2023**, the Representative designated this group formed.

On **September 13, 2023,** Federal Specialized Services filed a jurisdictional challenge on behalf of the Medicare Contractor, challenging the group issue. On **September 19, 2023**, the Board on its own motion, issued an order extending the Group's time to file its response to the jurisdictional challenge until November 14, 2023**.**

On **September 21, 2023**, the Board issued Notice of CIRP Group Fully Formed and Critical Due Dates ("Critical Due Dates Notice"). In particular, the Critical Due Dates Notice set the parties' deadlines for filing preliminary position papers, where the Group's preliminary position paper was

due November 20, 2023 and the Medicare Contractor's was due January 19, 2024. The Notice warned the representative that: "The parties ***must*** meet the following due dates *regardless of any outstanding jurisdictional challenges*, motions, or subpoena requests. If the Group misses any of its due date the Board ***will*** *dismiss the appeal*."[1]

On **October 12, 2023**, the Representative requested its deadline to respond to the jurisdictional challenge be either postponed until the conclusion of the *St. Mary's* case in pending federal court[2] or, in the alternative, be extended an additional 150 days from the current November 14, 2023 deadline.

On **October 19, 2023,** the Board further extended the deadline for the Group to file its responsive brief to the jurisdictional challenge until May 20, 2024**.**

On **November 7, 2023**, Hall Render timely filed a Rule 20 Certification, advising that the group was fully populated in the Office of Hearings Case & Document Management System ("OH CDMS").

On **November 21, 2023**, following the expiration of the preliminary position paper deadline, the Board dismissed Case No. 20-2071GC because the Group failed to timely file the preliminary position paper by the November 20, 2023 filing deadline.

On **November 21, 2023**, the Representative filed a request for reinstatement of its case. In its request Hall Render attributed its missing the filing deadline to "the failure of the [*sic*] its docketing system." While the Representative did not explain what the system "failure" was, it offered the following in support of its motion: (1) it filed the missing preliminary position paper with its motion, less than 16 hours after the November 20, 2023 deadline; and (2) the Representative has a ". . . large docket and a system failure is very rare from us."

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 final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

Hall Render has filed a motion requesting that the Board reinstate the case. Board Rule 47.1 governs motions for reinstatement of an issue or case:

> **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

[1] (Emphasis added.)
[2] *St. Mary's Med. Ctr. et al. v. Becerra*, Case No. 1:23-cv-01594-RCL (D.D.C.).

> Board will not reinstate an issue(s)/case if the provider was at fault. If an issue(s)/case was remanded pursuant to a CMS ruling (e.g., CMS Ruling 1498-R), the provider must address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board reinstates an issue(s) or case, the provider will have the same rights (no greater and no less) that it had in its initial appeal. . . .
>
> ****
>
> **47.3 Dismissals for Failure to Comply with Board Procedures**
>
> **Upon written motion demonstrating good cause**, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, **administrative oversight**, settlement negotiations or a change in representative **will not be considered good cause to reinstate**. If the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, then the motion for reinstatement must, ***as a prerequisite***, include the required filing before the Board will consider the motion.[3]

Board Rule 47.1 states that the Board will not reinstate if the provider was at fault and Board Rule 47.3 further clarifies that, when the dismissal is based on the failure to comply with Board Procedures (such a filing a required position paper), the Board may reinstate for good cause which does ***not*** include administrative oversight. Here, while Ascension met the "*prerequisite*" for Board consideration of a Motion for Reinstatement under Board Rule 47.3 by belatedly filing its preliminary position paper, the Board finds that the Representative was at fault in missing its filing deadline since it failed to meet the preliminary position paper deadline due to a self-admitted administrative error. Specifically, the Representative simply describes its error as "the failure of the [*sic*] its docketing system" without any further explanation beyond the assertion that "a system failure is very rare from us." Further, the Representative's motion for reinstatement is deficient because, contrary to Board Rule 44 governing motions, it did not include a statement confirming it had contacted the Medicare Contractor prior to filing the motion to determine if the Medicare Contractor would concur or oppose the motion.

In denying the request, the Board notes that the September 21, 2023 "CIRP Group Fully Formed and Critical Due Dates" notice clearly stated that "The parties ***must*** meet the following due dates *regardless of any outstanding jurisdictional challenges* . . . ." and that "[i]f the Group misses any of its due dates, the Board will dismiss the appeal." Further, the Notice is consistent with the following Board Rules:

> **4.4.2 Due Dates for Other Filings**
>
> All filings other than an appeal request or request to add issues (*e.g.*, position papers and other responsive documents) must be received by the Board no later than the date specified on the Board's notice or, if silent, the date specified in these Rules. If a party fails to file by the established due date, the Board may take action as described in 42 C.F.R. § 405.1868. For example, Rule

[3] (Italics and underline emphasis in original, and bold emphasis added except the titles had bold emphasis in original.)

23.4 addresses the timely filing of preliminary position papers and specifies that the Board will dismiss the appeal if the representative for the provider(s) fails to file their preliminary position paper or PJSO by the established due date.

****

Rule 14 Acknowledgement of Group Appeal

The Board will send an Acknowledgement and Critical Due Dates Notice via email to the group representative and the lead Medicare contractor confirming receipt of the group appeal and the case number assigned. . . .

The acknowledgement (or future correspondence) may also set various deadlines and due dates including, but not limited to, position paper deadlines, full formation of the group, discovery and other documentation requirements. Failure by a party to comply with such deadlines may result in the Board taking any of the actions described in 42 C.F.R. § 405.1868.

****

23.3 Preliminary Position Papers Required if PJSO Is Not Executed

If the parties do not jointly execute and file a PJSO by the due date, the position paper deadlines established in the acknowledgement letter will control. Both parties must file preliminary position papers that comply with Rule 25 (and exchange documentation) by their respective due dates.

****

23.6 Miscellaneous Motions Filed Prior to . . . Position Paper Deadline

Matters pending before the Board that have not yet been completed or ruled upon (such as transfer requests, requests for abeyance, expedited judicial review, mediation, jurisdictional challenges, discovery, or other motions) will not suspend these filing requirements. If a motion or request is not complete or has not been ruled on, the parties must proceed as if it will not occur (or will not be granted) and comply with all filing deadlines. If an issue(s) or the case is not timely addressed as required in this Rule because the parties have relied on an incomplete action or a pending request that has not yet ruled upon, it is subject to dismissal at any time during the proceedings.[4]

[4] (Underline emphasis added.)

These Board Rules are consistent with 42 C.F.R. § 405.1853(b) which explicitly acknowledges the Board's authority to "establish[] deadlines as to when the provider(s) and the contractor must submit position papers to the Board."

The Board acknowledges that the Representative is claiming that the position paper was filed less than 24 hours after the due date. However, this does not change the fact that it was required to make the preliminary position paper *by the filing deadline*. The Board is aware of Hall Render's large docket and its familiarity with the processes set forth in the Critical Due Dates notices and the Board Rules. However, these factors are insufficient under Board Rules to excuse the Representative for its failure to carry out its responsibilities and are not considered good cause for failing to meet the filing deadline:

> **5.2 Responsibilities**
>
> *The case representative is responsible for being familiar with the following rules and procedures* for litigating before the Board:
>
> - The Board's governing statute at 42 U.S.C. § 1395oo;
> - The Board's governing regulations at 42 C.F.R. Part 405, Subpart R; and
> - These Rules, which include any relevant Orders posted at https://www.cms.gov/Regulations-and-Guidance/ReviewBoards/PRRBReview/PRRB-Instructions (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.[5]

In summary, pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b), the Board denies the Representative's request for reinstatement of Case No. 20-2071GC. The Board finds that the Representative was a fault and failed to establish good cause under Board Rules 47.1 and 47.3 as it admitted fault for missing the preliminary position paper deadline and failed to confer with the Medicare Contractor prior to filing the motion as required by Board Rules 47.1 and 44. Therefore, the Board finds it properly exercised its authority under 42 C.F.R. § 405.1868(b) to dismiss the case and declines to exercise its discretion to reinstate Case No. 20-2071GC. The Board's original dismissal and denial of reinstatement is consistent with numerous cases in which federal courts have

[5] (Bold emphasis in original and italics and underline emphasis added.)

upheld the Board's authority to dismiss cases for failure of the provider to timely file position papers or other Board filings.[6] Accordingly, this case remains closed and off the Board's docket.

Board Members:
Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

5/17/2024

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

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

[6] *Kaiser Found. Hosps. v. Sebelius*, 649 F.3d 1153 (9th Cir. 2011) (upholding dismissal for failure to file preliminary position paper); *Baptist Mem'l Hosp.-Golden Triangle v. Sebelius*, 566 F.3d 226 (2009) (upholding dismissal for failure to file preliminary position paper); *High Country Home Health Inc. v. Thompson*, 359 F.3d 1307 (10th Cir. 2004); *Inova Alexandria Hosp. v. Shalala*, 244 F.3d 342, 351 (4th Cir. 2001) (upholding dismissal for failure to file preliminary or final position papers and stating "The Hospital argues that the Board irrationally concluded that administrative oversight is not a valid excuse. We disagree. Because the Hospital's failure to file timely position papers was due to circumstances entirely within its own control, the Board had a rational basis for its decision."); *UHI, Inc. v. Thompson*, 250 F.3d (6th Cir. 2001); *Lutheran Med. Ctr. v. Burwell*, No. 14-VC-731, 2016 WL 3882896 (E.D. N.Y. July 13, 2016); *Rapid City Reg. Hosp. v. Sebelius*, 681 F. Supp. 2d 56 (D.D.C. 2010) (upholding dismissal for failure to file preliminary position paper and citing to "the general proposition that legitimate procedural rules can be relied upon to control the Board's docket by dismissing appeals that are not timely filed" (citations omitted) and upholding Board denial based on the); *S.C. San Antonio Inc. v. Leavitt*, No. SA-07-CA-527-OG, 2008 WL 4816611(W.D. Tex. Sept. 30, 2008); *Lutheran Med. Ctr. v. Thompson*, No. 02-CV- 6144, 2006 WL 2853870 (E.D. N.Y. Oct. 2, 2006); *Novacare, Inc. v. Thompson*, 357 F. Supp. 2d 268, 272-273 (D.D.C. 2005) (upholding denial of reinstatement where the Board explained that "failure to communicate clearly with its counsel was insufficient basis to justify reinstatement"); *Saint Joseph Hosp. v. Shalala*, No. 99-C7775, 2000 WL 1847976 (N.D. Ill. Dec. 15, 2000). *See also Memorial Hosp. of S. Bend v. Becerra*, No. 20-3461, 2022 WL 888190 at *10 (D.D.C. Mar. 25, 2022); *Akron Gen. Med. Ctr. v. Azar*, 836 Fed. Appx. 13 (D.C. Cir. 2021), *aff'g*, 414 F. Supp. 3d 73 (D.D.C. 2019).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Notice of Dismissal***
Case Nos. 23-0711GC, *et al.* (*see* Attachment A listing of 15 cases)

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests and final determinations in the fifteen (15) appeals identified on Attachment A. They are made up of fourteen (14) common issue related party ("CIRP") group appeals and one (1) *optional* group appeal. The Board's decision to dismiss these 15 cases is set forth below.

Issue in Dispute

The Providers are appealing from the issuance of the Fiscal Year ("FY") 2023 Inpatient Prospective Payment System ("IPPS") Final Rule published in the Federal Register on August 10, 2022. The Provider state that the sole issue in these cases is "CMS's unlawful application of 42 U.S.C. § 1395ww(h)(4)(C) in counting full-time equivalent residents (FTEs) for purposes of Direct Graduate Medical Education (DGME) payments when the hospital's total number of FTEs, including residents outside the initial residency period (post-IRP) and fellows exceeded the FTE cap set in 1996." Significantly, all of the providers in these groups are seeking to have their *settled* cost reports for all fiscal years impacted by the DGME post-IRP issue "reopened." Specifically, the Providers' issue statements[1] describe the issue as follows:

> Providers request a group appeal hearing in accordance with 42 C.F.R. §§ 405.1835 and 405.1837 to challenge CMS's unlawful application of 42 U.S.C. § 1395ww(h)(4)(C) in counting full-time equivalent residents (FTEs) for purposes of Direct Graduate Medical Education (DGME) payments when the hospital's total number of FTEs, including residents outside the initial residency period ("Post-IRP") and fellows (collectively herein, "fellows"), exceeded the FTE cap set in 1996.

[1] The Board's decision encompasses one (1) optional group appeal and one (14) common issue related party ("CIRP") group appeals. The issue statements are materially identical in all 15 cases.

By statute, Congress directed CMS to calculate the number of FTEs by weighting the number of resident FTEs at 1.0 and fellow FTEs at 0.5. 42 U.S.C. § 1395ww(h)(3)(C); *see also Milton S. Hershey Medical Center v. Becerra,* No. 1:19-cv-02680-TJK, 2021 WL 1966572 (slip copy) (D.D.C. May 17, 2021) ("Hershey"). When a hospital's total number of FTEs exceeded its 1996 cap, however, CMS's regulation implementing the statute applied a formula that improperly resulted in weights that were lower than those set by Congress. *See* 42 C.F.R. § 413.79(c)(2)(iii) (prior to the 2022 amendments discussed below). The formula error resulted in underpayments to affected hospitals for all fiscal years beginning on or after October 1, 1997, when the improper FTE counting method was first effective, FY 2023 IPPS Final Rule, 87 Fed. Reg. 48,780, 49,067 (Aug 10, 2022). The fact that CMS's implementing regulation violated the statute was confirmed by the D.C. District Court in *Hershey*, and acknowledged by CMS in the FY 2023 IPPS Final Rule, which purports to correct the error for "all payments, both past and future," retroactively to cost reporting periods beginning on or after October 1, 2001. 87 Fed. Reg. at 49,066-072 (finding it "necessary to recalculate past payments in light of the *Hershey* decision," and implying that hospitals "similarly situated" to the *Hershey* plaintiffs may "file administrative appeals in order to obtain the benefit of the new payment formula.").

In *Hershey*, the D.C. District Court held that the regulation was unlawful:

> Simply put, the text of the statute does not give the Secretary the latitude to decide, under these conditions, to change the weights that Congress assigned to residents and fellows when he calculates the FTE residents for each hospital. Rather, the statute is clear: the Secretary's rules "shall provide in calculating the number of [FTE] residents in an approved residency program," that residents be weighted at 1.0 and fellows at 0.5 § 1395ww(h)(4)(C). When Congress uses the word "shall," its language is mandatory or imperative, not merely practory." *See United States v. Monzel*, 641 F.3d 528, 531 (D.C. Cir. 2011). Thus, the Court[]. . . holds that the regulation is unlawful as applied to Plaintiffs.

2021 WL 1966572 at *5.

In 2022, CMS acknowledged that its "existing formula for computing the number of FTEs was inconsistent with the statutory requirements," and finalized a rule that applies a new formula for calculating FTEs, aligned with the decision in *Hershey.* FY 2023 IPPS Final Rule, 87 Fed. Reg. at 49,067; *see id.* at 49,066-072. CMS said the Final Rule's new FTE calculation is effective retroactively to cost reporting periods beginning on or after October 1, 2001. *Id.* at 49,067. *See also* 42 C.F.R. § 405.1885(c)(1), (3) and CMS Pub. 15-1, Ch. 29, §§ 2930 *et. seq*.

By applying CMS's unlawful regulation, the Medicare Administrative Contractors (MAC) incorrectly counted FTEs for purposes of calculating the Provider's DGME payments for cost reporting years beginning on or after October 1, 1997. Providers appeal from the FY 2023 IPPS Final Rule, seeking a correction to their FTE counts by applying 42 C.F.R. § 413.79(c)(2)(iii), as amended by the Final Rule, to accurately weight resident and fellows FTEs as the statute requires, and a recalculation of their DGME payments for all impacted cost reporting periods. FY 2023 IPPS Final Rule 87 Fed. Reg. at 49,067-072. To the extent that any impacted cost reporting period was settled within 180 days prior to this filing (or 185 days, as permitted), those Providers further appealed from those specific determinations.

Additionally, and importantly, the unlawful reductions of FTE resident counts in prior cost reporting years adversely affects the Providers' DGME payments for the fiscal years impacted by the FY 2023 IPPS Final Rule, as well as future fiscal years if not corrected, because the FTE calculation for each year uses, in part, the prior and penultimate year FTE resident counts, and therefore the prior and penultimate year FTE resident counts must be corrected, as required in the FY 2023 IPPS Final Rule and prior case law. *See* FY 2023 IPPS Final Rule, 87 Fed. Reg. 48,780 (Aug. 10, 2022).

Due to the fact the *Hershey* court ruled that 42 C.F.R. § 413.79(c)(2)(iii) (prior to the 2022 amendments) was unlawful, the law requires Congress's statutory directive to be applied to all FY's beginning on or after October 1, 1997 and forward pursuant to Congress's clear direction that "for purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before application of weighting factors . . . may not exceed the period ending on or before December 31, 1996." *Hershey*, 2021 WL 1966572 at *2, and that the weighting factors be applied as written and without further reduction. **Fully <u>retroactive</u> application to all impacted cost**

> **reporting periods, whether open or closed, is further supported by the fact that the 2023 IPPS Final Rule itself purports to correct the issue retroactively to 2001**.
>
> **Providers are seeking reopening and correction of their cost reports for all fiscal years impacted by this appeal**, as required under 42 C.F.R. § 405.1885 and other applicable regulations, as further required under the Medicare Act, and pursuant to applicable case law. *See State of Or. On Behalf of Oregon Health Sciences University v. Bowen*, 854 F. 2d 346 (9th Cir. 1988). *Mem'l Hosp. v. Sullivan*, 779 F. Supp. 1410 (D.D.C. 1991); 42 U.S.C. §§ 1302, 1395x(v)(1)(A)(ii), 1395hh.[2]

Background

A. History of the DGME Methodology

The Medicare statute requires the Secretary[3] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME").[4] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[5]

The Medicare statute prescribes a formula for computing annual DGME payments to hospitals. The statutory formula consists of three components:

1. The hospital's number of FTE residents, or "FTE count;"
2. The hospital's average cost per resident (*i.e.* the per resident amount or "PRA"); and
3. The hospital's patient load, which is the percentage of a hospital's inpatient treatment days attributable to Medicare Part A and Part C beneficiaries.[6]

These appeals concern the first component of the DGME payment calculation—the resident FTE count.

A hospital's FTE count for DGME reimbursement is the number of residents trained at the hospital as adjusted by three statutory provisions. First, the statute, 42 U.S.C. § 1395ww(h)(4)(C), assigned different weights to residents depending on their status. The statute states that:

---

[2] (Bold and underline emphasis added.)
[3] of the Department of Health and Human Services.
[4] 42 U.S.C. § 1395ww(h).
[5] *See* S. Rep. No. 404, 89th Cong. 1st Sess. 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).
[6] 42 U.S.C. § 1395(h).

> (C) . . . [I]n calculating the number of full-time equivalent residents in an approved residency period---
>
> (ii) . . .for a resident who is in the resident's initial residency period . . . the weighting factor is 1.0 . . .
>
> (iv) . . .for a resident who is not in the resident's initial residency period . . . the weighting factor is .50.

Pursuant to this statutory provision, FTEs attributable to residents who are training in their initial residency period[7] ("IRP residents") are weighted at 100 percent or 1.0, while FTEs attributable to residents who are not in their initial residency period (commonly referred to as "fellows") are weighted at 50 percent or 0.5. The sum of the weighted FTEs for IRP residents and fellows in a given year is known as a hospital's "weighted FTE count." For example, under this weighting assignment, a hospital that trained 10 IRP residents and 10 fellows in a given year would have a weighted FTE count of 15.

On August 5, 1997, Congress enacted § 4623 of the Balanced Budget Act of 1997 ("BBA")[8] which added 42 U.S.C. § 1395ww(h)(4)(F) to establish a limit on the number of osteopathic and allopathic residents that a hospital can include in its FTE count for DGME payments. For cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted DGME FTE count could not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. In this regard, § 1395(h)(4)(F)(i) states:

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[9]

Further, 42 U.S.C. § 1395ww(h)(4)(G)(i) provides that residents are counted on a three-year average. Finally, 42 U.S.C. § 1395ww(h)(4)(A) directs the Secretary to "establish rules consistent with [§ 1395ww(h)(4)] for the computation of the number of full-time equivalent residents in an approved medical residency training program."

---

[7] "Initial residency period" is defined in the statute as the minimum number of years required for Board eligibility. 42 U.S.C. § 1395ww(h)(5)(F).

[8] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).

[9] 42 U.S.C. § 1395ww(h)(4)(F)(i) (emphasis added). Further, 42 U.S.C. § 1395ww(h)(4)(H) directs the Secretary to establish rules for determining the caps of hospitals that establish new programs after December 31, 1996.

CMS implemented BBA § 4623, in part, by promulgating regulations at 42 C.F.R. § 413.86(g)(4) to implement the unweighted FTE cap.[10] Specifically, in the FY 1998 inpatient prospective payment system ("IPPS") final rule published on August 20, 1997 ("FY 1998 IPPS Final Rule"), CMS promulgated revisions to 42 C.F.R. § 413.86(g)(4) and included the following explanation in the preamble to that rule:

> *To address situations in which a hospital increases the number of FTE residents* ***over*** *the cap*, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.
>
> - *Determine the ratio of* the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, *to* the hospital's number of FTE residents without application of the cap for the cost reporting period at issue.
>
> - *Multiply the ratio determined above by* the weighted FTE count for those residents for the cost reporting period. Add the weighted count of residents in dentistry and podiatry to determine the weighted FTEs for the cost reporting period. This methodology should be used for purposes of determining payment for cost reporting periods beginning on or after October 1, 1997. . . .
>
> For example, if the hospital's FTE count of residents in its cost reporting period ending December 31, 1996 is 100 residents before application of the initial residency weighting factors and the hospital's number of residents for its December 31, 1990 [*sic*] cost reporting period is 110 FTE residents, the ratio of residents in the two cost reporting periods equals 100/110. If the hospital's weighted FTE count is 100 FTE residents in the December 31, 1998 cost reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
>
> ****
>
> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[11]

[10] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).
[11] 62 Fed. Reg. at 46005 (emphasis added).

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[12] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

> *Step 1.* Determine that the hospital's total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in allopathic and osteopathic medicine do not exceed the hospital's FTE cap for these residents in accordance with § 413.86(g)(4). *If the hospital's total unweighted FTE count in a cost reporting period exceeds its cap*, the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately* in the following manner:
>
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and obstetrics and gynecology FTEs in the cost reporting period)
> >
> > plus
> >
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period).
>
> Add the two products to determine the hospital's reduced cap.[13]

To codify this change, the Secretary added clause (iii) to 42 § 413.86(g)(4). In the final rule published on the August 11, 2004, CMS relocated 42 C.F.R. § 413.86(g)(4)(iii) to 42 C.F.R. § 413.79(c)(2)(iii) (2004).[14] This regulation is the focus of this appeal, and it stated the following:

---

[12] 66 Fed. Reg. 39826 (Aug. 1, 2001).
[13] *Id.* at 39894 (emphasis added).
[14] *See* 69 Fed. Reg. 48916, 49258-64. As part of the relocation, CMS modified the language slightly by removing the references to "paragraph (g)" that was in the prior version of the regulation and replacing it them with reference to "the limit described in this section."

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e*., the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonresidents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.[15]

As previously noted, this regulation addressed how to reduce a hospital's weighted FTE count for a fiscal year when the unweighted FTE count for that fiscal year exceeds the hospital's unweighted FTE cap.

On their cost reports, hospitals report the number of allopathic and osteopathic FTE residents (before applying the weighting factors mentioned above) that were actually trained at the facility in that year.[16]

In addition, the statute sets the number of FTEs a hospital can claim for reimbursement as the hospital's average FTE count between the present, prior and penultimate years. The statute states:

> [T]he total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.[17]

Therefore, a hospital's present year FTE count, after applying the weighting factors and FTE caps, was averaged with the FTE counts from the prior and penultimate years.

B. The Board's Analysis of 42 C.F.R. § 413.79(c)(2)(iii) (2004)

The Board has received a number of appeals concerning the DGME methodology for which it granted Expedited Judicial Review ("EJR").[18] Providers would typically assert that the regulation at 42 C.F.R. § 413.79(c)(2)(iii) (2004) penalized hospitals which exceeded their FTE caps. They would assert that § 413.79(c)(2)(iii) (2004) stated the following equation for calculating the weighted cap (*i.e.* "Allowable FTE Count") for a particular FY and that this formula resulted in the perceived disparate treatment between IRP residents and fellows. Specifically, in their EJR request, providers often presented the following equation used to calculate the allowable count for primary care and obstetrics and gynecology residents and separately for nonprimary care residents:

---

[15] 42 C.F.R. §§ 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.
[16] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")
[17] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[18] *See, e.g.,* PRRB Case 19-2489GC, EJR Determination (July 26, 2022).

$$\text{WFTE}\left(\frac{\text{UCap}}{\text{UFTE}}\right) = \text{WCap}\,[19]$$

Accordingly, the Board set out to confirm the Providers' assertion that § 413.79(c)(2)(iii) does in fact set forth the above equation.

The Board noted that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[20] As such, the equation would logically appear to be a method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" was consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[21] Accordingly, the Board referred to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii) (2004).

Bearing this concept in mind, the Board reviewed the regulation closely and agreed that § 413.79(c)(2)(iii) (2004) essentially states the above equation, albeit in a slightly different form where the difference is inconsequential and it gives the same results. In its entirety, § 413.79(c)(2)(iii) (2004) stated:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[22]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear

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[19] *Id.* at 4.
[20] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).
[21] 66 Fed. Reg. at 39894 (emphasis added).
[22] (Emphasis added.)

that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[23] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[24] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[25] (*i.e.*, ratios) using variables a, b, c, and d:

$$If\ \frac{a}{b} = \frac{c}{d}\ then\ \text{c} = \frac{a}{b}\ x\ d$$

On the first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or limit]." This phrase (the ***Unweighted FTE Cap*** is to the ***FY's Unweighted FTE Count***) expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[26]

On the other side of the algebraic equation (*i.e.*, the ratio of "c /d") is the following phrase: "the hospital's weighted FTE count (before application of the limit) . . . will be reduced in the same proportion." This phrase expressed as a ratio ("c/d") is an *unknown* Weighted FTE Cap over the FY's Weighted FTE Count. In other words, the unknown Weighted FTE Cap is the resulting value of the weighted FTEs being reduced in the same proportion as the FY Unweighted FTE Count exceeds the Unweighted FTE cap. The full proportional equation is expressed as follows:

$$\frac{Unweighted\ FTE\ Cap\ (a)}{FY's\ Unweighted\ FTE\ Count\ (b)} = \frac{Weighted\ \ FTE\ Cap\ (c)}{FY's\ Weighted\ FTE\ Count\ (d)}$$

The unknown Weighted FTE Cap (variable "c") is then determined by a/b x d. In other words, the unknown Weighted FTE Cap is determined by the following formula:

$$\boldsymbol{Weighted\ FTE\ cap} = \frac{Unweighted\ \ FTE\ Cap}{Unweighted\ FTE\ Count} \times\ Weighted\ FTE\ Count$$

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[23] *See* 62 Fed. Reg. at 46005 (emphasis added).

[24] *Id.* (emphasis added). *See also* 66 Fed. Reg. at 39894 ("[F]or primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately…."* (Emphasis added.)).

[25] Two alternative ways to express the algebraic principle of equivalent functions include:
If a/b = c/d, then c = (a x d) / b ; and
If a/b = c/d, then c = (a/b) x d.

[26] Note that, in using equivalent ratios, the key is the relationship of the ratios. As such, the relation between the ratios does not change if they are flipped. For example, if these ratios are flipped, then the initial equation becomes the FY's Weighted FTE Count (variable d) over the Weighted FTE Cap (variable c) equals the FY's Unweighted FTE Count (variable b) over the Unweighted FTE Cap (variable a). The unknown variable is still "c" and you would get the same results where rule would then be: If b/a = d/c, then c = (a/b) x d.

This formula is clearly stated in the preambles to both the FYs 1998 and 2002 IPPS Final Rules as previously quoted.

Based on the above, the Board found that 42 C.F.R. § 413.79(c)(2)(iii) (2004) did set forth the equation being challenged and, accordingly, that the providers were challenging the validity of § 413.79(c)(2)(iii) (2004). The Board also found that EJR was appropriate for the issue under dispute in the cases challenging the DGME methodology.

C. Milton S. Hershey Med. Ctr. v. Becerra and 42 C.F.R. § 413.79(c)(2)(iii) (2022)[27]

One group of providers appealed to U.S. District Court for the District of Columbia in *Hershey* to challenge the regulation setting forth the DGME methodology.[28] The Court ultimately found that CMS' "application of the regulation to calculate [the providers'] reimbursement payments was unlawful because, in calculating the weighted number of FTE residents, the regulation effectively changed the weighting factors for residents and fellows that Congress established in the Medicare statute."[29]

The Court looked to the enabling statute for the DGME payment at 42 U.S.C. § 1395ww(h)(4)(C), noting it commanded that rules promulgated by the Secretary would weight residents at 1.0 and fellows at 0.5.[30] The regulation at 42 C.F.R. § 413.79(c)(2)(iii) (2004), however, effectively reduced the weighted FTE count when a hospital exceeds its FTE cap and employs fellows. The Court found that "the text of the statute does not give the Secretary the latitude to decide . . . to change the weights that Congress assigned to residents and fellows when he calculates the FTE residents for each hospital."[31] The Court also found the statute at 42 U.S.C. § 1395ww(h)(4)(C) was not ambiguous, but clear, and since the challenged regulation contradicted mandatory (*i.e.*, "shall") provisions of the statute, the regulation failed the first step in the analysis set forth in *Chevron.*[32] Thus, the Court held the DGME regulation was unlawful as applied to the providers in that case.[33]

Following the decision in *Hershey*, the Secretary issued the FY 2023 Final Rule to replace the policy at 42 C.F.R. § 413.79(c)(2)(iii) (2004) and implement a modified policy applicable to all teaching hospitals, effective as of October 1, 2021.[34] While the DGME methodology struck down in *Hershey* was first applicable to cost reports beginning October 1, 1997, the Secretary noted there did not appear to be any "open or reopenable" Notices of Program Reimbursement ("NPRs") for 1997-2001 and, as such, opted to amend the policy for cost reporting periods

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[27] 2021 WL 1966572 (D.D.C. 2021) ("*Hershey*").
[28] *Hershey* at *1.
[29] *Id.* at *3.
[30] *Id.* at *5.
[31] *Id.*
[32] *Chevron v. Nat. Res. Def. Council*, 467 U.S. 837 (1984).
[33] *Id.*
[34] 87 Fed. Reg. 28108, 28410-28412 (May 10, 2022).

beginning on or after October 1, 2001.[35] The Secretary acknowledged that the policy set forth in 42 C.F.R. § 413.79(c)(2)(iii) (2004) was inconsistent with the statutory requirements of 42 U.S.C. § 1395ww(h)(4)(C). Since, however, 42 U.S.C. § 1395ww(h)(4)(A) directs the Secretary to "establish rules consistent with [§ 1395ww(h)(4)] for the computation of the number of full-time equivalent residents in an approved medical residency training program[,]" the Secretary determined retroactive rulemaking was necessary to modify the methodology for cost reporting periods beginning on or after October 1, 2001. As such, the regulation at 42 C.F.R. § 413.79(c)(2)(iii) and the related cost reporting instructions were revised to incorporate a new methodology that "would address situations for applying the FTE cap when a hospital's weighted FTE count was greater than its FTE cap, but would not reduce the weighting factor of residents that are beyond their IRP by an amount less than 0.5."[36] However, the Secretary specifically noted that, consistent with 42 C.F.R. § 405.1885(c)(2), the retroactive rule would ***not*** cover cost reporting periods for which any NPRs had already been settled.[37]

The Secretary maintained, over commenters' objections, that retroactive rulemaking was the appropriate means to implement its new DGME methodology because: (1) 42 U.S.C. § 1395ww(h)(4)(A) states that "[t]he Secretary shall establish rules *consistent with this paragraph* for the computation of the number of full-time equivalent residents in an approved medical residency training program; and (2) The Court in *Hershey* held, and the Secretary agreed, that the method for computing FTEs was not consistent with statutory requirements.[38] The Secretary also maintained that declining to open closed cost reports through this retroactive rule was consistent with 42 C.F.R. § 405.1885(c)(2), which states that a "change of legal interpretation or policy by CMS in a regulation . . . made in response to judicial precedent," is "not a basis for reopening a CMS or contractor determination."[39]

Decision of the Board

The Providers are challenging the refusal of the CMS to apply the newly revised 42 C.F.R. § 413.79(c)(2)(iii) (2022) to the fiscal years at issue.[40] They argue that the CMS' determination to not reopen and revise the closed cost reports at issue is contrary to law.[41] Specifically, the Providers argue that "[b]y applying CMS's unlawful regulation, the Medicare Administrative Contractors (MAC) incorrectly counted FTEs for purposes of calculating the Provider's DGME payments for cost reporting years beginning on or after October 1, 1997."[42]

The Providers assert the following:

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[35] *See* 87 Fed. Reg. 48780, 49067 (Aug. 10, 2022). CMS had solicited comments alerting them of any open or openable NPRs for 1997-2001, but this discussion suggests that apparently CMS did not receive any such comments.
[36] *Id.* at 49067-49068.
[37] *Id.* at 49067, 49070.
[38] *Id.* at 49068-49069.
[39] *Id.* at 49070.
[40] Issue Statement at 2.
[41] *Id.*
[42] *Id.*

> Providers appeal from the FY 2023 IPPS Final Rule, seeking a correction to their FTE counts by applying 42 C.F.R. § 413.79(c)(2)(iii), as amended by the Final Rule, to accurately weight resident and fellows FTEs as the statute requires, and a recalculation of their DGME payments for all impacted cost reporting periods.
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> ****
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> *Providers are seeking* ***reopening*** and correction *of their cost reports* for all fiscal years impacted by this appeal, *as required under 42 C.F.R. § 405.1885* and other applicable regulations, as further required under the Medicare Act, and pursuant to applicable case law.[43]

42 C.F.R. § 405.1885(c)(1)(i) provides an example of a CMS-directed reopening:

> A contractor determination . . . must be reopened and revised if CMS provides explicit notice to the contractor that the contractor determination . . . is inconsistent with the applicable law, regulations, CMS ruling, or other interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS in effect, and as CMS understood those legal provisions, at the time the determination or decision was rendered by the contractor. CMS may also direct the contractor to reopen a particular contractor determination or decision in order to implement a final agency decision (as described in §§405.1833, 405.1871(b) and 405.1875 of this subpart), a final, non-appealable court judgment §405.1877, or an agreement to settle an administrative appeal or a lawsuit, regarding the same determination or decision.

As set forth below, the Board hereby dismisses the Providers' appeals because they failed to appeal from a "final determination" as that term is used in 42 U.S.C. § 1395oo(a)(1)(A)(ii).

A. The Providers have failed to appeal a "final determination" as that term is issued in 42 U.S.C. § 1395oo(a)(1).

While a provider typically has appeal rights from the publication of a final rule in the Federal Register,[44] the policy being appealed here is not a "***final*** determination"[45] within the context of 42 U.S.C. § 1395oo(a)(1) because the policy has no reimbursement impact on cost reports at issue *that have already been settled and closed*. 42 U.S.C. § 1395oo(a) typically allows two types of appeals: directly from a Medicare Contractor's "final determination" issued in the form of a Notice of Program Reimbursement ("NPR"), or from the issuance of a notice of what will be

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[43] *Id.*
[44] *See Washington Hosp. Ctr. v. Bowen,* 795 F.2d 139 (D.C. Cir. 1986).
[45] (Emphasis added.)

paid under the IPPS system.[46] With regard to the latter, once a hospital's IPPS payment amounts are finally determined or set by CMS, there has been a "final determination" that is subject to an appeal before the Board.[47] In these cases, the Providers' IPPS payment amounts were finally determined when their NPRs were issued in accordance with the prior DGME policy. The revised DGME policy set forth in the FY 2023 IPPS Rule has not altered or set any payment amount the Providers received or will receive. Indeed, that is the crux of the Providers' challenge: that their payment amounts have not been, and will not be, set to a different amount.

The Supreme Court addressed this very issue in its 1999 decision for *Your Home Visiting Nurse Services, Inc. v. Shalala*.[48] Specifically, the Supreme Court confirmed that the decision of the Medicare Contractor, CMS or the Secretary to not reopen a final determination is precluded from administrative and judicial review:

> Petitioner relies upon 42 U.S.C. § 1395*oo* (a)(1)(A)(i), which says that a provider may obtain a hearing before the Board with respect to a cost report if the provider "is dissatisfied with a final determination of . . . its fiscal intermediary . . . as to the amount of total program reimbursement due the provider . . . for the period covered by such report . . . ." Petitioner maintains that the refusal to reopen a reimbursement determination constitutes a separate "final determination . . . as to the amount of total program reimbursement due the provider." The Secretary, on the other hand, maintains that

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[46] *Id.* at 144-145.

[47] *Id.* at n.7. *See also Abbott-Northwestern Hosp. v. Leavitt*, 377 F.Supp.2d 119, 127 (D.D.C. 2005) (noting that a letter from the Secretary declining a hospital's request to revise certain payments was a "final determination" because it "did not suggest that the decision would be revisited, and it established definitely the amount" of certain payments.). In their appeal requests, the Providers cite to a 1993 decision of the Administrator pertaining to an appeal of the 1992 wage index rates published in the Federal Register. However, that decision is not supportive as made plain by the following excerpt from that decision:

> After a review of the record, the law, applicable regulations and court's decision in Washington Hospital Center, the Administrator determines that the Providers can appeal the validity of the wage index that the Secretary has established for Federal fiscal year 1992 for the District of Columbia hospitals, within 180 days of the publication of the wage index in the Federal Register. Both the Board and BPD, although finding that publication of the rates did not constitute a final determination of the Secretary, failed to cite what constituted such a determination for purposes of appeal under PPS.
>
> The controlling case law clearly holds that Congress did not intend for a PPS hospital to wait until the issuance of an NPR before it can appeal the final determination of the Secretary as to the amount of payment under subsection (b) or (d) of Section 1886 [PPS]. The publication of the wage index is the only formal notice, other than the NPR, that these Providers received regarding their DRG prospective payment rate under Section 1886(d) of the Act. Therefore, the finding that this publication is not a final determination of the Secretary conflicts with the court's reasoning in Washington Hospital Center. Based on the controlling case law, the Administrator determines that the publication of the wage index in the Federal Register constitutes a "final determination of the Secretary" for purposes of Section 1878(a)(1)(A)(ii) of the Act.

District of Columbia Hospital Association Wage Index Group Appeal, Adm'r Dec. (Jan. 15, 1993), *vacating* PRRB Juris. Dec., Case No. 92-1200G (Nov. 18, 1992) (footnotes omitted).

[48] 525 U.S. 449 (1999).

> this phrase does not include a refusal to reopen, which is not a "final determination . . . as to the amount," but rather the *refusal* to make a new determination. The Secretary's reading of § 1395*oo* (a)(1)(A)(i) frankly seems to us the more natural—but it is in any event well within the bounds of reasonable interpretation, and hence entitled to deference under *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.,* 467 U.S. 837, 842 . . . (1984).
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> The reasonableness of the Secretary's construction of the statute is further confirmed by *Califano v. Sanders,* 430 U.S. 99 . . . (1977), in which we held that § 205(g) of the Social Security Act does not authorize judicial review of the Secretary's decision not to reopen a previously adjudicated claim for benefits. In reaching this conclusion we relied, in part, upon two considerations: that the opportunity to reopen a benefit adjudication was afforded only by regulation and not by the Social Security Act itself; and that judicial review of a reopening denial would frustrate the statutory purpose of imposing a 60–day limit on judicial review of the Secretary's final decision on an initial claim for benefits. *Id.,* at 108. Similar considerations apply here. The right of a provider to seek reopening exists only by grace of the Secretary, and the statutory purpose of imposing a 180–day limit on the right to seek Board review of NPRs, see 42 U.S.C. § 1395*oo* (a)(3), would be frustrated by permitting requests to reopen to be reviewed indefinitely.
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> Finally, we do not think that the Secretary's position is inconsistent with 42 U.S.C. § 1395x(v)(1)(A)(ii), which provides that the Secretary's cost-reimbursement regulations shall "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." Petitioner asserts that the reopening regulations, as construed by the Secretary, do not create a "suitable" procedure for making "retroactive corrective adjustments" because an intermediary's refusal to reopen a determination is not subject to administrative review. . . .
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> This argument fails for two reasons. First, and most importantly, petitioner's construction of § 1395x(v)(1)(A)(ii) is inconsistent with our decision in *Good Samaritan Hospital v. Shalala,* 508 U.S. 402 . . . (1993), in which we held that the Secretary reasonably construed clause (ii) to refer to the year-end reconciliation of monthly payments to providers, see 42 U.S.C. § 1395g, with the total amount of program reimbursement determined by the intermediary. Although we did not specifically consider the procedure for

> reopening determinations *after* the year's books are closed, we think our conclusion there—that clause (ii) refers to the year-end book balancing—forecloses petitioner's contention that clause (ii) requires any particular procedure for reopening reimbursement determinations. And second, the procedures for obtaining reimbursement would not be "unsuitable" simply because an intermediary's refusal to reopen is not administratively reviewable. Medicare providers already have the right under § 1395*oo* (a)(3) to appeal an intermediary's reimbursement determination to the Board. Title 42 C.F.R. § 405.1885 (1997) generously gives them a second chance to get the decision changed—this time at the hands of the intermediary itself, but without the benefit of administrative review. That is a "suitable" procedure, especially in light of the traditional rule of administrative law that an agency's refusal to reopen a closed case is generally " 'committed to agency discretion by law' " and therefore exempt from judicial review. See *ICC v. Locomotive Engineers,* 482 U.S. 270, 282 . . . (1987).[49]

Accordingly, it is clear that the Providers have no basis to appeal CMS' refusal to reopen the cost reports at issue.

Indeed, the substantive rule actually promulgated (*i.e.*, amending a regulation to implement a new DGME policy at 42 C.F.R. § 413.79(c)(2)(iii) (2022)) is not being challenged. Rather, the Providers' arguments, as a whole, challenge CMS' decision not to reopen certain cost reports. Again, the Supreme Court has affirmed that the refusal to reopen a reimbursement determination is not a final determination for which the Board has jurisdiction to review.[50] Refusing to reopen is, more simply, a refusal to make a new determination.[51] 42 C.F.R. § 405.1885(a)(6) also specifically states that "a determination or decision to reopen or not to reopen a determination or decision is not a final determination or decision" which is subject to administrative or judicial review. Pursuant to 42 C.F.R. § 405.1867, the Board is bound by that regulation and must find that the Providers have failed to appeal a final determination over which it has jurisdiction under 42 U.S.C. § 1395oo(a)(1).

B. CMS' decision not to reopen is consistent with its regulations governing reopening of final determinations.[52]

42 C.F.R. § 405.1885(c) specifies that Medicare contractors have discretion whether to reopen final determinations that they have issued, but with one caveat. The Medicare contractor's

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[49] *Id.* at 453-55. *See also Barlett Mem. Med. Ctr., Inc. v. Thompson*, 347 F.3d 828 (10th Cir. 2003); *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013); *Baptist Mem. Hosp. v. Sebelius*, 603 F.3d 57 (D.C. Cir. 2010).
[50] *Your Home Visiting Nurse Services, Inc. v. Shalala,* 525 U.S. 449, 449-450 (1999).
[51] *Id.*
[52] The Board has no authority to otherwise alter or amend the Secretary's policy finalized in the preamble to the FFY 2023 IPPS Final Rule. In this section, the Board is merely expounding on the Secretary's rationale on how the reopening regulation serves as a basis for its policy.

exercise of discretion is "***subject to a directive from CMS*** to reopen ***or not reopen*** the determination . . . ."[53] With regard to the retroactive application of 42 C.F.R. § 413.79(c)(iii) (2022), CMS has specifically directed Medicare contractors *to* ***not*** *reopen and revise* closed or settled cost reports.[54]

Reopening the cost reports in question would be "prohibited reopening[s]" under 42 C.F.R. § 405.1885(c)(2). CMS is obligated to interpret and apply the Medicare Statute.[55] Thus, consistent with this obligation, 42 C.F.R. § 405.1885(c)(2) specifically states that a "change of legal interpretation or policy by CMS in a regulation . . . *whether made in response to judicial precedent or otherwise*, is ***not*** a basis for reopening a CMS or contractor determination . . . ."[56] This is precisely the situation in these cases; CMS changed its interpretation of 42 U.S.C. § 1395ww(h)(4)(C) as set forth in its regulations "in response to judicial precedent" (*i.e.*, the *Hershey* decision).[57]

Finally, the Board suspects that for many of the fiscal years at issue the relevant settled cost report has been closed for over three years. As a result, unless fraud or similar fault standards applied (which is not alleged in the issue statement), those older settled cost reports could not be eligible to be reopened under the normal 3-year period provided in 42 C.F.R. 405.1885(b)(2).

C. Even if the CMS' Refusal Reopen Published in the FY 2023 IPPS Final Rule Could Be Appealed as a "Final Determination" Under 42 U.S.C. § 1395oo(a)(1)(A)(ii), the Providers' Appeal Requests Failed to Meet the Minimum Content Requirements For an Appeal Request to Demonstrate that this Refusal Was, In Fact, Applicable to Them For the Fiscal Years at Issue.

42 C.F.R. § 405.1837(c) specifies the content requirements for a request for a Board hearing as a group appeal. The Providers have not provided any explanation in their appeal requests of why the Board has jurisdiction over their appeal and *none has included* ***any*** *information related to any relevant NPRs or revised NPRs or any information on any settled costs reports that they seek to be reopened*. In this regard, the Board notes that it is the Providers' responsibility under 42 C.F.R. § 405.1837(c) and Board Rules to include the necessary documentation in the appeal request to demonstrate the Board's jurisdiction over the appeals.

42 C.F.R. § 405.1837(a)(1) makes clear that a provider's right to a Board hearing as part of group appeal is dependent on "[t]he provider satisfy[ng] individually the requirements for a Board hearing under § 405.1835(a) or § 405.1835(c), except for the $10,000 amount in controversy requirement." One of the requirements in § 405.1835(a) is that the provider is appealing "a final contractor or Secretary determination."

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[53] (Emphasis added.) *See also* 42 C.F.R. § 405.1885(a)(3) ("A contractor's discretion to reopen or not reopen a matter is subject to a contrary directive from CMS to reopen or not reopen that matter.").
[54] 87 Fed. Reg. at 49067.
[55] *See, e.g., MacKenzie Med. Supply, Inc., v. Leavitt*, 506 F.3d 341, 346 (4th Cir. 2007) (". . . the Secretary is charged with administering the Medicare Act . . . .")
[56] (Emphasis added.)
[57] 87 Fed. Reg. at 49067.

The content requirements for a group appeal request are located at 42 C.F.R. § 405.1837(c) and specify that the appeal request must "demonstrate[e] that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section" and that, in addition to the "final contractor or Secretary determination under appeal", must include "any other documentary evidence the providers consider to satisfy the hearing request requirements of paragraphs (c)(1) . . . of this section."

Here, none of the Providers include as part of their appeal requests any documentation relating to the actual settled cost reports for which they contest CMS' decision not to reopen, notwithstanding their responsibilities under 42 C.F.R. § 405.1837(c) as quoted above.

Without having the settled cost report/NPR or any additional documentation on the Providers' final determination as it relates to the fiscal years at issue, the Board cannot confirm what years if any, the contested refusal to reopen applies. The Group Representative only includes the an obtuse description that does not identify the *specific particular* fiscal years at issue. For example, in Case No. 23-711GC, the Group Representative included the following description of the cost reporting periods at issue in the appeal for the participant Overlook Medical Center (Prov. No. 31-0051):

> The FFY 2023 Medicare IPPS Final Rule corrects this issue retroactively to 2001, resulting in multiple cost reporting periods that are affected by this rule. *Therefore this appeal encompasses* ***all of the providers' cost reporting periods*** *from 1998 through 2023* ***for which the providers received incorrectly calculated DGME payments***. However, the OH CDMS portal does not accommodate appeals in which the cost reporting periods affected exceed two cost reporting periods.
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> Since this appeal affects twenty-six (26) cost reporting periods, we have elected to include only the first cost reporting period affected, FY 1998, and the final cost reporting period affected, FY 2023 to comply with the PRRB's appeal filing requirements.

While the Group Representative specifies the years FY 1998 to FY 2023, it states that the appeal is limited to those years "for which the providers received incorrectly calculated DGME payments" and is not limited to whether the cost reporting period is settled, closed, reopened or on appeal to the Board. Which years are those? Did the Provider receive DGME for all of those years? Here, the Providers in these appeal requests fail to: (1) identify the specific cost reporting periods appealed s (date and year) for which they contest CMS' decision not to reopen, notwithstanding their responsibilities under 42 C.F.R. § 405.1837(c) as quoted above; and (2) provide supporting documentation confirming, by year, what settled cost report is at issue.

Without this documentation, it is unclear whether *any* of the providers in these groups received DGME, much less whether any were impacted by the change in policy for ***each*** of the contested

years (which again have not yet been specifically identified). Moreover, the Board notes that some of the Providers in these groups may have pursued, or still be pursuing, this DGME post-IRP issue in a Board appeal for certain fiscal years. For example, CHS has a CIRP group pending under Case No. 23-0956GC entitled "CHS CYs 2018-2019 DGME Post Initial Residency Period FTE Weighting CIRP Group" that clearly is duplicates part of the CHS CIRP under Case No. 23-0761GC that would cover years 1998 to 2023.[58] This illustrates why their issue description is too broad and generic to comply with the content requirements in 42 C.F.R. § 405.1837(c)(2) knowing that these groups were to pertain to only one year in compliance with 42 C.F.R. §§ 405.1837(b)(1), (b)(1), and (e)(1). In other words, for each year, an appeal request must meet the § 405.1837(c)(2) requirements and that clearly has not been done here when it is not even clear that each participant for each year has a settled cost for which they received DGME which in turn was impacted by DGME post-IRP issue.

Similarly, as noted in Section B, the date of the settled cost report at issue for each year is needed to determine whether the limitation on reopening in 42 C.F.R. § 405.1885 is applicable. If it is applicable to a particular settlement cost report, then it would mean that the amount in controversy would be $0 for the year covered by that settled cost report.

Based on the above, it is clear that the Providers appeals are ***fatally flawed*** and the Board would exercise its discretion to dismiss those appeals for failure to comply with the mandatory content requirements for appeal requests located at 42 C.F.R. §§ 405.1837(c).

D. ***The Providers' Appeal Requests Pertains to Multiple Years, in violation of Board Rules and 42 C.F.R. § 405.1837(b)(1)***

Board Rule 12.5 reads, in pertinent part:

> A group may cover ***only*** *one calendar year* ***unless*** *the Board allows the group to be expanded*. Specifically, providers in a group appeal must have final determinations for their cost reporting periods that end within the same calendar year. However, a group may submit a written request to include more than one calendar year if it cannot meet the minimum number of provider or the $50,000 amount in controversy requirements.[59]

42 C.F.R. § 405.1837(b)(1)(ii) and (b)(2)(ii) specify that confers on the Board the discretion on whether to allow a group to expand beyond one calendar year, with one exception. The only exception is when a fully formed group fails to meet the minimum $50,000 threshold for a group and seek to include another year in order to meet that requirement.

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[58] For example, a prohibited duplicate appeal would occur if a particular provider for FY 2005 had a FY 2005 settled cost report that was impacted by the DGME post-IRP issue: (1) was part of this appeal seeking reopening of its settled cost report; and (2) had an appeal on the FY 2005 settled cost report pending before the Board for the DGME post-IRP issue. See Board Rules 46, 47.2.3.

[59] (Emphasis added.)

Here, the instant appeals pertain to multiple years in violation of Board Rules as recognized in the group statements: "The Office of Hearings Case and Document Management System ("OH CDMS") portal does not accommodate Federal Register Notice appeal, like this appeal, that affect more than two cost reporting periods. Thus, to comply with the Board's filing requirements, Providers have identified the first and final cost reporting periods affected by the Final Rule in their OH CDMS submissions."[60]

Indeed, the Board would deny the request because there is insufficient information in the record to base a consolidation. Specifically, as discussed in Section C above, the precise closed, settled cost reports at issue are unknown and, as a result, it is unknown what specific years would be consolidated into each case. As such, there is also insufficient information upon which to base a bifurcation as again the precise years are unknown (indeed, it is unknown how many participants there would be for each year and whether each year would have the minimum 2 participants). Accordingly, the Board finds the Providers failed to comply with the Board's governing regulations and rules limiting group appeals to one year unless approved by the Board in advance. The Group Representative did not obtain approval from the Board prior to filing. These procedural violations augment the bases for dismissal made in Section C above and further illustrate how the appeals are fatally flawed.

Conclusion:

The Board hereby dismisses the fifteen (15) appeals from the FY 2023 IPPS Final Rule filed by Hall, Render, Killian, Heath, & Lyman, P.C. because the Providers failed to appeal a "final determination" as that term is issued in 42 U.S.C. § 1395oo(a)(1) and a decision not to reopen is not an appealable determination per the Supreme Court decision in *Your Home*. Moreover, CMS' decision not to reopen is consistent with its regulations governing reopening of final determinations. Regardless, the Providers appeals are fatally flawed and failed to meet the minimum content requirements under 42 C.F.R. § 405.1837(c). Accordingly, the Board hereby closes these fifteen (15) appeals and removes them from its docket.

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

Board Members Participating:

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

For the Board:

5/17/2024

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

[60] Statement on Multi-Year Impact of Final Rule in PRRB Case No. 24-0317G (Dec. 2, 2023).

cc: Michael Redmond, Novitas Solutions, Inc. (J-L)
Pamela VanArsdale, National Government Services, Inc. (J-6)
John Bloom, Noridian Healthcare Solutions (J-F)
Byron Lamprecht, WPS Government Health Administrators (J-5), (J-8)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Judith Cummings, CGS Administrators (J-15)
Danelle Decker, National Government Services, Inc. (J-K)
Wilson Leong, FSS

LISTING OF CASES

23-0711GC	Atlantic Health FFY 2023 DGME Post Initial Residency Period FTE Weighting CIRP Group
23-0712GC	HealthPartners FFY 2023 DGME Post Initial Residency Period FTE Weighting CIRP Group
23-0713GC	Lehigh Valley Health FFY 2023 DGME Post Initial Residency Period FTE Weighting CIRP Group
23-0714GC	Advocate Aurora Health FFY 2023 DGME Post Initial Residency Period FTE Weighting CIRP Group
23-0715GC	NorthShore Edward Elmhurst FFY 2023 DGME Post Initial Residency Period FTE Weighting CIRP Group
23-0743GC	Jefferson Health FFY 2023 DGME Post Initial Residency Period FTE Weighting CIRP Group
23-0753GC	Ascension Health FFY 2023 DGME Post Initial Residency Period FTE Weighting CIRP Group
23-0761GC	CHS FFY 2023 DGME Post Initial Residency Period FTE Weighting CIRP Group
23-0764GC	Corewell Health FFY 2023 DGME Post Initial Residency Period FTE Weighting CIRP Group
23-0766GC	Sanford Health FFY 2023 DGME Post Initial Residency Period FTE Weighting CIRP Group
23-0769GC	Mountain Health Network FFY 2023 DGME Post Initial Residency Period FTE Weighting CIRP Group
23-0771GC	TriHealth FFY 2023 DGME Post Initial Residency Period FTE Weighting CIRP Group
23-0850G	Hall Render FFY 2023 DGME Post Initial Residency Period FTE Weighting Group
23-0797GC	Lifespan FFY 2023 DGME Post Initial Residency Period FTE Weighting CIRP Group
23-0869GC	Mayo Clinic FFY 2023 DGME Post Initial Residency Period FTE Weighting CIRP Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Ms. Maureen O'Brien Griffin, Esq.
Hall, Render, Killian, Heath & Lyman, P.C.
500 North Meridian St., Ste. 400
Indianapolis, IN 46204

RE: ***Board Decision - Request for Reconsideration***
Case No. 13-0779GC – Ascension 2007 DSH SSI Data Match CIRP Group

Dear Ms. O'Brien Griffin:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Motion for Reconsideration filed on October 12, 2023 in the above-captioned common issue related party ("CIRP") group involving Ascension Health ("Ascension") by its designated representative, Hall, Render, Killian, Heath & Lyman, P.C. ("Hall Render" or Group Representative). As set forth below, the Board **declines** to exercise its discretion to reinstate this CIRP group.

Background

A. Procedural History

On **February 7, 2013**, the Group Representative filed a group appeal request with the Board to establish the CIRP group under Case No. 13-0779GC on behalf of Ascension. The request stated that "[w]e anticipate adding additional Providers to the Group Appeal as they receive eligible final determinations."

On **February 20, 2013**, the Board issued the Group Acknowledgment to the parties that confirmed receipt of the group appeal request and the establishment of Case No. 13-0779GC. The Board specified in the Group Acknowledgement that "Group Representative *Action is* ***Required***"[1] to notify the board when the group is fully formed:

> Group Representative *Action is* ***Required***:
>
> *Upon full formation of the group appeal* ***you must so advise*** the Board in writing. At that time the Board will issue a Critical Due Dates letter which will set up deadlines for the submission of the Schedule of Providers with supporting documentation and a preliminary position paper/proposed Joint Scheduling Order You will be notified later of final position paper deadlines when the Notice of Hearing is issued.[2]

[1] (Underline emphasis removed and bold and italics emphasis added.)
[2] (Italics and bold emphasis added.)

Significantly, the Acknowledgement specifically asked the Group Representative to "reply to this e-mail to acknowledge receipt." On **February 20, 2013**, the Group Representative *confirmed* its receipt of the Board's February 20, 2013 Group Acknowledgement by emailing "Received."

From **February 2013** through **September 2013**, various participants were added to the group. On **June 23, 2014**, the Group Representative withdrew a participant. On **July 21, 2017**, the Group Representative requested that the Board transfer certain inpatient rehabilitation facilities ("IRFs") to a different group. On **July 28, 2017,** the Board granted the transfer request.[3]

On **March 25, 2019**, the Group Representative added the ***last*** participant to this group using OH CDMS.[4] As part of the OH CDMS filing, the Group Representative represented that, *at that time*, the group was ***not*** fully formed. However, this representation apparently was not true as no further participants were subsequently added to this group during the ensuing 4+ years before the Group Representative's *belated* confirmation of full formation on September 1, 2023.

A year later, on **March 25, 2020**, the Board issued Alert 19, which indefinitely suspended "Board-Set Deadlines" from Friday, March 13, 2020, forward and "encourage[d] Providers and their representatives to continue to make these filings electronically through OH CDMS, as appropriate and in keeping with public health precautions."

On **November 7, 2022**, the Board issued Alert 23 entitled "Resumption of Normal Board Operations Following the COVID-19 Pandemic, Effective December 7, 2022 . . .". Among other things Alert 23 specified that:

> In Alert 19, the Board suspended "Board-Set Deadlines" from Friday, March 13, 2020 forward, subject to the Board returning to normal operations. ***Effective Wednesday, December 7, 2022***, Board Order No. 3 ceases suspension of deadlines and will hold parties to the deadline specified in: (1) *any* Board rule or instruction; and/or (2) *any* Board notice or correspondence issued ***on or after that date***.

On **July 31, 2023**, *due to the fact that this case had been dormant with* ***no activity*** *for over 4 years*, the Board issued a CIRP Group ***Status*** Request letter for the purpose of determining whether Ascension was still pursuing the case and, if so, whether the group was fully formed or whether there are any providers that will join the group but have not received their final determinations. The Notice gave the Group Representative 30 days to respond (*i.e.*, respond no later than Wednesday, **August 30, 2023)**.[5] The Board was clear in its letter that a failure to submit

---

[3] On July 21, 2017, Ascension requested to transfer the rehab units of the providers to a different group, Case No. 16-1943G, Hall Render 2006-2007 LIP Rehab Post 1498R DSH SSI Data Match Group II. On July 28, 2017, the Board granted this request.

[4] The Board's electronic docketing system is known as "OH CDMS" or the Office Hearings Case Docketing and Management System and first went live in August 2018. Electronic filing using OH CDMS did not become mandatory until November 1, 2021, per the Board Rules that went into effect on that date. *See* PRRB Order No. 2 (Sept. 30, 2021) (available at: https://www.cms.gov/files/document/prior-prrb-rules-v-31-board-order-no-2-november-1-2021.pdf (last accessed: May 16, 2024).

[5] The 30-day period for the Status Report is more than the 15-day period set forth in 42 C.F.R. § 405.1837(e)(1).

a timely response to the request would result in a dismissal of the case, stating: "Failure to submit a timely response to this request ***will*** result in dismissal of the case."[6]

However, the Group Representative failed to file a response to the Board's CIRP Group Status Request by the Wednesday, August 30, 2023 filing deadline. Accordingly, on **September 1, 2023**, pursuant to 42 C.F.R. § 405.1868, the Board issued a Dismissal for Untimely Filing letter to the Group Representative. In the Board's letter, the Board stated its authority to dismiss the appeal with prejudice in response to a party's failure to comply with Board rules or orders, specifically if a provider fails to meet a filing deadline or other requirement. The letter referenced the prior CIRP Group ***Status*** Request letter the Board sent on July 31, 2023, to advise the Group that it was required to submit a status report regarding the full formation of the group by August 30, 2023, and informed that the case was dismissed because the Group failed to respond by the due date for this request.

On **Friday, September 1, 2023**, the Group Representative filed an *untimely* response to the Board's CIRP Group Status Request and this response simply confirmed that the Group was fully formed. Significantly, the Group Representative's filing failed to acknowledge that its response was filed late and did include any explanation of why it was filed ***2 days after the filing deadline***. The Group Representative's filing was made at 9:27 am EDT on September 1, 2023 and the Board dismissal was issued 43 minutes later at 10:10AM on September 1, 2023.

On **October 12, 2023**, the Group Representative filed a Motion for Reconsideration requesting the Board reconsider its dismissal and reinstate the CIRP Group Appeal. The MAC opposes the motion.

B. Ascension's Motion for Reconsideration

In Ascension's Motion of Reconsideration, the Group Representative presents the following arguments in support of its request that the dismissal of this case be reversed, or alternatively, be reinstated for good cause. It further notes that the MAC opposes the Motion.

1. Ascension contends the Board's actions are inconsistent with Board Rule 19 governing Full Formation of Groups.

The Group Representative argues that the dismissal for failure to meet the group completion deadline is inconsistent with Board Rule 19.2. Specifically, the Group Representative argues:

> Board Rule 19 provides that for Optional and CIRP Groups, the consequence upon passing of the full formation deadline is that the Board will deem the group fully formed. Under Board Rule 19.2, which governs CIRP Groups:
>
> > The Board ***deems*** a CIRP Group appeal fully formed (*i.e.,* complete) upon ***the earlier of:***
> >
> > - The filing of a notice from the group representative that the group is fully formed;

[6] PRRB's CIRP Group Status Request (Jul. 31, 2023) (emphasis added).

> - An Order by the Board finding that the group is fully formed where the Order is issued *after the group representative has had the opportunity* to present evidence regarding whether any CIRP providers who have not yet received their final determinations could potentially join the group; or
> - The filing of a request for expedited judicial review ("EJR") . . . .
>
> Board Rule 19.2 (emphasis added).[7]

Essentially, the Group Representative argues that it notified the Board the group was fully formed prior to the Board's dismissal and that the Board's CIRP Group Status Request letter *afforded the Group an opportunity to present evidence of any additional providers who may potentially join the group*. Although the Group Representative concedes that that opportunity was not taken advantage of, it contends that 42 C.F.R. § 405.1837(e)(1) and Rule 19.2 required the Board to issue an Order deeming the group fully formed. Specifically, the Group Representative quotes the following excerpt from Board Rule 19.2 and then argues:

> As stated in 42 C.F.R. § 405.1837(e)(1), "[w]hen the Board has determined that a [CIRP Group] is fully formed, absent an order from the Board modifying its determination, no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.
>
> Board Rule 19.2 (brackets in original).
>
> Nothing in Rule 19 indicates that the Board will dismiss an appeal with prejudice if it must resort to deeming a group fully formed by order after the group completion deadline passes.[8]

In support of its position, the Group Representative contrasts Rule 19 with Rule 23.4, Failure to Timely File [PJSO or PPP]:

> The provider's preliminary position paper due date will be set on the same day as the PJSO due date. According, if neither a PJSO nor the provider's preliminary position paper is filed by the filing due date, *the Board will dismiss the case.*
>
> Board Rule 23.4 (emphases added).[9]

---

[7] Ascension's Motion for Reconsideration at 5 (Oct. 12, 2023) (quoting an excerpt from Board Rule 19.2 but adding emphasis).
[8] *Id.* at 5-6.
[9] *Id.* at 6 (quoting Board Rule 23.4 but adding emphasis).

The Group Representative contends that, if the Board dismisses the appeal, then it would be denying the other CIRP Group participating providers their right to appeal without due process:

> Dismissal with prejudice of the timely appeals filed by the CIRP Group Participating Providers on account of other hypothetical CIRP providers having potentially missed the deadline to join the group deprives the existing providers of their right to appeal without due process. This is contrary to the Board Rules governing full formation of groups, and is not in furtherance of justice.[10]

In making this argument, the Group Representative is asserting that the CIRP Group Status Request *only* pertained to determining whether any other participants would be joining the group.

2. <u>Ascension contends the Group satisfies the Board's good causes standard for reinstatement under Rule 47.3.</u>

Alternatively, the Group Representative argues that the circumstances that led the Group's missed deadline meets the Board's good cause standard for reinstatement, citing Board Rule 47.3:

> Upon written motion demonstrating good cause, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, administrative oversight, settlement negotiations or a change in representative will not be considered good cause to reinstate. If the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, then the motion for reinstatement must, as a prerequisite, include the required filing before the Board will consider the motion.
>
> Board Rule 47.3[11]

In its motion, the Group Representative argues that: (1) it submitted its CIRP Group Status Response to inform the Board of the group's full formation less than an hour before the Board issued its Notice of Dismissal; and (2) its failure to timely file was not due to administrative oversight where the deadline was never recorded or after being recorded was forgotten:

> [T]his is not an issue of administrative oversight where a deadline was never recorded or after being recorded was forgotten. Rather, *because of* ***an unknown technological process*** *built into [its] docketing software*, the person responsible for the task of submitting the CIRP Group Status Response was not alerted to the upcoming deadline. This was the first time any such issue has arisen. This was an unusual circumstance created by the age of this appeal, and the unintended software process that caused the error was identified and corrected moving forward.[12]

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[10] *Id.*
[11] *Id.* at 7 (quoting Board Rule 47.3 entitled "Dismissal for Failure to Comply with Board Procedures").
[12] *Id.* (emphasis added.)

The technological malfunction that the Group Representative refers to is described in detail in its motion. The Group Representative acknowledges that, when it received the Board's letter, it docketed what it describes as a "group closure deadline" *in its **proprietary software** for docketing and tracking reimbursement appeals for its hospital clients*.[13] The Group Representative states that its proprietary software allows "group closure deadlines" to be docketed and assigned as "tasks" either manually, or automatically (which also may be adjusted manually). The proprietary software also generates reports listings, to include all active incomplete tasks due within the next 60 days, which the representative refers to as a "Deadline Notification Report."[14]

In this case, the Group Representative states that the failure of its proprietary software was the result of a feature *in its proprietary software* that it evidently designed to prevent pending tasks from "becoming stale," explaining that the Deadline Notification Reports' past due tasks may be automatically marked complete when they are "sufficiently aged, though it remains unknown where that threshold lies."[15]

In the case of the instant appeal, the Group Representative states that the case was ten years old. When one of its users went into the software to manually add the new task related to responding to the CIRP Group Status Request letter, *they were not aware they needed to manually unmark the prior group closure task to keep this task on the weekly Deadline Notification Reports*. The Group Representative says this is why the deadline to respond to the CIRP Group Status Request letter was missed.[16]

Board's Decision

As set forth below, the Board **declines** to exercise its authority to reconsider its dismissal and/or reinstate this case. The Board maintains its position outlined in the September 1, 2023, decision to dismiss Ascension's CIRP group appeal was correct because: (1) the CIRP Group failed to meet a filing deadline or other requirement established by the Board in a rule or order pursuant to 42 C.F.R. § 405.1868; and (2) *given the procedural history of this case and Ascension's failure to comply with Board procedures and deadlines*, dismissal was an appropriate remedial action.

The Group Representative makes two arguments to support its Motion for Reinstatement: (1) the Board's decision to dismiss the appeal is inconsistent with Board Rule 19.2, which governs the formation of CIRP Groups; and (2) the Group meets the Board's standards for good cause for reinstatement. Both arguments are discussed herein.

A. The Board's dismissal is consistent with Board Rule 19.2 (Nov. 2021) and its consideration of the appropriate remedial action is not limited to that Rule.

As explained below, the Board rejects the Group Representative's argument that the Board's decision to dismiss the appeal is inconsistent with Board Rule 19.2 because the Group Representative misconstrues Board Rule 19.2 and fails to appreciate the applicability of other

[13] *Id.* at 3.
[14] *Id.*
[15] *Id*.
[16] *Id.* at 4-5.

Board Rules and regulations as well as the procedural history of this CIRP group case, including the Board's February 20, 2013 Group Acknowledgment and July 31, 2023 CIRP Group Status Request and the fact that this CIRP group case had been dormant for over 4+ years due to the Group Representative's failure to confirm that this group was fully formed after the last participant was added 4+ years ago on March 25, 2019.

The Group Representative argues that it filed notice to the Board that the group was fully formed before the Board issued its dismissal and that, as a result, the Board should have deemed the group fully formed rather than dismissing the CIRP group. The Board disagrees. The fact that the dismissal was issued 43 minutes after the Group Representative filed its response to the CIRP Group Status Request does not change the fact that the Group Representative filed that response ***2 days after*** *the Wednesday, August 30, 2023 filing deadline* (or failed to promptly update the Board on the completeness of the group since the last participant was added more than 4 years ago on March 25, 2019).[17] In this respect, the Group Representative misrepresents what Board Rule 19.2 says and incorrectly suggests that, under this Rule, "the Board ***will*** *issue an order* deeming the group fully formed if the representative misses the group completion deadline."[18] Rather, Board Rule 19.2 (Nov. 1, 2021) provides a framework for determining *on what date* a group is deemed fully formed as made clear by the opening phrase of the following excerpt:

> **The Board deems a CIRP group appeal fully formed** (*i.e.*, complete) **upon the earlier of**:
>
> - The filing of a notice from the group representative that the group is fully formed;
> - An Order by the Board finding that the group is fully formed where the Order is issued after the group representative has had the opportunity to present evidence regarding whether any CIRP providers who have not received final determinations could potentially join the group; or
> - The filing of a request for [EJR] by the group representative if: (1) the group representative has not previously certified that the CIRP group is fully formed; and (2) the EJR does not include the representation that the CIRP group is fully formed. In this situation, the Board deems the CIRP group fully formed.
>
> As stated in C.F.R. § 405.1837(e)(1), "[w]hen the Board has determined that a [CIRP group] is fully formed, absent an order from the Board modifying its determination, no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.

[17] The belated filing is only relevant here for purposes of Board Rule 47.3 which specifies that, when the Board dismisses a case for failure to comply with Board Procedures and the dismissal "was for failure to file with the Board . . . a . . . filing, then the motion for reinstatement must, *as a prerequisite*, include the required filing before the Board will consider the motion." (Emphasis in original.)

[18] (Emphasis added.)

Thus, Board Rule 19.2 clearly outlines the three circumstances by which the Board determines the date on which a group fully formed and only the first two are relevant in this case. The first circumstance is upon notice from the provider, which was not given in this case ***until after*** the Group Representative missed its deadline to do so. The second is if the Board issues an Board Order finding that the group is fully formed. Here, the Group Representative alleges that the Board is ***obligated*** to issue such an order but the language from the Rule itself does not support such an inference. Rather, Rule 19.2 simply states that the Board will determine the date a group is fully formed "*upon the earlier of*" one of the three circumstances of which one is *if the Board issues* an Order finding the Group fully formed.

Significantly, the Rule does not address or otherwise prevent the Board from taking remedial action, as relevant and appropriate, pursuant to a Board Order/Issuance, other Board Rules or regulations such as 42 C.F.R. § 405.1868(b). Rather, that is addressed elsewhere. In this respect, Board Rule 4.4.2 addresses due dates for filings other than new appeals:

> **4.4.2 Due Dates for Other Filings**
>
> *All filings* other than an appeal request or request to add issues (e.g., position papers and other responsive documents) *must be received by the Board no later than the date specified on the Board's notice* or, if silent, the date specified in these Rules. *If a party fails to file by the established due date, the Board may take action as described in 42 C.F.R. § 405.1868*. For example, Rule 23.4 addresses the timely filing of preliminary position papers and specifies that the Board will dismiss the appeal if the representative for the provider(s) fails to file their preliminary position paper or PJSO by the established due date.[19]

Similarly, when the group appeal was filed on February 20, 2013, the Board Rules then in effect similarly made this clear in Board Rule 14 and specifically refences deadlines for full formation of the group. Indeed, this ***same*** language continues to exist in the current version of Board Rule 14:

> **Rule 14 – Acknowledgment of Group Appeal**
>
> ****
>
> *The acknowledgment (or future correspondence) may also set various deadlines and due dates including, but not limited to*, position paper deadlines, *full formation of the group*, the Schedule of Providers (See Appendix - Model Form G), discovery and other documentation requirements. *Failure by a party to comply* with such deadlines *may result in the Board taking any of the actions described in 42 CFR §405.1868*.[20]

Finally, Board Rule 41.2 confirms that the Board may dismiss an appeal for failure to comply with Board procedures or filing deadlines:

[19] (Underline and italics emphasis added.)
[20] (Underline and italics emphasis added.)

41.2 Own Motion

The Board may dismiss a case or an issue on its own motion:
• if it has a reasonable basis to believe that the issues have been fully settled or abandoned;

• upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868);

• 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.[21]

Consistent with the above Rules, the Board's CIRP Group Status Request specified that Ascension must respond to the CIRP Group Status Request no later than August 30, 2023 (*i.e*., within 30 days), and specifically warned Ascension in advance of the remedial action planned by the Board, namely that "[f]ailure to submit a timely response to this request will result in dismissal of the case." In this respect, the July 31, 2023 CIRP Group Status Request noted that this case had been dormant since the last participant of the Group was added on March 25, 2019. *It is this 4+-year dormancy that prompted the CIRP Group Status Request in the first instance*.[22] As previously noted, the Board's February 20, 2013 Group Acknowledgment, confirmed that "Group Action [is] ***Required***"[23] when the group is fully formed and "***you must so advise*** the Board in writing."[24] Notwithstanding Ascension failed to *promptly* notify the Board the CIRP group had been fully formed following the addition of the last participant on March 25, 2019. In this respect, the Group Representative is myopic in only looking to Board Rule 19.2 and fails to appreciate the procedural history of this case, the Board's February 20, 2013 Group Acknowledgment, the Board's July 31, 2023 CIRP Group Status Request, and the Board's authority under 42 C.F.R. § 405.1868(b) to take remedial action for failure to comply with those Board orders and deadlines.

In summary, Ascension's Group Representative failed to timely file a response by the August 30, 2023 deadline set in the Board's July 31, 2023 CIRP Group Status Request. Accordingly, given the 4+-year dormancy of the case and Ascension's failure during that dormancy to promptly notify the Board that the group had been fully formed (as required under the initial February 20, 2013 Group Acknowledgment), the Board properly exercised its discretion under 42 C.F.R. § 405.1868(b) to dismiss this case for failure to comply with the Board's order, instructions, and deadlines.

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[21] (Underline emphasis added.)

[22] The Group Representative's apparent delay in carrying out its responsibility to promptly notify the Board of full formation (as explained in the February 20, 2013 Acknowledgment) in turn prevented the case from moving forward to the regular Board proceedings. As explained in that Acknowledgment, after a group is fully formed, the case then moves forward with the Critical Due Date letter: "At that time the Board will issue a Critical Due Dates letter which will set up deadlines for the submission of the Schedule of Providers with supporting documentation and a preliminary position paper/proposed Joint Scheduling Order You will be notified later of final position paper deadlines when the Notice of Hearing is issued."

[23] (Underline emphasis removed and italics and bold emphasis added.)

[24] (Emphasis added.) Similarly, under the Board 19.2 as modified in August 2021, there an active expectation that "at the one-year mark (if they had not previously done so), they must notify the Board if the group is complete, and, *if not, which providers have not yet received a final determination for the specified fiscal year and intend to join the group*."

B. The Group fails to meet the Board's standards for good cause for reinstatement.

Board Rule 47.1 addresses motions for reinstatement and sets forth the general principle that the Board will not reinstate if the provider is at fault for the dismissal:

> **47.1 Motion For Reinstatement**
>
> A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s) (see 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (*see* Rule 44 governing motions). The Board will not reinstate an issue(s)/case if the provider was at fault. If an issue(s)/case was remanded pursuant to a CMS ruling . . . . , the provider must address whether the CMS ruling permits reinstatement of such issue(s)/ case. If the Board reinstates an issue(s) or case, the provider will have the same rights (no greater and no less) that it had in its initial appeal. These requirements also apply to Rule 47.2 below.[25]

Board Rule 47.3 provides additional guidance on reinstatement motions involving dismissals for failure to comply with Board procedures and notes that administrative oversight will not be considered good cause to reinstate:

> **47.3 Dismissals for Failure to Comply with Board Procedures**
>
> Upon written motion demonstrating good cause, the Board may reinstate a case dismissed for failure to comply with Board procedures. **Generally, administrative oversight**, settlement negotiations or a change in representative will **not** be **considered good cause to reinstate**. If the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, then the motion for reinstatement must, *as a prerequisite*, include the required filing before the Board will consider the motion.[26]

Ascension contends that it meets the good cause standards for reinstatement and essentially asserts it is not at fault. The Board disagrees. While Ascension met the "*prerequisite*" for Board consideration of a Motion for Reinstatement under Board Rule 47.3 by belatedly filing its response to the CIRP Group Status Request, the Board finds that the Group Representative is at fault for missing the filing deadline in the first instance due to administrative error or oversight (arising, in whole or in part, from the apparent failure to properly docket the deadline in its proprietary software) and, as such, failed to establish good cause.

Moreover, as noted above, Ascension should have promptly notified the Board that the group was fully formed more 4 years ago after the last provider was added on March 25, 2019. Ascension

[25] (Underline emphasis added and bold and italics emphasis in original.)
[26] (Bold emphasis added and underline and italics emphasis in original.)

apparently misrepresented, at that time, that the group was not fully formed given the fact that no provider was subsequently added to the group over the ensuing 4+ years. As specified in the Board's February 20, 2013 Group Acknowledgment, "Group Action [is] ***Required***" as follows: "*[u]pon full formation of the group appeal* ***you must so advise*** the Board in writing."[27] Ascension clearly failed to meet this requirement since it failed to *promptly* act *for over 4 years* to advise the Board of the group's full formation after the last provider was added on March 25, 2019.

It was due to this inactivity that the Board issued its CIRP Group Status Request on July 31, 2023 requiring Ascension to respond *in 30 days* regarding the CIRP group status and warned that "[f]ailure to submit a timely response to this request ***will*** result in dismissal of the case."[28] However, the Group Representative missed this August 30, 2023 deadline. Instead, it filed a response 2 days after this deadline and, did so, without explaining why the response was filed late.

The Group Representative argues that their failure to file timely *within 30 days* was due to an unknown technological feature that is part of the software it uses to track and respond to Board filing tasks, including what it describes as "group closure deadlines." The Group asserts that "this is not an issue of administrative oversight where a deadline was never recorded or after being recorded was forgotten."[29] However, the group representative's user-error (*i.e*., failure to docket properly using its own proprietary software[30]) is the type of administrative error or oversight that does not meet the Board's standard for good cause.

Ascension's letter makes clear that the user who was responsible for filing the notice to the Board to inform the group was fully formed was aware of the filing deadline but failed to properly docket the filing. In this respect, the Board takes administrative notice that the Group Representative did *not* have an issue with timely responding to CIRP Group Status Requests during this same time period *for similarly-aged* ***10+ year*** *cases* where the response was filed during August 2023.[31] Again, even beyond this administrative error or oversight, the Group Representative failed to promptly notify the Board that the group was fully formed as far back as four years ago, when the last provider expected to join the group was added on March 25, 2019. Indeed, the Group Representative suggests that it was able to very quickly confirm on the morning of September 1, 2023 (***before*** *its 8:28 am CT filing*) that the group was fully formed and then file its response at 8:28 am CT with the Board.[32] As a result, it is unclear why the Group Representative took more

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[27] (Emphasis added.)
[28] PRRB's CIRP Group Status Request (Jul. 31, 2023) (emphasis added).
[29] Group Request for Reconsideration at 7 (Oct. 12, 2023).
[30] The user error occurred in Group Representative's proprietary software that it apparently designed specifically for itself, including the feature it evidently designed to prevent certain pending tasks from "becoming stale."
[31] More specifically, the Board takes administrative notice that, *during this same time frame* ***and*** *prior to September 1, 2023*, the Group Representative did timely respond to group status requests *in several other cases* which were several months ***more aged*** than this 10+ year old case. Two examples include: (1) Case No. 13-0605GC (appeal filed Jan. 29, 2013, CIRP group status request issued Jul. 26, 2023 to Ms. O'Brien Griffin, response filed on Aug 21, 2023); and (2) Case No. 13-0151GC (appeal filed Dec. 10, 2012, CIRP group status request issued Jul. 31, 2023 to Ms. O'Brien Griffin, response filed on Aug. 30, 2023). Similarly, the Board takes administrative notice: (1) the Group Representative filed a motion for reinstatement of the CIRP group under Case No. 20-2071GC (established on Sept. 14, 2020) that the Board dismissed for failure to file *a preliminary position paper* by a November 20, 2023 deadline; and (2) the motion explained without further description that the missed deadline was due to "the failure of its docketing system." The Board is similarly denying that reinstatement under separate cover concurrent with this decision.
[32] Ascension's Motion for Reconsideration at 4. The Group Representative's user was located in the Central Time Zone.

than *30 days* to confirm the group was fully formed (much less more than 4 years after the last participant was added on March 25, 2019).[33]

* * * * *

In summary, the Board hereby declines to act on Ascension's Motion for Reinstatement as the Board maintains the Group failed to comply with Board rules and orders. Specifically, this case had been dormant and the Group failed to promptly notify the Board that the group was fully formed following the addition of the last participant to the group on March 25, 2019 and then failed to meet the August 30, 2023 filing deadline for filing its response to the Board's CIRP Group Status Request. Moreover, the Ascension's Motion for Reinstatement fails to establish that, pursuant to Board Rules 47.1 and 47.3, it was not at fault and, otherwise, had good cause for missing the filing deadline. Accordingly, Case No. 13-0779GC remains closed. Finally, the Board notes that its decision is consistent with numerous cases in which federal courts have upheld the Board's authority to dismiss cases for failure of the provider to timely file position papers or other Board filings.[34]

Board Members Participating:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

5/17/2024

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

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

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[33] Further, the Group Representative states that: "While in [the Group Representative's] appeals database on or about the morning of September 1, 2023, *[the user] ran an individual* ***report of all her own active tasks***, without regard to their completion status, ***to identify*** *those that she could now inactivate or mark as complete*. At that time, she discovered that this group closure deadline had already been marked complete, and been missed." *Id.* It is similarly unclear what prompted the user to run this global report or why the report, if routinely needed or done, was not run earlier during the 30 days prior to the August 30, 2023 filing deadline. These factors suggest administrative error and fault of the user, and further illustrate that good cause has not been established. *See also supra* note 22.

[34] *Kaiser Found. Hosps. v. Sebelius*, 649 F.3d 1153 (9th Cir. 2011) (upholding dismissal for failure to file position paper); *Baptist Mem'l Hosp.-Golden Triangle v. Sebelius*, 566 F.3d 226 (2009) (upholding dismissal for failure to file position paper); *High Country Home Health Inc. v. Thompson*, 359 F.3d 1307 (10th Cir. 2004); *Inova Alexandria Hosp. v. Shalala*, 244 F.3d 342, 351 (4th Cir. 2001) (upholding dismissal for failure to file position papers and stating "The Hospital argues that the Board irrationally concluded that administrative oversight is not a valid excuse. We disagree. Because the Hospital's failure to file timely position papers was due to circumstances entirely within its own control, the Board had a rational basis for its decision."); *UHI, Inc. v. Thompson*, 250 F.3d (6th Cir. 2001); *Lutheran Med. Ctr. v. Burwell*, No. 14-VC-731, 2016 WL 3882896 (E.D. N.Y. July 13, 2016); *Rapid City Reg. Hosp. v. Sebelius*, 681 F. Supp. 2d 56 (D.D.C. 2010) (upholding dismissal for failure to file position paper and citing to "the general proposition that legitimate procedural rules can be relied upon to control the Board's docket by dismissing appeals that are not timely filed" (citations omitted) and upholding Board denial based on the); *S.C. San Antonio Inc. v. Leavitt*, No. SA-07-CA-527-OG, 2008 WL 4816611(W.D. Tex. Sept. 30, 2008); *Lutheran Med. Ctr. v. Thompson*, No. 02-CV- 6144, 2006 WL 2853870 (E.D. N.Y. Oct. 2, 2006); *Novacare, Inc. v. Thompson*, 357 F. Supp. 2d 268, 272-273 (D.D.C. 2005) (upholding denial of reinstatement where the Board explained that "failure to communicate clearly with its counsel was insufficient basis to justify reinstatement"); *Saint Joseph Hosp. v. Shalala*, No. 99-C7775, 2000 WL 1847976 (N.D. Ill. Dec. 15, 2000). *See also Memorial Hosp. of S. Bend v. Becerra*, No. 20-3461, 2022 WL 888190 at *10 (D.D.C. Mar. 25, 2022); *Akron Gen. Med. Ctr. v. Azar*, 836 Fed. Appx. 13 (D.C. Cir. 2021), *aff'g*, 414 F. Supp. 3d 73 (D.D.C. 2019).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Porter Regional Hospital (Provider No. 15-0035)
FYE 12/31/2017
Case No. 22-0393

Dear Mr. Ravindran,

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

Background:

A. *Procedural History for Case No. 22-0393*

On **July 21, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end February 28, 2018. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **January 11, 2022**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that

[1] On Aug. 15, 2022, this issue was transferred to PRRB Case No. 20-0997GC.
[2] On Aug. 15, 2022, this issue was transferred to PRRB Case No. 19-2620GC.
[3] On Aug. 15, 2022, this issue was transferred to PRRB Case No. 20-1383GC.

reason, on **August 15, 2022**, the Provider transferred Issues 2, 4, and 5 to CHS groups. As a result of the case transfers, there are two (2) remaining issues in the appeal: Issue 1 (DSH – SSI Percentage Provider Specific) and Issue 3 (DSH – Medicaid Eligible Days).

On **January 12, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

On **August 24, 2022**, the Provider timely filed its preliminary position paper. With respect to Issue 3, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2017 cost report does not reflect an accurate number of Medicaid eligible days." As a result, the Provider included, as an Exhibit, the original "estimated impact" for this issue of $92,734 based on an *estimated* 150 days.

On **August 25, 2022**, the Medicare Contractor filed its 1st Request for DSH Package in connection with issue 3.

On **October 28, 2022**, the Medicare Contractor filed its 2nd and Final Request for DSH Package in connection with Issue 3. In this filing, the Medicare Contractor noted that, on August 25, 2022, it had previously requested that the Provider send it a DSH package to resolve Issue 3. As no response was received, the Medicare Contractor formally filed the 2nd and Final Request for DSH Package to formally request that a listing of the Medicaid eligible days at issue plus supporting documentation be provided to the Medicare Contractor on or before November 27, 2022 (*i.e.*, within 30 days). Notwithstanding the formal request, the Provider failed to file any response to the Medicare Contractor.

[4] (Emphasis added.)

On **December 12, 2022**, the Medicare Contractor filed a Jurisdictional Challenge[5] with the Board over Issues 1 and 3 requesting that the Board dismiss these issues. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **December 30, 2022**, the Medicare Contractor filed its preliminary position paper. With regard to Issue 3, the Medicare Contractor's position paper noted that: (1) the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position; and (2) the Provider had failed to respond to any of the Medicare Contractor's requests for that Medicaid eligible days listing.

On **November 3, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **November 7, 2023**, almost ***one year*** after the deadline for responding to the MAC's request for DSH package and the Jurisdictional Challenge, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the *caveat* that the "Listing [is] *pending finalization* upon receipt of State eligibility data."[6] The Listing was 4 pages with over 700 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again over 700 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 700 included in this belated listing is larger than the original *estimated* impact of 150 days included with the appeal request.

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

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

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

[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] (Emphasis added.)

> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[7]

The group issue statement in Case No. 20-0997GC, CHS CY 2017 DSH SSI Percentage CIRP Group, to which the Provider transferred issue 2 reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[8]

[7] Statement of Issue 1 (Jan. 11, 2022).
[8] Group Issue Statement, Case No. 20-0997GC.

On August 24, 2022, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (December 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[9]

The amount in controversy listed for both Issues 1 and Issue 2 in the individual appeal request is $86,411.

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue for three reasons. First, the MAC argues that the appeal is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in

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

> 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.[10]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH/SSI Percentage (Systemic Errors) issue in PRRB Case No. 20-0997GC are considered the same issue by the Board.[11]

Finally, the MAC argues "the Provider did not file a **complete** preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3."[12] The MAC posits that the Provider "failed to sufficiently develop and set forth the relevant facts and regarding the merits of its claim in its Preliminary Position Paper."[13]

Issue 3 – DSH Payment – Medicaid Eligible Days

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

> The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.
>
> Within its Provider's preliminary position paper, the Provider makes the broad allegation, ". . . the Provider contends that the total number of days reflected in its' [sic] 2018 cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the

[10] Jurisdictional Challenge at 6-7 (Dec. 12, 2022).
[11] *Id*. at 4-6.
[12] *Id*. at 7.
[13] *Id*. at 9.

> material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats their appeal request.[14]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[15] The Provider has ***not*** filed a response to the December 12, 2022 Jurisdictional Challenge and the 30-day time frame 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."

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 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. As set forth below, the Board dismisses both aspects of Issue 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 PRRB Case No. 20-0997GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[16] The Provider's legal

[14] *Id*. at 11.
[15] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[16] Issue Statement at 1.

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 that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[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 the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-0997GC. 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.

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, is pursuing that issue as part of the group under Case No. 20-0997GC, 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.[20] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-0097GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-0997GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (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

[17] *Id.*
[18] *Id.*
[19] PRRB Rules v. 3.1 (Nov. 2021).
[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).

and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 (Nov. 1, 2021) to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[21]

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

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

[21] (Emphasis added).
[22] Last accessed March 27, 2024.

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[23]
Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 20-0997GC.

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 20-0997GC are the same issue.[24] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing 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 did not include a list of the specific additional Medicaid eligible days that are in dispute in either the initial appeal or the position paper.

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

7.3.1.2 No Access to Data

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

> 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.[25]

So, essentially, 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**[26]
>
> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

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

25.1 Content of Position Paper Narrative

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

25.1.1 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 January 12, 2022, 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.[27]

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

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

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the

[27] (Emphasis added.)

> data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

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

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

On August 22, 2022, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[28] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $92,734 based on an estimated 150 days). The Provider's complete briefing of this issue in its position paper is as follows:

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

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

> [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2017 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Jurisdictional Challenge and position paper, 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 Rules.

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 25, 2022. The second, final request was filed formally with the Board in OH CDMS on October 28, 2022, *five years after the end of the Provider's cost reporting period*. The Medicare Contractor also informed the Provider in its final request for information that the deadline to respond was November 27, 2022. The Provider failed to file any response to the request.

The Medicare Contractor filed subsequently filed a Jurisdictional Challenge requesting dismissal of DSH Medicaid Eligible Days, as discussed above. The Medicare Contractor 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.[29]

Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** timely respond to that Motion by the July 21, 2023 filing deadline (*i.e.*, 30 days after June 21, 2023).

However, on November 7, 2023 (almost one year after the deadline to respond to the Challenge), QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the caveat that the "Listing [is] pending finalization upon receipt of State eligibility

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

data." QRS' filing did not explain why the listing of so many days (over 700 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***. Additionally, the Provider did not explain why the roughly 700 included in this belated listing is larger than the original estimate of 150 days included with the appeal request. Regardless, this filing was almost one year past the deadline for responding to the Jurisdictional Challenge *and, more importantly,* ***was also more than a year past the deadline for including it with its preliminary position paper*** since the position paper deadline was September 8, 2022. Finally, the listing clearly had not been verified with the State (as denoted by the header "Listing pending finalization upon receipt of State eligibility data") and, as such, failed to meet its minimum threshold burden of proof under 42 C.F.R. § 412.106(b)(4)(iv). Accordingly, the Board refuses to accept the late-filed exhibit into the record of this case.

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

The fact that the Listing was filed ***one 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 7, 2023 filing as a "Supplement to Position Paper" and does not accept that filing because:

1. The alleged "Supplement" was filed ***more than one year*** *after the deadline* for that exhibit to be included with its preliminary position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)). Indeed, the Provider failed to timely reply to the Jurisdictional Challenge and the alleged "Supplement" was filed ***more than one year*** *after the deadline* for filing a response.

2. The alleged "Supplement" fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the over 700 days was not previously available, *in whole or in part* (*i.e*., it is not clear why the Provider failed to identify a single day at issue until more than 4 years after this appeal was filed and more than 6 years after the fiscal year at issue had closed); and (c) why the listing still was ***not*** a "*final*" listing at this late date. In this respect, the Board notes the Secretary has stated that 17 months following the close of a fiscal year

is ample time to identify any additional days missed in the as-filed cost report which here would have been by June 1, 2019 (*i.e.*, before this appeal was filed on July 21, 2021).[30]

3. Neither the Board Rules nor the January 12, 2022 Case Acknowledgment and Critical Due Dates permit the Provider to file a "Supplement" to its preliminary position paper (nor did the Provider allege in the "Supplement" filing that they do).

4. Given the fact that the *material* facts (*e.g.*, the days at issue) and all available exhibits were required to be part of the position paper filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its preliminary position paper or a supplement of documents that were identified in the preliminary position paper as being unavailable consistent with Board Rule 25.2.2. However, neither the preliminary position paper nor the alleged "Supplement" identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the alleged "Supplement" cannot be considered a refinement of the position paper since no specific days or listing were included with the preliminary position paper (indeed the *tentative* 700 days listed in the alleged "Supplement" is, without explanation, much larger than the original estimated 150 days included with the appeal request).[31]

5. As noted above, the listing was *not* final and had *not* been verified with the State even at this late date, notwithstanding its burden of proof under 42 C.F.R. § 412.106(b)(iii). It is unclear why this has not *already* been done even at that late November 2023 date (almost 6 years after the close of the FY 2017 cost reporting period at issue).[32]

6. Finally, even if the Board had accepted the late-filed listing, there is no indication that any of the late-filed 700+ additional days 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). The fact that the Provider is claiming a materially large number of days (+700 days) suggests that they may be an unclaimed cost for which the Board would lack jurisdiction under 42 C.F.R. § 405.1835(a)(1)(i)-(ii) (2012) as clarified by CMS Ruling 1727-R.[33]

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[30] In this regard, the Board notes that the Secretary stated in the final rule published on November 13, 2015 that generally 17 months after the close of a provider's fiscal year (the filing of the cost report is due the last day of the 5th month after the close of the fiscal year) is *sufficient time* for the provider to identify any additional Medicaid eligible days missed in the as-filed cost report:

> In our experience, we believe an additional 12 months [after the filing of the cost report on the last day of the 5th month following the end of the fiscal year] is sufficient time for States to make Medicaid eligibility determinations and for hospitals to revise its number of Medicaid-eligible patient days in order to make an appropriate cost report claim for a DSH payment adjustment.

80 Fed. Reg. 70298, 70564 (Nov. 13, 2015).

[31] *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."

[32] *See supra* note 30 and accompanying text.

[33] *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 06-1852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days because no days were claimed with the as-filed cost report due to choice, error and/or inadvertence and, as such, the practical impediment standard or futility concept in the *Norwalk* and *Danbury* decisions under PRRB Dec. Nos. 2012-D14 and 2014-D03 is not applicable (available at: https://www.cms.gov/regulations-and-guidance/review-boards/prrbreview/list-of-prrb-jurisdiction-decisions-items/2017-11 (last accessed May 17, 2024)).

In rejecting the late-filed exhibit, the Board takes administrative notice that it has made similar dismissal in other cases in which QRS was the designated representative[34] as well as cases involving CHS providers.[35] Notwithstanding, there is no explanation provided even in the late-filed November 2023 alleged supplement.

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"[36] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute ***as part of the position paper filing*** (much less provide the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3), Board Rule 25, and the January 12, 2022 Notice, 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.[37]

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[34] Examples of cases in which QRS was the designated representative and which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days at issue include, but are not limited to: Case No. 14-2674 (by Board letter dated 5/5/2022); Case No. 16-2521 (by Board letter dated 5/5/2022); Case No. 16-0054 (by Board letter dated 5/5/2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, 16-1712 (by Board letter dated 9/30/2022). Moreover, in Case Nos. 13-3022, 13-3211, 14-2506, and 14-4313, the Board's attention to the filing deficiency was brought to the Board's attention via a motion to dismiss filed by the Medicare Contractor in its position paper (on December 10, 2020, December 11, 2020, March 12, 2021, March 12, 2021 respectively).

[35] Examples of CHS individual provider cases which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0076 (dismissed by Board letter dated Dec. 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper); Case No. 22-0376 (dismissed by Board letter dated February 22, 2023 based on a MAC December 14, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

[36] (Emphasis added.)

[37] *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.

*****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 20-0997GC and 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), Board Rule 25, and the January 12, 2022 Notice. As no issues remain pending, the Board hereby closes Case No. 22-0393 and removes it from the Board's docket.

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

Board Members Participating:

Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

5/17/2024

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

cc: Wilson C. Leong, Esq., Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Toyon FFY 2024 ATRA/MACRA .9412% Adjustment Groups
Case Nos. 24-1419GC, *et al*. (*see* Appendix A for listing of 18 group cases)

Dear Ms. Ellis:
QRS & Hall Render
Toyon
Moss Adams

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced group appeals. The decision of the Board to dismiss the appeals for lack of substantive jurisdiction is set forth below.

Issue in Dispute:

The Providers challenge their federal fiscal year ("FY") 2024 IPPS payments on the grounds that those payments were (and continue to be) improperly reduced due to the failure to eliminate the adjustments under paragraph 7(b)(1)(B) of the TMA Abstinence Education, and QI Programs Extension Act of 2007, Pub. L. No. 110–90, 121 Stat. 984, 986-87, *as amended* ("TMA"),[1] such that a negative 0.9412 percent adjustment continues past FFY 2023. This negative 0.9412 percent adjustment to IPPS rates is the net result of all adjustments under section 7(b)(1)(B) of the TMA that were continued rather than eliminated in the FY 2024 IPPS Final Rule.[2]

Statutory and Regulatory Background:

In the FY 2008 inpatient prospective payment system ("IPPS") final rule,[3] the Secretary[4] adopted the Medicare severity diagnosis-related group ("MS–DRG") patient classification system for the IPPS, effective October 1, 2007, to better recognize severity of illness in Medicare payment rates for acute care hospitals. The adoption of the MS–DRG system resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008. The Secretary believed that, by increasing the number of MS–DRGs and more fully taking into account patient severity of illness

[1] As discussed *infra*, the TMA has been amended multiple times.
[2] *E.g.*, PRRB Case 24-1419GC Statement of the Issue at 1-2 (Feb. 22, 2024).
[3] 72 Fed. Reg. 47130, 47140-47189 (Aug. 22, 2007).
[4] of the Department of Health and Human Services.

in Medicare payment rates for acute care hospitals, MS–DRGs would encourage hospitals to improve their documentation and coding of patient diagnoses.[5]

In the FY 2008 IPPS final rule, the Secretary indicated that the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for additional documentation and coding. In that final rule, the Secretary exercised the authority under section 42 U.S.C. § 1395ww(d)(3)(A)(vi), which authorizes the Secretary to maintain budget neutrality by adjusting the national standardized amount, to eliminate the estimated effect of changes in coding or classification that do not reflect real changes in case-mix. CMS actuaries estimated that maintaining budget neutrality required an adjustment of -4.8 percent to the national standardized amount. The Secretary provided for phasing in this -4.8 percent adjustment over 3 years. Specifically, the Secretary established prospective documentation and coding adjustments of -1.2 percent for FY 2008, -1.8 percent for FY 2009, and -1.8 percent for FY 2010.[6]

On September 29, 2007, Congress enacted the TMA [Transitional Medical Assistance], Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007 ("TMA").[7] TMA § 7(a) reduced the documentation and coding adjustment made as a result of the MS–DRG system that the Secretary adopted in the FY 2008 IPPS final rule to -0.6 percent for FY 2008 and -0.9 percent for FY 2009.[8]

The Secretary implemented a series of adjustments required under TMA §§ 7(b)(1)(A) and 7(b)(1)(B) based on a retrospective review of FY 2008 and FY 2009 claims data. The Secretary completed these adjustments in FY 2013. However, the Secretary commented in the FY 2013 IPPS final rule that delaying full implementation of the adjustment required under TMA § 7(b)(1)(A) until FY 2013 had resulted in payments in FY 2010 through FY 2012 being overstated, and that these overpayments could not be recovered.[9]

Congress revisited TMA § 7(b)(1)(B) as part of the American Taxpayer Relief Act of 2012 ("ATRA").[10] Specifically, ATRA § 631 amended TMA § 7(b)(1)(B) to add clause (ii) which required the Secretary to make a recoupment adjustment or adjustments totaling $11 billion for discharges occurring during FYs 2014 to 2017. Per the revisions made by ATRA § 631(b), this adjustment "represents the amount of the increase in aggregate payments from fiscal years 2008 through 2013 for which an adjustment was not previously applied" (*i.e.*, represents the amount of the increase in aggregate payments as a result of not completing the prospective adjustment authorized under TMA § 7(b)(1)(A) until FY 2013).[11] As discussed above, this delay in implementing TMA § 7(b)(1) resulted in overstated payment rates in FYs 2010, 2011, and 2012 and the resulting overpayments could not have been recovered under the original TMA § 7(b).

[5] 81 Fed. Reg. 56762, 56780 (Aug. 22, 2016).
[6] *See* 82 Fed. Reg. 37990, 38008 (Aug. 17, 2017).
[7] Pub. L. 110–90, 121 Stat. 984 (2007).
[8] *Id.* at 986.
[9] *See* 82 Fed. Reg. at 38008.
[10] Pub. L. 112-240, 126 Stat. 2313 (2013).
[11] *Id.* at 2353.

The adjustment required under ATRA § 631 was a one-time recoupment of a prior overpayment, not a permanent reduction to payment rates. Therefore, the Secretary "anticipated that any adjustment made to reduce payment rates in one year would eventually be offset by a positive adjustment in FY 2018, once the necessary amount of overpayment was recovered."[12] However, Congress again stepped in to revise TMA § 7(b)(1)(B). First, in § 414 of the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), Congress revised TMA § 7(b)(1)(B) to add clause (iii) which replaced the single positive adjustment the Secretary intended to make in FY 2018 with a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023.[13] Second, in § 15005 of the 21st Century Cures Act ("21-CCA"),[14] Congress amended the MACRA revision in TMA § 7(b)(1)(B)(iii) by reducing the adjustment for FY 2018 from 0.5 percentage points to 0.4588 percentage points.[15]

The Secretary's "actuaries estimated that a -9.3 percentage point adjustment to the standardized amount would be necessary if CMS were to fully recover the $11 billion recoupment required by [ATRA § 631] in FY 2014." Consistent with the policies that the Secretary has adopted in many similar situations, the Secretary implemented a phased in approach. For the first year, FY 2014, he implemented a -0.8 percentage point recoupment adjustment to the standardized amount. The Secretary declined, at that time, to set specific adjustments for FYs 2015, 2016, or 2017 "[a]s estimates of any future adjustments are subject to variations in total savings[.]"[16] However, he did estimate that, if adjustments of -0.8 percentage point were implemented in FYs 2014, 2015, 2016, and 2017, using standard inflation factors, then the requisite $11 billion would be recouped by the end of the statutory 4-year timeline.[17]

Consistent with the approach discussed in the FY 2014 rulemaking for recouping the $11 billion required by ATRA § 631, in the FY 2015 IPPS/LTCH PPS final rule[18] and the FY 2016 IPPS/LTCH PPS final rule,[19] the Secretary implemented additional -0.8 percentage point recoupment adjustments to the standardized amount in FY 2015 and FY 2016, respectively. The Secretary estimated that these adjustments, combined with leaving the prior -0.8 percentage point adjustments in place, would recover up to $2 billion in FY 2015 and another $3 billion in FY 2016. When combined with the approximately $1 billion adjustment made in FY 2014, the Secretary estimated that approximately $5 to $6 billion would be left to recover under ATRA § 631 by the end of FY 2016.

In the FY 2017 IPPS/LTCH PPS proposed rule,[20] due to lower than previously estimated inpatient spending, the Secretary determined that an adjustment of -0.8 percentage point in FY 2017 would not recoup the $11 billion under ATRA § 631. For the FY 2017 IPPS/LTCH PPS Final Rule,[21] the Secretary's actuaries estimated that, to the nearest tenth of a percentage point, the FY 2017 documentation and coding adjustment factor that would recoup as closely as possible $11 billion from FY 2014 through FY 2017 without exceeding this amount is -1.5 percentage points. Based on

[12] 82 Fed. Reg. at 38008.
[13] Pub. L. 114–10, § 414, 129 Stat. 87, 162-163 (2015).
[14] Pub. L. 114–255, 130 Stat. 1033 (2016).
[15] *Id.* at 1319-1320. *See also* 82 Fed. Reg. at 38008.
[16] 82 Fed. Reg. at 38008.
[17] *Id.*
[18] 79 Fed. Reg. 49853, 49874 (Aug. 22, 2014).
[19] 80 Fed. Reg. 49326, 49345 (Aug. 17, 2015).
[20] 81 Fed. Reg. 24946, 24966 (Apr. 27, 2016)
[21] 81 Fed. Reg. 56761 (Aug. 22, 2016).

those updated estimates by the Office of the Actuary, the Secretary made a -1.5 percentage point adjustment for FY 2017 as the final adjustment required under ATRA § 631.[22]

Once the recoupment required under ATRA § 631 was complete, the Secretary anticipated making a single positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631. However, MACRA § 414 (which was enacted on April 16, 2015) replaced the single positive adjustment the Secretary intended to make in FY 2018 with a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. In the FY 2017 rulemaking, the Secretary indicated that he would address the adjustments for FY 2018 and later fiscal years in future rulemaking. As noted previously, 21-CCA § 15005, which was enacted on December 13, 2016, amended TMA § 7(b)(1)(B) (as amended by ATRA § 631 and MACRA § 414) to reduce the adjustment for FY 2018 from a 0.5 percentage point to a 0.4588 percentage point. The Secretary believed the directive under 21-CCA § 15005 to be clear and, as a result, in the FY 2018 IPPS/LTCH PPS proposed rule for FY 2018, the Secretary proposed to implement the required +0.4588 percentage point as a permanent adjustment to the standardized amount.[23]

A. The Final IPPS Rule for FY 2018

In response to the +0.4588 percentage point adjustment, several commenters reiterated their disagreement with the -1.5 percentage point adjustment that CMS made for FY 2017 under ATRA § 631, which exceeded the estimated adjustment of approximately -0.8 percentage point described in the FY 2014 IPPS/LTCH PPS rulemaking. Commenters contended that, as a result, hospitals would be left with a larger permanent cut than Congress intended following the enactment of MACRA. They asserted that CMS' proposal to apply a 0.4588 percent positive adjustment for FY 2018 misinterprets the relevant statutory authority, and urged the Secretary to align with their view of Congress' intent by restoring an additional +0.7 percentage point adjustment to the standardized amount in FY 2018 (*i.e.*, the difference between the -1.5 percentage point adjustment made in FY 2017 and the initial estimate of -0.8 percentage point discussed in the FY 2014 IPPS/LTCH PPS rulemaking). The commenters also urged the Secretary to use his discretion under 42 U.S.C. § 1395ww(d)(5)(I) to increase the FY 2018 adjustment by 0.7 percentage point. Other commenters requested that, despite current law, CMS ensure that adjustments totaling the full 3.9 percentage points withheld under ATRA § 631 be returned.[24]

The Secretary responded by stating that, as discussed in the FY 2017 IPPS/LTCH PPS Final Rule,[25] CMS had completed the $11 billion recoupment required under ATRA § 631. The Secretary also continued to disagree with commenters who asserted that MACRA § 414 was intended to augment or limit the separate obligation under the ATRA to fully offset $11 billion by FY 2017.[26] Moreover, the Secretary pointed out in the FY 2018 IPPS/LTCH PPS proposed rule, he believed that the directive regarding the applicable adjustment for FY 2018 is clear. While the Secretary had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 requires that he not make the single positive adjustment he intended to make in FY 2018 but instead make a 0.5 percentage point positive

[22] *Id.* at 56785.
[23] 82 Fed. Reg. at 38009.
[24] *Id.*
[25] 81 Fed. Reg. 56783-85.
[26] *Id.* at 56784.

adjustment for each of FYs 2018 through 2023. The Secretary pointed out that, as noted by the commenters and discussed in the FY 2017 IPPS/LTCH PPS Final Rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the 3.2 percentage point adjustment originally estimated in the FY 2014 IPPS/LTCH PPS final rule.[27] Finally, the Secretary noted that 21-CCA § 15005 further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point and that this change was enacted on December 13, 2016, ***after*** CMS had proposed and finalized the -1.5 percentage point adjustment as the final adjustment required under ATRA § 631 in the FY 2017 rulemaking. The Secretary finalized the +0.4588 percentage point adjustment to the standardized amount for FY 2018, as required under 21-CCA § 15005.[28]

B. The FY 2019 Adjustment to the Standardized Amount

In the Final Inpatient PPS Rule for FY 2019,[29] the Secretary finalized a +0.5 percentage point adjustment to the standardized amount for FY 2019, as required under MACRA § 414.

In the IPPS Final Rule, several commenters argued that the Secretary misinterpreted the Congressional directives regarding the level of positive adjustment required for FY 2018 and FY 2019. The commenters contended that, while the positive adjustments required under MACRA § 414 would only total 3.0 percentage points by FY 2023, the levels of these adjustments were determined using an estimated positive ''3.2 percent baseline'' adjustment that otherwise would have been made in FY 2018. The commenters believed that, because CMS implemented an adjustment of -1.5 percentage points instead of the expected -0.8 percentage points in FY 2017, totaling -3.9 percentage points overall, the Secretary has imposed a permanent -0.7 percentage point negative adjustment beyond its statutory authority, contravening what the commenters contend was Congress' clear instructions and intent. The commenters requested that the Secretary reverse his previous position and implement additional 0.7 percentage point adjustments for both FY 2018 and FY 2019. Some of the commenters requested that the Secretary use his statutory discretion to ensure that all 3.9 percentage points in negative adjustment be restored. In addition, some of the commenters acknowledged that CMS may be bound by law but expressed opposition to the permanent reductions and requested that the Secretary refrain from making any additional coding adjustments in the future.[30]

The Secretary responded by stating that, as discussed in the FY 2019 IPPS/LTCH PPS proposed rule, he believed MACRA § 414 and 21-CCA § 15005 clearly set forth the levels of positive adjustments for FYs 2018 through 2023. He was not convinced that the adjustments prescribed by MACRA were predicated on a specific ''baseline'' adjustment level. While he had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 required that a 0.5 percentage point positive adjustment be implemented for each of FYs 2018 through 2023, rather than the single positive adjustment he had anticipated making in FY 2018. As discussed in the FY 2017 IPPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the

[27] 78 Fed. Reg. 50496, 50515 (Aug. 19, 2013).
[28] 82 Fed. Reg. at 38009.
[29] 83 Fed. Reg. 41144 (Aug. 17, 2018).
[30] *Id.* at 41157.

3.2 percentage points adjustment originally estimated in the FY 2014 IPPS final rule.[31] Moreover, as discussed in the FY 2018 IPPS Final Rule, 21-CCA § 15005 further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point and this adjustment was enacted on December 13, 2016, ***after*** the Secretary had proposed and finalized the final negative -1.5 percentage points adjustment required under ATRA § 631. The Secretary did not believe that Congress enacted these adjustments with the intent that there would be an additional +0.7 percentage point adjustment in FY 2018 to compensate for the higher than expected final ATRA adjustment made in FY 2017.[32]

C. The FY 2020 to FY 2023 Adjustments to the Standardized Amount

In IPPS Final Rules for FYs 2020 through FY 2023, the Secretary adopted only a +.5 percent adjustment. In this regard, the Secretary stated the following in the preamble to the FY 2020 IPPS Final Rule:

> In the FY 2020 IPPS/LTCH PPS proposed rule (84 FR 19170 through 19171) consistent with the requirements of section 414 of the MACRA, we proposed to implement a 0.5 percentage point positive adjustment to the standardized amount for FY 2020. We indicated that this would constitute a permanent adjustment to payment rates. We stated in the proposed rule that we plan to propose future adjustments required under section 414 of the MACRA for FYs 2021 through 2023 in future rulemaking.
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> As we discussed in the FY 2020 IPPS/LTCH PPS proposed rule (84 FR 19170 through 19171), and in response to similar comments in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41157), we believe section 414 of the MACRA and section 15005 of the 21st Century Cures Act set forth the levels of positive adjustments for FYs 2018 through 2023. We are not convinced that the adjustments prescribed by MACRA were predicated on a specific adjustment level estimated or implemented by CMS in previous rulemaking. While we had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under section 631 of the ATRA, section 414 of the MACRA required that we implement a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023, and not the single positive adjustment we intended to make in FY 2018. As discussed in the FY 2017 IPPS/LTCH PPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, section 414 of the MACRA would not fully restore even the 3.2 percentage point adjustment originally estimated by CMS in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50515). Moreover, as discussed in the FY 2018 IPPS/LTCH PPS final rule, Public Law 114-255, which further reduced the positive adjustment required for FY 2018 from 0.5 percentage point

[31] 78 Fed. Reg.at 50515.
[32] 83 Fed. Reg. at 41157.

> to 0.4588 percentage point, was enacted on December 13, 2016, after CMS had proposed and finalized the final negative -1.5 percentage point adjustment required under section 631 of the ATRA. We see no evidence that Congress enacted these adjustments with the intent that CMS would make an additional +0.7 percentage point adjustment in FY 2018 to compensate for the higher than expected final ATRA adjustment made in FY 2017, nor are we persuaded that it would be appropriate to use the Secretary's exceptions and adjustments authority under section 1886(d)(5)(I) of the Act to adjust payments in FY 2020 to restore any additional amount of the original 3.9 percentage point reduction, given Congress' prescriptive adjustment levels under section 414 of the MACRA and section 15005 of the 21st Century Cures Act.
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> After consideration of the public comments we received, we are finalizing our proposal to implement a 0.5 percentage point adjustment to the standardized amount for FY 2020.[33]

Similar statements were issued for FYs 2021[34] and 2022,[35] and both adopted a +.5 percent adjustment. In the FY 2023 IPPS Final Rule, the Secretary implemented the final, 0.4588 percentage point positive adjustment to the standardized amount and specifically noted that it was a "permanent adjustment" to the rates (*i.e*., that it would carry forward to future years)

> Consistent with the requirements of section 414 of the MACRA, we proposed to implement a 0.5 percentage point positive adjustment to the standardized amount for FY 2023. *We stated that this would constitute a* ***permanent*** *adjustment to payment rates*. We also stated that this proposed 0.5 percentage point positive adjustment is the final adjustment prescribed by section 414 of the MACRA. Along with the 0.4588 percentage point positive adjustment for FY 2018, and the 0.5 percentage point positive adjustments for FY 2019, FY 2020, FY 2021, and FY 2022, this final adjustment will result in combined positive adjustment of 2.9588 percentage points (or the sum of the adjustments for FYs 2018 through 2023) to the standardized amount.
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> We received no public comments on the proposed adjustment for FY 2023 and are finalizing our proposal to implement a 0.5 percentage point positive adjustment to the standardized amount for FY 2023. As indicated, this finalized 0.5 percentage point positive adjustment for FY 2023 is the final adjustment prescribed by section 414 of the MACRA.[36]

Providers' Requests for Hearing:

[33] 84 Fed. Reg. 42044, 42057 (Aug. 16, 2019).
[34] 85 Fed. Reg. 58432, 58444-45 (Sept. 18, 2020).
[35] 86 Fed. Reg. 44774, 44795 (Aug. 13, 2021).
[36] 87 Fed. Reg. 48780, 48800 (Aug. 10 ,2022) (emphasis added).

The Providers claim their FFY 2024 payments are incorrectly low "in violation of section 7 of the [TMA], as amended by the [ATRA], section 414 of the [MACRA] and the 21st Century Cures Act."[37] They argue that CMS's "unlawful retention of the 0.9412% reduction in FFY 2024 constitutes arbitrary and capricious action and an abuse of discretion."[38]

The Providers explain that:

> After a decade of enduring the Secretary's negative and positive adjustments as outlined above, Providers still face a remaining net negative reduction of 0.9412% to their standardized payment amounts. Rather than reverse this negative adjustment in FFY 2024 as expected, the Secretary has retained this reduction in its FFY 2024 Medicare IPPS Final Rule. 88 Fed. Reg. at 58653-54. Providers assert the Secretary's retention of this reduction in FFY 2024 is a violation of mandates established by ATRA, MACRA and the 21st Century Cures Act that Medicare's recoupment actions outlined above should only occur through 2023.
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> ***
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> As statutory mandates explicitly state that the base rate reductions should only apply through 2023, the Secretary is barred from further applying any of the adjustments of ATRA, MACRA, and the 21st Century Cures Act to discharges in FFY 2024. *See* TMA §§ 7(b)(1), (4), as amended. Further, the Secretary's unlawful retention of the 0.9412% reduction in FFY 2024 constitutes arbitrary and capricious action and an abuse of discretion. 5 U.S.C. § 706(2)(A). Providers challenge the Secretary's retention of the 0.9412% base rate reduction, and request the Provider Reimbursement Review Board direct the Secretary to make a positive adjustment to Providers' standardized payment amount.[39]

Board's Decision:

A. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers are permitted to appeal from a published Federal Register;

[37] *E.g.*, PRRB Case 24-1419GC Statement of the Issue at 1.
[38] *Id*. at 2.
[39] *Id.* at 1 – 2.

- The matter at issue involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[40]

As noted above, the Medicare Contractor has not filed any jurisdictional challenge or noted any jurisdictional impediments for any providers in any of the eighteen (18) appeals that are the subject of the initial appeals.

The Providers have all appealed from the Federal Register, a valid final determination, within the required timeframe and each case has an amount in controversy that exceeds $50,000. The cases also involve a single interpretation of law that is common to each Provider in each group.

The Board would normally have jurisdiction over this type of issue; however, section 5 of the TMA, however, specifically precludes administrative or judicial review of adjustments made thereunder:

> (5) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1878 of the Social Security Act (42 U.S.C. 1395oo) or otherwise of any determination or adjustments made under this subsection.

B. D.C. District Court in Fresno Community Hosp. & Med. Ctr. v. Azar[41]

In *Fresno v. Azar*, hundreds of hospitals argued "that an adjustment of at least +1.1588% was required in order for the Secretary not to continue unlawfully a prior -0.7% recoupment adjustment made in fiscal year 2017."[42] The Secretary moved to dismiss the claims in Providers' Complaint, arguing that Congress has prohibited review of the Secretary's determinations and adjustments made under § 7(b) of the TMA.[43] The U.S. District Court for the District of Columbia ("D.C. District Court") agreed with regard to three of five counts, also finding that the claims did not fit within the narrow *ultra vires* exception to Congress' bar on judicial review. Two claims survived the Motion to Dismiss because they pertained to the Secretary's failure to exercise his "exceptions and adjustments" discretion under 42 U.S.C. § 1395ww(d)(5)(I), not adjustments under TMA § 7(b).[44]

The five counts brought by the Providers in *Fresno v. Azar* were as follows:

1. The Secretary's failure to restore the additional -0.7 percent ATRA reduction in 2018 adjustment was unlawful based on the Administrative Procedure Act ("APA"), the Medicare Act, and other statutes;

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[40] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[41] 370 F.Supp.3d 139 (D.D.C. 2019) ("*Fresno v. Azar*").
[42] *Id.* at 142.
[43] *Id.*
[44] *Id.* at 143.

2. The Secretary violated the APA, the Medicare Act, and other statutes by failing to explain his reasons for not offsetting the additional -0.7 percent recoupment adjustment in 2018 through his "exceptions and adjustments" discretion;
3. The Secretary violated the APA, the Medicare Act, and other statutes by failing to adequately address commenters' questions and requests concerning the use of the Secretary's "exceptions and adjustments" discretion in implementing the 2018 adjustment;
4. The Providers requested that the Court mandamus the Secretary to restore the additional -0.7 percent adjustment which was made in 2017; and
5. Under the All Writs Act, Providers argued that they were entitled to an offsetting positive adjustment of +0.7 percent for fiscal year 2018.[45]

In support of these claims and that they were not precluded from review, the Providers made three arguments. First, that they were not seeking to review the +0.4588 percent positive adjustment for FY 2018 but rather the wrongful continuation of a -0.7 percent recoupment adjustment into FY 2018. Second, that the court could review the +0.4588 percent positive adjustment and the continuation of the -0.7 percent recoupment adjustment because it was plainly unlawful. Third, and finally, that even if other claims are precluded from review, the claims challenging the Secretary's failure to exercise his "exceptions and adjustments" discretion are not barred by the preclusion statute.

With regard to the first argument that the Providers' challenge was not to the +0.4588 percent positive adjustment for FY 2018 but rather the wrongful continuation of a -0.7 percent recoupment adjustment, the D.C. District Court disagreed and noted that "crafty pleading" and "clever phrasing" could not avoid the bar on judicial review.[46] It reasoned:

> Plaintiffs' assertion that the Secretary improperly determined that TMA § 7(b)(2) permitted him to continue a -0.7% recoupment adjustment into fiscal year 2018 still challenges a determination or adjustment made under TMA § 7(b). Accordingly, judicial review is barred.
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> In order to grant Plaintiffs' requested relief, the Court would need to order the Secretary to make a different adjustment for 2018 than the one that he decided was required. To order the Secretary to make a different adjustment than the one he intended would necessarily require the Court to review an adjustment made under TMA § 7(b), which is prohibited by the preclusion statute. *See* TMA § 7(b)(5). Accordingly, Plaintiffs' claims fall under the clear language of the TMA's preclusion statute.[47]

[45] *Id.* at 148.
[46] *Id.* at 149.
[47] *Id.* at 150.

The Providers also claimed that continuing the -0.7 percent recoupment adjustment into FY 2017 violated TMA § 7(b)(2), which states that an adjustment made under § 7(b)(1)(B) for discharges in a year cannot be included in the determination of standardized amounts for subsequent years. Since the FY 2017 recoupment adjustment was -1.5% instead of -0.8%, the implementation of a +0.4588 adjustment as mandated by Congress fell short when failing to take into account the excess -0.7 percent. Thus, since the adjustment was unlawful, the Providers claimed the preclusion provision did not apply.[48]

The court disagreed, finding that TMA § 7(b)(5) precluded review of *any* determination or adjustment made under § 7(b), not just "proper" ones.[49] More importantly, this argument would completely subsume the *ultra vires* doctrine, which specifically deals with adjustments made "in violation" of a law giving agencies authority:

> Accordingly, Plaintiffs' argument that the Secretary's +0.4588% adjustment violated TMA § 7(b)(2) by leaving in place a recoupment adjustment from 2017 does not overcome the TMA's preclusion statute. Instead, Plaintiffs' argument should be addressed under the ultra vires doctrine[.][50]

The court then turned to the Providers' second argument, that the continuation of the -0.7% recoupment adjustment was plainly unlawful – or that the Secretary had acted *ultra vires*:

> Even if the preclusion statute applies to Plaintiffs' claims, the Court may still be able to review those claims under the ultra vires doctrine. Congress has not and cannot limit judicial review to correct a patently unlawful agency action. Under the ultra vires doctrine, an agency action is open to judicial review, even in the face of an applicable preclusion statute, when it "patently misconstrues a statute, disregards a specific and unambiguous statutory directive, or violates a specific command of a statute. [51]

The court acknowledged the Providers' argument: the +0.4588 percent adjustment required by TMA § 7(b)(1)(B)(iii) for fiscal year 2018 was predicated on the 2014 to 2017 recoupment adjustments totaling only -3.2 percent, but there had been an additional -0.7 percent recoupment adjustment in 2017. The FY 2018 +0.4588 percent adjustment did not "remove" the FY 2017 -0.7 percent recoupment adjustment, which violated TMA § 7(b)(2) by allowing adjustments from prior years to be included in adjustments for subsequent years. Since the adjustment violates TMA § 7(b)(2), it is "plainly unlawful" or *ultra vires* and subject to judicial review, despite the preclusion provision at TMA § 7(b)(5).[52]

The court disagreed, noting that TMA § 7(b)(1)(B)(iii) *explicitly* required the Secretary to make the +0.4588 percent adjustment, and *only* that adjustment, for FY 2018. It also explained that

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[48] *Id.*
[49] *Id.*
[50] *Id.* at 152.
[51] *Id.* (citations omitted).
[52] *Id.* at 153.

this very specific mandate was enacted later in time than the general prohibition on continuing recoupment adjustments found in TMA § 7(b)(2). The court concluded:

> The Secretary's decision to follow the explicit Congressional mandate to implement a +0.4588% adjustment and "not make the adjustment . . . that would otherwise apply" in 2018, which Congress passed with full knowledge of the greater-than-previously-estimated 2017 recoupment adjustment, was not an ultra vires act.[53]

Thus, the court found that the preclusion of administrative or judicial review applied to counts 1, 4, and 5 of the Providers' Complaint. Counts 2 and 3, however, concerned whether the "Secretary failed to adequately explain the rationale for[, and failing to address commenters' questions and requests regarding,] not applying his 'exceptions and adjustments' discretion under 42 U.S.C. § 1395ww(d)(5)(I) to make an additional +0.7% adjustment in 2018, offsetting the 2017 -0.7% recoupment adjustment."[54] The court noted it could not review a claim that was "inextricably intertwined" with barred claims.[55] The Secretary argued that he did not use his "exceptions and adjustments" discretion because he determined a +0.7 percent adjustment was prohibited under TMA § 7(b)(1)(B)(iii).[56] The court found, however:

> It is not clear from the 2018 final rule, or from any other source provided by Defendant, that the Secretary considered whether or not to grant a +0.7% adjustment under the "exceptions and adjustments" discretionary authority, despite comments urging him to do so.[57]

The court acknowledged that perhaps the Secretary declined to exercise his discretionary authority because he considered it to be prohibited under the TMA, thus making Counts 2 and 3 "inextricably intertwined" with the other, precluded claims. The court found, however, that the Secretary failed to prove that and, as a result, it had jurisdiction over these two, specific claims.[58]

C. D.C. Circuit Court in Fresno Community Hosp. & Med. Ctr. v. Azar[59]

The Providers appealed to the U.S. Circuit Court for the District of Columbia ("D.C. Circuit Court"). It found that TMA § 7(b)(5) defeats the presumption favoring review of agency action, so the only question was whether the challenged action was "the sort shielded form review."[60] It made the same finding as the D.C. District Court: that labeling the challenge as a continued inclusion or failure to reverse a -0.7 percent adjustment is still, in reality, a challenge to an "adjustment" which is barred by TMA § 7(b)(5).[61]

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[53] *Id.*
[54] *Id.* at 156-157.
[55] *Id.* at 157.
[56] *Id.*
[57] *Id.* at 158.
[58] *Id.*
[59] 987 F.3d 158 (D.C. Cir. 2021) ("*Fresno v. Cochran*").
[60] *Id.* at 161 (quoting *Amgen Inc. v. Smith*, 357 F.3d 103, 113 (D.C. Cir. 2004).
[61] *Id.* at 161-162.

The court next considered the Providers' argument that the -0.6 percent adjustment should be set aside as *ultra vires*, noting that they had the burden of showing "that the Secretary flouted a clear, specific, statutory command."[62] The Providers made the same argument as before the D.C. District Court: that TMA § 7(b)(2) bars the Secretary from allowing any recoupment adjustment to continue into a subsequent year, and by carrying over the -0.7% adjustment into 2018, the Secretary violated an explicit statutory prohibition.[63] The D.C. Circuit Court disagreed, noting that the Providers did not object to *other* adjustments being carried over in prior fiscal years. Ultimately, the court found that TMA § 7(b)(2) did not actually forbid the Secretary from carrying over adjustments and affirmed the D.C. District Court's decision.

D. Preclusion of Board Jurisdiction

As noted above and in the decision of both the D.C. District Court and the D.C. Circuit Court in *Fresno v. Azar*, TMA § 7(b)(5) generally prohibits administrative and judicial review of any determinations or adjustments made pursuant to the TMA. The Providers in these appeals challenge their FFY 2024 IPPS payments on the grounds that those payments were (and continue to be) improperly reduced due to the "**unlawful retention of the 0.9412% reduction in FFY 2024** . . . ."[64]

The D.C. District Court directly addressed these arguments and found that the distinction between challenging an adjustment and challenging the failure to eliminate an adjustment amounts to nothing more than "crafty pleading" and "clever phrasing" that cannot avoid the bar on judicial review.[65] In this regard, the Board further notes that, in the preamble to the FY 2024 IPPS Final Rule, the Secretary responded to directly to the issue raised in this appeal and *relied on the TMA*, as amended, in declining "to adjust any payments in FY 2024 [*sic* to] restore any additional amount of the original 3.9 percentage point reduction."[66] Indeed, the *permanence* of the adjustment made in

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[62] *Id.* at 162 (citing *Nyunt v. Chairman, Broad Bd. Of Govs*., 589 F.3d, 449 (D.C. Cir. 2009)).
[63] *Id.*
[64] *E.g.*, PRRB Case 24-1419GC Statement of the Issue at 2 (Feb. 22, 2024) (emphasis added).
[65] *Fresno v. Azar* at 149.
[66] 88 Fed. Reg. at 58654. The following is an excerpt from this preamble discussion in the FY 2024 IPPS Final Rule at 88 Fed. Reg. 58654 to give the context for the quote:

> *Comment*: Several commenters requested that CMS make a positive adjustment to restore the full amount of the documentation and coding recoupment adjustments in the FY 2024 IPPS final rule which they asserted is required under section (7)(B)(2) and (4) of the TMA . . ., Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007 (Pub. L. 110–90). Commenters stated that the statute is explicit that CMS may not carry forward any documentation and coding adjustments applied in fiscal years 2010 through 2017 into IPPS rates after FY 2023. Commenters contended that CMS, by its own admission, has restored only 2.9588 percentage points of a total 3.9 percentage point reduction. By not fully restoring the total reductions, commenters believe that CMS is improperly extending payment adjustments beyond the FY 2023 statutory limit. A commenter stated that, even if CMS disputes it is required to make such an adjustment, CMS should use its special exceptions and adjustments authority to address the shortfall.
> *Response*: As of FY 2023, CMS completed the statutory requirements of section 7(b)(1)(B) of Pub. L. 110–90 as amended . . . . As we discussed in the FY 2022 IPPS/LTCH PPS final rule (86 FR 44794 through 44795), the FY 2021 IPPS/LTCH PPS final rule (85 FR 58444 through 58445) and in prior rules, we believe section 414 of the MACRA and section 15005 of the 21st Century Cures Act set forth the levels of positive adjustments for FYs 2018 through 2023. We are not convinced that the adjustments prescribed by MACRA were predicated on a specific adjustment level estimated or

the FY 2023 IPPS Final Rule was specifically discussed as part of that rulemaking as noted by the Secertary in the preamble to the FY 2023 IPPS Final Rule: "We stated [in the proposed rulemaking] that this would constitute a *permanent* adjustment to payment rates."[67] Accordingly, the Board finds that the Board jurisdiction over this appeal is precluded by TMA § 7(b)(5).

The only claims which survived in *Fresno v. Azar* were those alleging the Secretary should have applied his "exceptions and adjustments" discretion under 42 U.S.C. § 1395ww(d)(5)(I) to make an additional +0.7 percent adjustment in 2018. The Providers in these group appeals have not cited 42 U.S.C. § 1395ww(d)(5)(I) or discussed the Secretary's "exceptions and adjustments" discretion in any capacity. Board Rule 7.2.1 (Nov. 2021) requires that, for each issue raised in an appeal request, a Provider must submit a concise issue statement describing, *inter alia*, the controlling authority, why the adjustment is incorrect, and the basis for jurisdiction before the Board. The Providers failed to make this argument in their requests for hearing and, as such, the Board will not address or consider it.

> implemented by CMS in previous rulemaking. We see no evidence that Congress enacted these adjustments with the intent that CMS would make an additional +0.7 percentage point adjustment in FY 2018 to compensate for the higher than expected final ATRA adjustment made in FY 2017, nor are we persuaded that it would be appropriate to use the Secretary's exceptions and adjustments authority under section 1886(d)(5)(I) of the Act **to adjust payments in FY 2024 restore any additional amount of the original 3.9 percentage point reduction, given Congress' directive regarding prescriptive adjustment levels under section 414 of the MACRA and section 15005 of the 21st Century Cures Act**. Accordingly, in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38009), we implemented the required +0.4588 percentage point adjustment to the standardized amount for FY 2018. In the FY 2019 IPPS/LTCH PPS final rule (FY 2019 final rule) (83 FR 41157), the FY 2020 IPPS/LTCH PPS final rule (FY 2020 final rule) (84 FR 42057), the FY 2021 IPPS/LTCH PPS final rule (FY 2021 final rule) (85 FR 58444 and 58445), the FY 2022 IPPS/LTCH PPS final rule (FY 2022 final rule) (86 FR 44794 and 44795), and the FY 2023 IPPS/LTCH PPS final rule (FY 2023 final rule) (87 FR 48800), consistent with the requirements of section 414 of the MACRA, we implemented 0.5 percentage point positive adjustments to the standardized amount for FY 2019, FY 2020, FY 2021, FY 2022 and FY 2023, respectively. As discussed in the FY 2023 final rule, the finalized 0.5 percentage point positive adjustment for FY 2023 is the final adjustment prescribed by section 414 of the MACRA.

(Italics emphasis in original and bold and italics emphasis added.)

[67] 87 Fed. Reg. at 48800 (emphasis added). Similarly, the Board notes that the FY 2023 IPPS Proposed Rule included the following discussion in the preamble at 87 Fed. Reg. 28108, 28126 (May 10, 2022) (emphasis added):

> In the FY 2019 IPPS/LTCH PPS final rule (83 FR 41157), the FY 2020 IPPS/ LTCH PPS final rule (84 FR 42057), FY 2021 IPPS/LTCH PPS final rule (85 FR 58444 and 58445), and the FY 2022 IPPS/LTCH PPS final rule (86 FR 44794 and 44795), consistent with the requirements of section 414 of the MACRA, we implemented 0.5 percentage point positive adjustments to the standardized amount for FY 2019, FY 2020, FY 2021, and FY 2022, respectively. *We indicated the FY 2018, FY 2019, FY 2020, FY 2021, and FY 2022 adjustments were **permanent** adjustments to payment rates*. We also stated that we plan to propose a future adjustment required under section 414 of the MACRA for FY 2023 in future rulemaking.
>
> ****
>
> Consistent with the requirements of section 414 of the MACRA, we are proposing to implement a 0.5 percentage point positive adjustment to the standardized amount for FY 2023. *This would constitute a **permanent** adjustment to payment rates*.

Based on the foregoing, the Board finds that, pursuant to TMA § 7(b)(5), it lacks substantive jurisdiction to review the issue appealed in the eighteen (18) group appeals listed in **Appendix A** and, therefore, is dismissing the cases.[68]

Accordingly, the Board closes these 18 groups and removes them from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

5/17/2024

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

Enclosure: Appendix A – List of 18 Group Cases Covered by this Dismissal Determination

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Byron Lamprecht – WPS Government Health Administrators (J-5)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Michael Redmond, Novitas Solutions, Inc. (J-L) (J-H)
John Bloom, Noridian Healthcare Solutions (J-F)
Judith Cummings, CGS Administrators (J-15)
Wilson Leong, FSS

[68] The Board recognizes that the Providers maintain the Board should find jurisdiction over the instant appeals "consistent with the Board's previous grants of EJR" for the cases underlying the *Fresno v. Azar* litigation. However, those prior determination did not address the TMA preclusion provisions, and it is clear that both the D.C. District Court and the D.C. Circuit Court specifically found that the TMA preclusion provisions were applicable to those appeals. Consequently, the Board finds that it erred in finding jurisdiction in those earlier cases as supported by the analysis in this determination and the Courts' decisions in the *Fresno v. Azar* litigation.

Appendix A
List of 18 Cases Covered by this Dismissal Determination

CASE NO.	CASE NAME
24-1419GC	Alameda Health System FFY 2024 ATRA/MACRA 0.9412% Adjustment CIRP Group
24-1425GC	Ardent Health FFY 2024 ATRA/MACRA 0.9412% Adjustment CIRP Group
24-1427GC	CHRISTUS Health FFY 2024 ATRA/MACRA 0.9412% Adjustment CIRP Group
24-1429GC	Emanate Health FFY 2024 ATRA/MACRA 0.9412% Adjustment CIRP Group
24-1432GC	Memorial Hermann FFY 2024 ATRA/MACRA 0.9412% Adjustment CIRP Group
24-1437GC	Medical Univ of SC FFY 2024 ATRA/MACRA 0.9412% Adjustment CIRP Group
24-1440GC	OhioHealth FFY 2024 ATRA/MACRA 0.9412% Adjustment CIRP Group
24-1444GC	Palomar Health FFY 2024 ATRA/MACRA 0.9412% Adjustment CIRP Group
24-1448GC	Pipeline FFY 2024 ATRA/MACRA 0.9412% Adjustment CIRP Group
24-1451GC	OHSU Health FFY 2024 ATRA/MACRA 0.9412% Adjustment CIRP Group
24-1452GC	RWJ Barnabas FFY 2024 ATRA/MACRA 0.9412% Adjustment CIRP Group
24-1453GC	St. Francis Health System FFY 2024 ATRA/MACRA 0.9412% Adjustment CIRP Group
24-1458GC	SSM Health FFY 2024 ATRA/MACRA 0.9412% Adjustment CIRP Group
24-1459GC	Sutter Health FFY 2024 ATRA/MACRA 0.9412% Adjustment CIRP Group
24-1461GC	Trinity Health FFY 2024 ATRA/MACRA 0.9412% Adjustment CIRP Group
24-1462GC	Univ of California FFY 2024 ATRA/MACRA 0.9412% Adjustment CIRP Group
24-1463GC	WellSpan Health FFY 2024 ATRA/MACRA 0.9412% Adjustment CIRP Group
24-1464G	Toyon Associates FFY 2024 ATRA/MACRA 0.9412% Adjustment Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Decision***
Berwick Hospital (Provider Number 39-0072)
FYE: 06/30/2016
Case Number: 19-0613

Dear Mr. Summar,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed documentation in Case No. 19-0613 pursuant to a jurisdictional challenge filed by the Medicare Administrative Contractor ("MAC"). The Board's decision is set forth below.

Background:

Procedural History for Case No. 19-0613

On May 31, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2016.

On November 29, 2018, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

- Issue 1: Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage- Provider Specific
- Issue 2: DSH SSI Percentage[1]
- Issue 3: DSH-Medicaid Eligible Days[2]
- Issue 4: Uncompensated Care ("UCC") Distribution Pool
- Issue 5: 2 Midnight Census IPPS Payment Reduction[3]

The DSH – SSI Percentage (Provider Specific) issue and Uncompensated Care Distribution Pool issue remain pending in the appeal.

[1] On 06/14/2019, this issue was transferred to PRRB Case No. 19-1409GC.
[2] On 03/02/2023, the Provider withdrew this issue.
[3] On 06/14/2019, the Provider transferred to PRRB Case No. 19-1410GC.

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

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

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

On July 23, 2019, the Provider submitted its preliminary position paper to the MAC. 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 State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of

[4] Issue Statement at 1 (Nov. 29, 2018).

> CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[5]

The amount in controversy for Issues 1 and 2 in the individual appeal are both listed as $7,000.

MAC's Contentions

Issue 1 – DSH – SSI Percentage (Provider Specific)[6]

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue for two reasons. First, the MAC argues that the appeal is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. The Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). The Provider has not exhausted all available remedies prior to requesting a [Board] appeal to resolve this issue. The MAC requests that the [Board] dismiss this issue consistent with other jurisdictional decisions.[7]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[8]

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)."[9]

---

[5] Provider's Preliminary Position Paper at 8-9 (July 23, 2019).
[6] The MAC also challenged jurisdiction over the Two Midnight Rule issue, however the Provider has since withdrawn that issue.
[7] Jurisdictional Challenge at 6-7 (March 11, 2019).
[8] *Id*. at 5-6.
[9] *Id.* at 8.

The MAC also contends that this issue is a duplicate of PRRB Case Nos. 15-1134GC and 16-0769GC, in which the Provider participated, and should therefore, be dismissed.[10]

Provider's Jurisdictional Response

Issue 1 – DSH – SSI Percentage (Provider Specific)

The Provider contends each of the appealed SSI issues are separate and distinct issues, and pursuant to Board Rule 8.1 "Some issues may have multiple components". The Provider argues it is entitled to appeal an item with which it is dissatisfied, and the MAC specifically adjusted the Provider's SSI percentage which resulted from its understated SSI percentage. The Provider cites *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) which contemplates whether Baystate's SSI fractions were understated due to the number of days included in the SSI ratio.[11]

Issue 4- DSH- Uncompensated Care

The Provider argues "[t]he Statute does not authorize the Secretary to estimate the uninsured patient population percentage"[12] and believes it is entitled to a writ of mandamus directing the Secretary to revise her estimates. Additionally, the statute does not preclude challenges to the regulations and policies relied upon by the Secretary in computing estimates for DSH Factors 1-3, even if challenges to the estimates themselves are precluded.[13]

Board Analysis and Decision:

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

A. 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

[10] *Id*. at 11.
[11] Provider's Response to Jurisdictional Challenge at 1-2 (April 10, 2019).
[12] *Id.* at 3.
[13] *Id.* at 4-5.

duplicative of the DSH - SSI Percentage (Systemic Errors) issue that was appealed in Group Case No. 19-1409GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[14] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[15] The Provider argues in its issue statement that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[16]

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. 19-0613 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,[17] the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board 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, the Provider has failed to explain how this argument is ***specific to this provider***, as the issue statement asserts. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[18] 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 and finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop

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

the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

> 25.2.2 Unavailable and Omitted Documents If documents necessary to support your position are still unavailable, then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule,

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

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

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

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[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. 19-1409GC.

Accordingly, based on the record before it, the Board finds that the SSI Provider Specific issue in Case No. 19-0613 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 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—must be dismissed for lack of jurisdiction and as premature. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…" Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider's DSH SSI Percentage realignment as such there is no "determination" to appeal and the appeal of this issue is otherwise premature.

B. UCC Distribution Pool

The Board finds that it does not have jurisdiction over the DSH UCC payment issue in the above-referenced appeal because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).[21]

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[19] Last accessed May 20, 2024.
[20] Emphasis added.
[21] The Provider was also a participant in PRRB Case Nos. 15-1134GC (appealing from the Fed. Reg. dated Aug. 22, 2014 and covering service dates July 1, 2015 through Sept. 31, 2015) and 16-0769GC (appealing from the Fed. Reg. dated Aug. 17, 2015 and covering service dates October 1, 2015 through June 30, 2016). Both CIRP Group appeals have been dismissed for a lack of jurisdiction.

1. Bar on Administrative Review

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

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[22]
>
> (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*"),[23] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[24] 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."[25] 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.[26]

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[22] 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.
[23] 830 F.3d 515 (D.C. Cir. 2016).
[24] 89 F. Supp. 3d 121 (D.D.C. 2015).
[25] 830 F.3d 515, 517.
[26] *Id.* at 519.

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.[27]

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*").[28] 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."[29] 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."[30] 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.[31]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[32] 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.[33] 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.[34] 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.[35] Nevertheless, the Secretary used each

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[27] *Id.* at 521-22.
[28] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[29] *Id.* at 506.
[30] *Id.*
[31] *Id.* at 507.
[32] 514 F. Supp. 249 (D.D.C. 2021).
[33] *Id.* at 255-56.
[34] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[35] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.

hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[36]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[37]

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."[38] 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.[39] 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.[40]

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.[41] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

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[36] *Id.*
[37] *Id.* at 262-64.
[38] *Id.* at 265.
[39] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[40] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[41] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).

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*").[42] 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.[43] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the providers' claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."[44] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[45] 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***."[46]

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

Decision

The Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from appeal as it is duplicative of the issue in PRRB Case No. 19-1409GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue.

Additionally, the Board dismisses the UCC Distribution Pool issue as the Board does not have jurisdiction because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation.

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[42] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[43] *Id*. at *4.
[44] *Id.* at *9.
[45] 139 S. Ct. 1804 (2019).
[46] *Ascension* at *8 (bold italics emphasis added).

As no issues remain pending, Case No. 19-0613 is closed and removed from the Board's docket.

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

Board Members:

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

For the Board:

5/20/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision: Untimely Added Issue***
John T. Mather Memorial Hospital (33-0185), FYE 12/31/2017
PRRB Case No. 22-1030

Dear Ms. Livreri and Ms. Decker,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the Provider's Motion to Add Issue to PRRB Case No. 22-1030. The Board's decision is set forth below.

Pertinent Facts

On May 5, 2022, the Board received the Provider's individual appeal request for fiscal year ending December 31, 2017. The initial Individual Appeal Request contained two (2) issues: Issue #1 challenging bad debts, and Issue #2 challenging the Medicare Contractor's adjustment to reduce the Full Time Equivalent Interns and Residents amount.

On May 6, 2022, the Board notified the Provider that Issues #1 and #2 were insufficient as filed. The Board noted that the issue statement for Issue #1 was insufficient and that the calculation support for Issue #2 did not match the amount in controversy. On May 20, 2022, the Provider resubmitted documents for both Issues in the appeal in accordance.

On December 1, 2023, the Provider submitted a request to the Board to Add an Issue to the Appeal. The Provider stated that adjustment #4 was made by the Medicare Contractor "MAC," reducing the reported Medicare HMO Subprovider IPF Days. The Provider asserts that the adjustment was made to agree to the Provider Reimbursement and Statistical Report (PS&R), but the PS&R did not accurately reflect the number of Medicare HMO Subprovider IPF Days due to issues with shadow billing.

Statutory and Regulatory Background

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.[11] A request to Add an Issue to an open appeal should be submitted to the Board no later than 60 days after the expiration of the applicable 180-day period for filing the initial hearing request, and the request must meet the minimum filing requirements as identified in 42 C.F.R.§ 405.1835(e). 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

Similarly, Board Rule 6.2 reads:

> **6.2 Adding a New Issue to an Individual Case**
>
> **6.2.1 Request and Supporting Documentation**
>
> Subject to the provisions of 42 C.F.R. § 405.1835€, an issue may be added to an individual appeal if the provider:
> - timely files a request with the Board to add issues to an open appeal ***no later than 60 days after the expiration of the applicable 180 day period for filing the initial hearing request***, and
> - the request meets the minimum filing requirements as identified in 42 C.F.R. § 405.1835(e).
>
> Reference Rules 7 and 8 as well as Model Form C – Request to Add Issue (Appendix C) for guidance on all required OH CDMS data fields and supporting documentation.[2]

Board's Decision:

The Board hereby ***denies*** the Provider's Motion to Add an Issue pursuant to 42 C.F.R. § 405.1835(e) and Board Rule 6.2. The Provider requested to Add an Issue to the Individual Appeal to reduce the Medicare HMO IPF Subprovider days reported ***719 days*** after the date of its final determination. The regulation and Board Rule cited above allow the Provider to add an issue to an Individual Appeal no later than 60 days after the expiration of the applicable 180-day period for filing an appeal. Here, as the Provider requested to untimely add the issue to its appeal, the Board denies that request. Case No. 22-1030 remains open.

---

[1] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[2] Emphasis added.

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

Board Members Participating:

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

For the Board:

5/20/2024

X Ratina Kelly

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

cc: Wilson Long, Federal Specialized Services

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Via Electronic Delivery

James Ravindran
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150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Notice of Dismissal***
Northwest Mississippi Regional Medical Center (Provider Number 25-0042)
FYE: 12/31/2015
Case Number: 19-0785

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-0785. Set forth below is the decision of the Board to dismiss the last remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) payment.

Background

A. *Procedural History for Case No. 19-0785*

On **July 5, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2015. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **December 19, 2018**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

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

[1] On July 22, 2019, this issue was transferred to Case No. 18-0588GC.
[2] On July 22, 2019, this issue was transferred to Case No. 18-0589GC.
[3] On July 22, 2019, this issue was transferred to Case No. 18-0584GC.

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

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **July 22, 2019**, the Provider transferred Issues 2, 3, 4, 6, 7, 8 and 9 to CHS CIRP groups.

On **October 28, 2019** and **April 19, 2024**, the Medicare Contractor filed Jurisdictional Challenges over Issue 1. The **April 19, 2024** challenge also covers issue 5, DSH -Medicaid Eligible Days.

On **May 2, 2024**, the Provider changed its designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **May 10, 2024**, the Provider withdrew Issue 5, DSH – Medicaid Eligible Days, from the appeal. As a result of the case transfers, and the Provider's request to withdraw Issue 5, the only issue remaining in the appeal is Issue 1 (DSH – SSI Percentage Provider Specific).

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-0588GC – QRS HMA 2015 DSH SSI Percentage CIRP Group

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

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

[4] On July 22, 2019, this issue was transferred to Case No. 18-0591GC.
[5] On July 22, 2019, this issue was transferred to Case No. 18-0585GC.
[6] On July 22, 2019, this issue was transferred to Case No. 18-0587GC.
[7] On July 22, 2019, this issue was transferred to Case No. 18-0592GC.

> 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).[8]

The Group Issue Statement in Case No. 18-0588GC, to which the Provider transferred Issue No. 2, reads, in part:

> **Statement of the Issue:**
>
> Whether the Medicare/SSI fraction used in the Medicare Disproportionate Share Hospital ["DSH"] 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 contends that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Provider(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 SSI payment.

[8] Provider's Initial Appeal Issue Statement at 1 (Dec. 19, 2018).

> The Provider(s) further contend(s) that the SSI percentages calculated by [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[9]

On February 28, 2024, the Board received the Provider's final position paper in 19-0785. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

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

[9] Group Appeal Issue Statement in Case No. 18-0588GC.

> Medicare fraction. The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[10]

The amount in controversy listed for both Issues 1 and 2 (which was transferred to 18-0588GC) in the Provider's individual appeal request is $19,000.

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 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. 18-0588GC, "QRS HMA 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:
>
> > The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
> >
> > The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]

[10] Provider's Final Position Paper at 8-9 (Feb. 28, 2024).

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

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

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

This component of Issue 1 is repeated by the Provider within Issue 2.

The MAC contends that the Provider raises the same disputes in Issue 2. The Provider describes Issue 2 as follows:

> The Provider contends that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by

> including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The Provider further contends that the SSI percentages calculated by [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 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.

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

As previously noted, Issue 2 has been transferred to Group Case No. 18-0588GC. This means that the Provider is appealing an issue from a single final determination in more than one appeal. The Board's Rules are clear on this matter: No duplicate filings. Board Rule 4.6.1 states:

> A provider may not appeal and pursue the same issue from a single final determination in more than one appeal (individual or group).

> Consistent with the Board's previous jurisdictional decisions[,] the MAC respectfully requests 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.[11]

The MAC also argues that the Provider has abandoned the issue of SSI realignment, and states:

> Issue 1 includes the Provider's appeal over SSI realignment. The Provider states:
>
> > 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 MAC contends that the Provider has abandoned the issue of SSI realignment and, therefore, it should be considered withdrawn. The Provider did not brief this issue within its preliminary position paper[.] PRRB Rule 25.3 addresses issues that are not briefed in a provider's position paper. In relevant part, this rule states:
>
> > Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.[12]

Additionally, the MAC argues that, even if the Provider did not abandon the issue, the Board lacks jurisdiction over SSI realignment, and the appeal is premature. The MAC contends:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. One the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> The regulations at 42 C.F.R. § 405.1835 set forth the criteria for a Provider's right to a Board hearing:
>
> > A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a <u>final contractor or Secretary determination</u> for the provider's cost reporting period[.] (Emphasis added).

[11] Jurisdictional Challenge at 5-6 (Apr. 19, 2024).
[12] *Id.* at 6-7.

> * * *
>
> 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]

The MAC makes a final argument stating that the Provider has failed to file a complete position paper. The MAC states that the Provider has failed to follow Board Rule 25.3 regarding the content of position papers. The Provider has not filed "a complete preliminary position paper with a fully developed narrative, all exhibits, 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."[14]

Provider's Jurisdictional Response

The Medicare Contractor filed two separate jurisdictional challenges, both of which challenged Issue 1. The first challenge was filed on October 28, 2019. The Provider timely filed its response on November 26, 2019.

In Provider's response to the MAC's jurisdictional challenge, it asserted the following arguments:

> **Duplicate SSI Issues:**
>
> The MAC argues issue 1 – SSI Provider Specific is a duplicate issue to issue 2 which was transferred on July 12, 2019 to Group Case No. 18-0588GC, QRS HMA 2015 DSH SSI Percentage CIRP Group. Provider contends each of the appealed SSI issues are separate and distinct issues, and that the Board should find jurisdiction over PRRB Case Number 19-0785.
>
> Board Rule 8.1 states[,] "Some issues may have multiple components. To comply with the [regulatory] requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible…" Appeal issue # 1 and 2 represent different components of the SSI issue, which was specifically adjusted during the audit. Since these specific appeal issue represent different aspects/components of the SSI issue, Provider contends the Board should find jurisdiction over both the SSI Systemic and SSI Provider Specific/Realignment issues.

[13] *Id.* at 7.
[14] *Id.* at 9.

. . .

SSI Systemic Issue:

The SSI Systemic issue addresses the various errors discussed in Baystate Medical Center v. Leavitt, 545 F. Supp. 2d 20 (D.D.C. 2008) in CMS' calculation of the disproportionate payment percentage, which result in the MedPAR not reflecting all individuals who are eligible for SSI, including such errors as: not accounting for retroactive SSI eligibility determinations by the Social Security Administration (SSA); omitting days of individuals who were eligible for SSI at the time of their stay due to their records being considered inactive by SSA due to their death following their stay; omitting SSI eligibility records of individuals who received a forced or manual payment on a temporary basis in lieu of the automated payments that are typically used for SSI payments, and the exclusion of days from the numerator of the Medicare Fraction belonging to patients who are not eligible to receive SSI payments at the time of their stay, but who have a special status under Section 1619(b) of the Social Security Act, 42 U.S.C. § 1382h(b), which enables them to receive Medicaid assistance based on a past entitlement to SSI payments. These systemic errors are the results of CMS's improper policies and data matching process. The SSI Systemic Issue also covers CMS Ruling 1498-R.

SSI Provider Specific Issue:

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

> Therefore, the Board should find jurisdiction over the SSI provider specific issue in the instant appeal.
>
> Accordingly, this is an appealable item because the MAC specifically adjusted the Providers SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2015, because of its understated SSI percentage due to errors of omission and commission.
>
> The Provider is entitled to appeal an item with which it is dissatisfied. Further, the Centers for Medicare & Medicaid Services ("CMS") in Northeast Hospital Corporation v. Sebelius, 657 F.3d 1 (D.C. Cir. 2011) specifically abandoned the CMS Administrator's December 1, 2008 decision that the SSI ratio cannot be revised based upon updated data after it has been calculated by CMS. Accordingly, the Provider has specifically identified patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS, due to errors that are or may be specific to the Provider, but in any case, are not the systemic errors that have been previously identified in the Baystate litigation. See Baystate Medical Center v. Leavitt, 545 F. Supp. 2d 20 (D.D.C. 2008). Once these patients are identified, the Provider contends that it will be entitled to a correction of these errors of omission to its SSI percentage.
>
> The DSH/SSI percentage was adjusted on the Provider's cost report. Accordingly, Provider requests the Board find that it has jurisdiction over the DSH/SSI provider specific issue.

The Medicare Contractor filed a second jurisdictional challenge on April 19, 2024, again challenging Issue 1, however the Provider failed to respond within thirty (30) days of the filing of that Jurisdictional Challenge.

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] 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."

[15] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

Decision of the Board

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

As set forth below, the Board hereby ***dismisses*** the Provider's last remaining issue, Issue # 1, SSI Provider Specific.

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Case No. 18-0588GC.

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 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. 18-0588GC 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. 19-0785 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 18-0588GC. Because the issue is

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

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.

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 and Final Position Papers to see if they further clarified Issue 1. However, they failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 18-0588GC, but instead referred to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. The Board finds that the Provider's Final Position Paper failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Aug. 29, 2018), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

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

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

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule,

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[19] PRRB Rules v. 2.0 (Aug. 2018).
[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] (Italics and underline emphasis added.)

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

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

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

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[23]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 18-0588GC.

Accordingly, based on the record before it, the Board finds that the SSI Provider Specific issue in Case No. 19-0785 and the group issue from the CHS CIRP group under Case No. 18-0588GC 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*

[22] Last accessed May 20, 2024.
[23] Emphasis added.

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 final remaining issue in this case – (Issue 1). As no issues remain, the Board hereby closes Case No. 19-0785 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

5/20/2024

X Kevin D. Smith, CPA

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

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

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RE: ***Request for Reconsideration and Reinstatement***
Baylor Scott & White All Saints Medical Center (Prov. No. 45-0187)
FYE 09/30/2013
Case No. 17-0244

Dear Messrs. Ravindran and Redmond:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 17-0244, as well as the Provider's Request for Reconsideration and Reinstatement dated February 2, 2024. As set forth below, the Board finds that the Request for Reconsideration/Reinstatement is now moot/effectively withdrawn/abandoned and, as such, that it need not address the request.

By way of background, by letter dated **December 18, 2023**, the Board dismissed from Issue 7 (the Medicaid eligible days issue) the sub-issue of § 1115 waiver days. Within that dismissal, the Board noted that "Case No. 17-0244 *remains* ***open*** *for resolution* of the DSH Medicaid Eligible Days issue [*i.e.*, Issue 7] *as modified by this determination*."[1] Accordingly, the Board specified that [r]eview 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 this appeal*."[2] As a result, that dismissal was preliminary until such full disposition as explained at 42 C.F.R. § 405.1840.

On **February 2, 2024**, the Provider filed a request for reconsideration of the December 18, 2023, dismissal determination and "requested that the Board issue a decision on our request ***by February 14, 2024***, so that the provider may timely file a civil action contesting the dismissal if necessary."[3]

On **March 4, 2024**, the Board issued a Scheduling Order requesting a status update on this case to delay issuing a ruling on the reconsideration request because of the following facts:

1. This case remained open and pending before the Board and the Board's dismissal of a sub-issue from Issue 7 was not yet ripe for review in federal court.

[1] (Italics emphasis in original and bold and underline emphasis added.)
[2] (Italics emphasis in original and bold and underline emphasis added.)
[3] (Emphasis added.)

2. It has came to the Board's attention that, on February 15, 2024, the Provider has filed a Complaint in the U.S. District Court for the Northern District of Texas ("Northern Texas District Court") appealing the Board's December 18, 2023 determination.

As part of the case status update, the Board required the Provider to address: (1) "[h]ow the Complaint filed in the Norther Texas District Court t impacts the proceedings before the Board and, as appropriate/relevant, file a renewal of its request for reconsideration taking into account the Board's observations above" and (2) "[w]hether the Provider has effectively withdrawn the Medicaid eligible days issue."

On **March 11, 2024**, the Provider timely filed its response to the Board's Scheduling Order. The Provider: (1) renewed its request for reconsideration; (2) asserted it had not "effectively" withdrawn the Medicaid eligible days issue and is willing to enter into and Administrative Resolution"; and (3) in connection with the Complaint pending in federal district court, asserted its belief that "the Board is not prevented from considering the Provider's renewed request from reconsideration, which, if granted, will result in the Provider withdrawing its complaint." Significantly, the Provider did not address the Board's its recitation in both the December 18, 2023 dismissal and the March 4, 2024 Scheduling Order that the dismissal of the sub-issue from Issue 7 was not ripe for review until "final disposition of this appeal."

On **March 18, 2024**, the Medicare Contractor filed its response but similarly did not address the fact that the dismissal of the sub-issue from Issue 7 was not ripe for review until "final disposition of this appeal."

On **April 16, 2024**, the Provider filed with the Board a filing identified in OH CDMS as "***Full*** Administrative Resolution Request."[4] The cover letter to this filing similarly is entitled "***FULL*** **ADMINISTRATIVE RESOLUTION SUBMISSION**"[5] and notes that attached to it is "a complete copy of the Administrative Resolution for case number **17-0244**."[6] Significantly, through the following statement, it is clear that the Administrative Resolution represented the full case outside of what had been transferred to group appeals: "All issues not resolvable through the Administrative Resolution Process have been transferred to group appeals." A review of the Administrative Resolution confirms this as it states that the parties are entered into the Administrative Resolution "for the purpose of setting forth the basis for resolving issues pending before the [Board}" and then goes through the status of each issue confirming whether it was transferred, dismissed, or withdrawn: Issue 1 was dismissed December 18, 2023, Issues 2 through 6 were transferred March 23, 2017, and Issue 7 resolved. For Issue 7, the Administrative Resolution states the parties agreed to resolve Issue 7 by "update[ing] the Provider's HMO days to include the 53 days requested and recalculated the DSH percentage based on the additional days." Significantly, the Administrative Resolution does not discuss or recognized the sub-issue for Issue 7 that the Board dismissed previously.

[4] (Emphasis added.)
[5] (Underline and italics emphasis added.)
[6] (Emphasis in original.)

On **April 17, 2024**, the Board issued an Acknowledgement of the "Full Administrative Resolution" finding that the Provider's Representative had filed "a request to withdraw the above captioned case due to a full administrative resolution." Accordingly, the Board closed the case as "there are no remaining issues to be adjudicated." The Board's actions are consistent with Board Rule 46 which states:

> **Rule 46 Withdrawal of an Appeal or Issue within an Appeal**
>
> If a provider desires to withdraw a case or issue(s), the provider must file a request to withdraw the issue(s) or case (*see* Rule 2). Further, it is the provider's responsibility to promptly file requests to withdraw in the following situations:
>
> • An issue(s) or case that the provider no longer intends to pursue;
> • An issue(s) or case in which an administrative resolution has been executed and attach a copy of such administrative resolution;
> • An issue(s) for which the Medicare contractor has agreed to reopen the final determination for that issue(s) and attach a copy of the correspondence from the Medicare contractor where the Medicare contractor agreed to that reopening;
> • All issues in a case where the provider intends to pursue reopening simultaneously with the appeal request (see Rule 47.2.3); and
> • A case in which all issues have been handled, whether by administrative resolution, transfer, dismissal, or withdrawal.
>
> When a provider notifies the Board that it is withdrawing an issue(s), the provider's notification must:
>
> 1. Describe the specific issue(s) being withdrawn;
> 2. Address whether the withdrawal is conditioned/dependent on the Medicare contractor's action through an administrative resolution or reopening; and
> 3. Confirm whether there are any other issues remaining in the case and, if so, provide the status on each remaining issue.
>
> NOTE: A provider's request for withdrawal is self-effectuating and does not require any action by the Board once it is filed. Notwithstanding, the Board or Board Staff generally will issue a notice acknowledging the withdrawal when it results in the closure of a case. The Board does ***not*** issue a similar notice when the withdrawal does not result in the closure of the case.[7]

[7] (Emphasis in original.)

Upon review, the Board:

(1) Affirms that, consistent with 42 C.F.R. §§ 405.1840, 405.1875 and 405.1877, its dismissal of the improperly-added sub-issue of Issue 7 (the § 1115 waiver days sub-issue) was preliminary and was ***not*** *ripe for appeal to federal district court* ***until*** *final disposition of this case* (as stated within the dismissal decision and restated in the Board's Scheduling Order);[8]

(2) Notes that the Board is not a party to administrative resolutions, including but not limited to the one filed in this case; and

(3) Pursuant to the terms of the Administrative Resolution entered into by the parties and consistent with Board Rule 46, finds that the Provider has effectively abandoned the § 1115 waiver day sub-issue to Issue 7 (Medicaid eligible days) because the Provider ***withdrew*** the case by filing a "full" administrative resolution which recites how each issue was resolve but which does not reference the dismissal of the sub-issue to Issue 7 notwithstanding the fact that the Board made clear in the December 18, 2023 dismissal by stating: "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 this appeal*."[9]

Accordingly, consistent with Board Rule 46, the Board finds that the reconsideration request is now moot/effectively withdrawn/abandoned and, as such, that it need not address the request. [10] This case remains closed.

Board Members Participating:

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

For the Board:

5/22/2024

X Clayton J. Nix

Clayton J. Nix, Esq.
Board Chair
Signed by: PIV

cc: Wilson Leong, Federal Specialized Services
Jacqueline Vaughn, CMS OAA

[8] In noting that the dismissal was not ripe for appeal, both the dismissal decision and scheduling order referenced 42 C.F.R. §§ 405.1875 and 405.1877 which make clear that dismissal of an issue that does not result in closure or full disposition of the case is not ripe for appeal *until closure/full disposition.* 42 C.F.R. § 405.1840 similarly makes this clear by discussing preliminary jurisdictional findings that are not final until full disposition of the appeal.
[9] (Emphasis in original.) In this respect, the Full Administrative Resolution does not acknowledge or reserve any right to pursue an appeal of the dismissal of the sub-issue to Issue 7 which, as discussed above, did not become final until *full disposition of the case*. Here, the full disposition of the case was a full administrative resolution with withdrawal of the case, thereby snuffing out any potential appeal rights associated with that dismissal.
[10] *See supra* notes 8 and 9 and accompanying text.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision*** **– SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**
Tennova Healthcare (Provider Number 44-0120)
FYE: 09/30/2018
Case Number: 23-1142

Dear Mr. Summar and Ms. Huggins,

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

Background:

A. ***Procedural History for Case No. 23-1142***

On **September 28, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2018.

On **March 15, 2023**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Unduly Narrow Definition of SSI Entitlement[1]
3. DSH Payment – Medicaid Eligible Days
4. Medicare Managed Care Part C Days- SSI and Medicaid Fractions[2]
5. Dual Eligible Days- SSI and Medicaid Fractions[3]

As the Provider is commonly owned/controlled by Community Health Systems ("CHS") it is thereby, subject to the mandatory Common Issue Related Party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). Therefore, on October 11, 2023, the Provider transferred Issues 2 , 4

[1] On October 11, 2023, the Provider transferred the issue to PRRB Case No. 21-1206GC.
[2] On October 11, 2023, the Provider transferred the issue to PRRB Case No. 20-2149GC.
[3] On October 11, 2023, the Provider transferred the issue to PRRB Case No. 21-0066GC.

and 5 to CIRP groups. As a result, the only remaining issues in Case No. 23-1142 are Issue #1, SSI Percentage (Provider Specific) and Issue #3, Medicaid Eligible Days.

On **November 9, 2023**, the Provider timely filed its preliminary position paper.

On **January 31, 2024**, the Medicare Contractor timely filed its preliminary position paper.

On **February 21, 2024**, the Medicare Contractor filed a Jurisdictional Challenge, requesting the dismissal of Issues 1 and 3. To date, the Provider has failed to respond.

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

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

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

The group issue statement in Case No. 21-1206GC, CHS CY 2018 DSH SSI Percentage CIRP Group, to which the Provider transferred Issue 2 reads, in part:

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

[4] Issue Statement at 1 (March 15, 2023).

Statement of the Legal Basis

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

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

1. Availability of MEDPAR and SSA records,

2. Paid days vs. Eligible days,

3. Not in agreement with provider's records,

4. Fundamental problems in the SSI percentage calculation,

5. Covered days vs. Total days and

6. Failure to adhere to required notice and comment rulemaking procedures.[5]

On November 9, 2023, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Issue #1: Provider Specific

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

The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the

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

> provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[6]

C. Description of Issue 3 in the Appeal Request

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

> **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.[7]

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

---

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

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

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

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue. First, the MAC argues that the Provider has abandoned the SSI realignment sub-issue: "the Provider has abandoned the issue of SSI realignment and, therefore, it should be considered withdrawn. The Provider did not brief this issue within its Preliminary Position Paper."[11] The MAC also argues the appeal is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[12]

[9] Provider's Preliminary Position Paper at 9.
[10] *Id.* at 9-10.
[11] Jurisdictional Challenge at 6 (Feb. 21, 2024).
[12] *Id*. at 6-7.

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH/SSI Unduly Narrow Definition of SSI Entitlement issue in PRRB Case No. 21-1206GC are considered the same issue by the Board.[13]

Finally, the MAC argues "the Provider did not file a **complete** preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.1 and 25.3."[14] The MAC posits that the Provider "failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper."[15]

Issue 2 – DSH Payment – Medicaid Eligible Days

The MAC contends that the Provider is attempting to untimely and improperly add the issue of Section 1115 waiver days as a sub-issue via its preliminary position paper, filed on November 9, 2023.[16] The MAC asserts that prior to the preliminary position paper, the Provider had not formally added the dispute to the appeal, nor had it otherwise raised the issue of section 1115 waiver days.[17] The MAC contends that the Provider's attempt to add the issue within its preliminary position paper is improper and untimely, citing 42 C.F.R. § 405.1835(e), which governs when specific Medicare payment issues may be added to the original hearing request, including a timeframe of no later than 60 days after the expiration of the applicable 180-day deadline to file an appeal.[18]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[19] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

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

[13] *Id*. at 4-5.
[14] *Id*. at 7.
[15] *Id*. at 9.
[16] *Id*. at 11.
[17] *Id*. at 14.
[18] *Id*. at 15.
[19] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

A. DSH Payment/SSI Percentage (Provider Specific)

The jurisdictional analysis for Issue 1 has several relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period; and 3) the Provider incorporating the arguments from *Advocate Christ*[20] into its appeal. As set forth below, the Board should dismiss all aspects of Issue 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 Unduly Narrow Definition of SSI Entitlement issue that was appealed in PRRB Case No. 21-1206GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[21] 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 that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[23]

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

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[20] The Provider has included the Appellants' Reply Brief in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214 (D.C. Cir.), which is on appeal from the decision in *Advocate Christ Med. Ctr. V. Azar*, 17-cv-1519 (TSC), 2022 WL 2064830, (D.D.C. June 8, 2022).
[21] Issue Statement at 1.
[22] *Id.*
[23] *Id.*
[24] PRRB Rules v. 3.1 (Nov. 2021).

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 21-1206GC, 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.[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 can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 21-1206GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 21-1206GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[26]

[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] (Emphasis added).

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule,

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

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

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh. [27]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[28]

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 21-1206GC are the same issue.[29] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

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[27] Last accessed February 24, 2023.
[28] Emphasis added.
[29] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Community Health Systems CIRP group per 42 C.F.R. § 405.1837(b)(1).

Additionally, in its Preliminary Position Paper, the Provider stated, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3)."[30] The Board finds that this purported argument does not comply with the regulations and Board rules to *fully* develop the Provider's position in the Preliminary Position Paper, because the Provider merely lists a case name and does not explain further what the arguments are that it would like to incorporate into its appeal.

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[31]

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

2. Second Aspect of Issue 1

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Further, the Board notes that the Provider's cost reporting period ends on 9/30, which is congruent with the Federal fiscal year. Thus, any realignment of the Provider's SSI would have no effect on reimbursement. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

1. *Section 1115 Waiver Days*

The Board finds that the section 1115 Waiver days issue is not a part of this appeal as it was not

[30] Provider's Preliminary Position Paper at 9.
[31] (Emphasis added).

properly or timely added. The Provider failed to include section 1115 Waiver days as a cost issue in its appeal request and failed to timely and properly add this additional issue to the appeal. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the section 1115 Waiver days.

The appeal was filed with the Board in April of 2023 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[32]

Board Rule 7.2.1 elaborated on this regulatory requirement instructing providers:

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
> - the relevant adjustment(s), including the adjustment number(s),
> - the controlling authority (e.g., specific regulation, Federal Register issuance, manual provision, or Ruling),
> - why the adjustment(s) is incorrect,
> - how the payment should be determined differently,
> - the reimbursement effect, and
> - the basis for jurisdiction before the Board.

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

[32] 42 C.F.R. § 405.1835(b).

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

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

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

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

Specifically, § 412.106(b)(4) (2022) states in pertinent part:

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

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

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

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

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

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

2. *Medicaid Eligible Days*

According to its Appeal Request, the Provider asserts that all Medicaid Eligible Days were not included in the calculations of the DSH calculation. The Provider's original issue statement is quoted above. The Provider failed to include a list of additional Medicaid eligible days they expect to be included in their Medicaid percentage and DSH computations, either with their appeal request or with their preliminary position paper, notwithstanding the fact that the

Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[36]

Board Rule 7.3.1.2 states:

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

In the present case, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[37] The Provider also failed to respond to the Contractor's Jurisdictional Challenge.

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[38]

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[36] Provider's Preliminary Position Paper at 10.
[37] *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.
[38] (Emphasis added).

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

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

Similarly, with regard to position papers,[39] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[40] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

Similarly, consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[41]

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

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

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

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to

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

> beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

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

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

The Board finds that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[42] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. Indeed, without any days identified in the position paper filing, the Board assumes that there are no days or amount in dispute for this issue.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.[43]

Accordingly, the DSH Payment – Medicaid Eligible Days issue is dismissed.

****

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

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

C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25 and the discussion of 1115 waiver days in the preliminary position paper is deemed to be a late addition of an issue to the appeal. As no issues remain pending, the Board hereby closes Case No. 23-1142 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

5/23/2024

X Kevin D. Smith, CPA

Clayton J. Nix, Esq.
Board Chair
Signed by: Kevin D. Smith -A

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Baylor Regional Medical Center at Plano (Provider Number 45-0890)
FYE: 12/31/2014
Case Number: 19-0156

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-0156. Set forth below is the decision of the Board to dismiss the two (2) remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) and Uncompensated Care ("UCC") payments.

Background

A. *Procedural History for Case No. 19-0156*

On **April 10, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2014.

On **October 12, 2018**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained ten (10) issues:

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

[1] On May 30, 2019, the Provider transferred the issue to PRRB Case No. 17-0806GC.
[2] On May 30, 2019, the Provider transferred the issue to PRRB Case No. 17-0809GC.
[3] On May 30, 2018, the Provider transferred the issue to PRRB Case No. 17-0811GC.
[4] On March 19, 2024, the Provider withdrew this issue.
[5] On May 30, 2019, the Provider transferred the issue to PRRB Case No. 17-0807GC.
[6] On May 30, 2019, the Provider transferred the issue to PRRB Case No. 17-0808GC.

8. Uncompensated Care ("UCC") Distribution Pool[7]
9. 2 Midnight Census IPPS Payment Reduction[8]
10. Standardized Payment Amount[9]

On **October 29, 2018**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[10]

On **March 27, 2019**, the Medicare Contractor filed a Jurisdictional Challenge with the Board over Issues 1, 8, and 9 requesting that the Board dismiss these issues. On **April 26, 2019**, the Provider filed a response.

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

On **March 18, 2024,** the Provider filed its Final Position Paper, and the Medicare Contractor filed its Final Position Paper on **April 8, 2024**.

As the result of a withdrawal and multiple case transfers, the remaining issues in this appeal are Issue 1 (the DSH – SSI Percentage Provider Specific issue) and Issue 8 (UCC Distribution Pool issue).

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 17-0806GC – QRS BSWH 2014 DSH SSI Percentage (Late Issuance of NPR) CIRP Group

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

---

[7] On May 30, 2019, the Provider requested to transfer the issue to Case No. 17-0810GC, however the Board denied the transfer request on February 14, 2020 because the Board had dismissed that group appeal on August 7, 2018.
[8] On May 30, 2019, the Provider transferred the issue to PRRB Case No. 18-1420GC.
[9] On May 30, 2019, the Provider transferred the issues to PRRB Case No. 19-1970GC.
[10] (Emphasis added.)

> 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).[11]

The Group Issue Statement in Case No. 17-0806GC, to which the Provider transferred issue #2 reads, in part (II: DSH/SSI Systemic Errors):

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage.
>
> **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)(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 Lead MAC to settle their Cost Report does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,

[11] Issue Statement at 1 (Oct. 12, 2018).

5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.[12]

On June 5, 2019, the Board received the Provider's preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (December 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services,* No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from [s]tate records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the completed MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008).[13]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $59,000.

C. MAC's Contentions

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

[12] Group Appeal Issue Statement in Case No. 17-0806GC.
[13] Provider's Preliminary Position Paper at 8-9 (June 5, 2019).

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

> The MAC contends that Issue 1 has 3 sub-issues. Sub-issues 1 (SSI data accuracy) and sub-issue 3 (individuals who are eligible for SSI but did not receive SSI payment) are duplicates of Issue 2 and should be dismissed. In sub-issue 1 and 3, the Provider states:
>
> 1. The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
>   The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
>   The Provider contends that the SSI percentage is flawed.
>
> 3. 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. The Provider states in Issue 2:

The Provider contends that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed.

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

The Provider further contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") fail to address all the deficiencies as described in Baystate Medical Center v. Michael O. Leavitt, 545 F. Supp. 2d 20, as amended, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.

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

> The MAC contends that the above argument is a duplicate of sub-issue 1 of Issue 1.
>
> The Provider further argues in Issue 2:
>
> > The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The MAC contends that the above argument is a duplicate of sub-issue 3 of Issue 1. [14]

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 the reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. The Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). The Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue. The MAC requests that the PRRB dismiss this issue consistent with recent jurisdictional decisions.[15]

[14] Jurisdictional Challenge at 5-7 (March 27, 2019).
[15] *Id.* at 7.

Issue 8 – UCC Distribution Pool

The MAC argues that "[t]he Board does not have jurisdiction over the UCC DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2)."[16]

Provider's Jurisdictional Response

SSI Provider Specific Issue

The Provider maintains it is "not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category."[17] The Provider argues that "this is an appealable item because the MAC specifically adjusted the SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2014, resulting from its understated SSI percentage due to errors of omission and commission."[18] The Provider cites to *Northeast Hospital Corporation v. Sebelius*, 657 F.3d I (D.C Cir. 2011), which, it states, "abandoned the CMS Administrator's December 1, 2008 decision that the SSI ratio cannot be revised based upon updated data after it has been calculated by CMS. Accordingly, the Provider has specifically identified patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS, due to errors that are or may be specific to the Provider, but in any case, are not the systemic errors that have been previously identified in the Baystate litigation."[19]

Uncompensated Care ("UCC") Distribution Pool

The Provider argues that "[t]he Statute does not authorize the Secretary to [e]stimate the Uninsured Patient Population Percentage."[20] The Provider "wish[es] to draw the Board's attention to the continuing uncertainty as to the legality of federal subsidies to individuals enrolling in health exchanges established by the federal government under the Affordable Care Act…Accordingly, we urge the Board to hold that the computation of the uninsured patient percentage must be based on actuals as opposed to estimates. Therefore, this percentage is subject to review by this tribunal."[21]

The Provider maintains that "[t]he PRRB may review the Secretary's estimates because the federal courts may also conduct such review. The provisions of 42 U.S.C. § 1395ww(r)(3) bar administrative or judicial review over certain "estimates" used by the Secretary. This suggests that Congress intended that administrative review and judicial review should be treated

[16] *Id.* at 10.
[17] Provider's Response to Jurisdictional Challenge at 2 (April 26, 2019).
[18] *Id.* at 2.
[19] *Id.*
[20] *Id.*
[21] *Id.* at 3.

similarly."[22] The argument continues, "[t]he provider is entitled to a writ of mandamus directing the Secretary to revise her estimates."[23] The Provider cites to *Ganem v. Heckler*, 746 F.2d 844 (D.C. Cir. 1984), stating, "the D.C. Circuit. . .conclud[ed] that mandamus jurisdiction was not precluded by Section 405(h) of the Social Security Act."[24] The Provider argues that "a similar issue exists in connection with the prohibition against judicial review contained in the DSH statute."[25] Further, the Provider argues that "a total preclusion of judicial review of the estimates used in computing Factors 1-3 could give rise to serious constitutional issues."[26]

Decision of the Board

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

As set forth below, the Board hereby ***dismisses*** the Provider's two (2) remaining issues.

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Case No. 17-0806GC. 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."[27] 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)."[28] The Provider

[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] *Id.* at 4.
[27] Issue Statement at 1.
[28] *Id.*

argues, in its issue statement, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[29]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 17-0806GC 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. 19-0156 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 17-0806GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[30], 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.[31] 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. 17-0806GC, 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.[32] Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Aug. 29, 2018), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

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[29] *Id.*
[30] PRRB Rules v. 2.0 (Aug. 2018).
[31] 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).
[32] It is also not clear whether this is a systemic issue for Baylor Scott & White 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.

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.[33]

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule,

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

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

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh. [34]

[33] (Italics and underline emphasis added.)
[34] Last accessed May 23, 2024.

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[35]

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. 17-0806GC.

Accordingly, based on the record before it, the Board finds that the SSI Provider Specific issue in Case No. 19-0156 and the group issue from Case No. 17-0806GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board dismisses this aspect of the appeal.

B. UCC Distribution Pool

Lastly, 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 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:

[35] Emphasis added.

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[36]

(B) Any period selected by the Secretary for such purposes.

2. Interpretation of Bar on Administrative Review

a. Tampa General v. Sec'y of HHS

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs*. ("*Tampa General*"),[37] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[38] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[39] The D.C Circuit also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[40]

The D.C. Circuit went on to address the provider's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[41]

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[36] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[37] 830 F.3d 515 (D.C. Cir. 2016).
[38] 89 F. Supp. 3d 121 (D.D.C. 2015).
[39] 830 F.3d 515, 517.
[40] *Id.* at 519.
[41] *Id.* at 521-22. *See also Yale New Haven Hosp. v. Becerra*, 56 F.4th 9 (2nd Cir. 2022) (citing to *Tampa General*"); *Ascension Providence v. Becerra*, No. 21-cv-369, 2023 WL 2042176 (N.D. Ind. 2023) (citing to *Tampa General*").

b. DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[42] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[43] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that it had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, the D.C. Circuit found the same relationship existed with regard to the methodology used to generate the estimates.[44]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[45] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[46] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[47] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[48] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[49] In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely

[42] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[43] *Id.* at 506.
[44] *Id.* at 507.
[45] 514 F. Supp. 249 (D.D.C. 2021).
[46] *Id.* at 255-56.
[47] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[48] *Id.* One provider had a cost report for the 6-month period from July 1, 2011 to December 31, 2011 and another for the 12-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the 9-month period from October 1, 2011 to June 30, 2012 and another for the 12-month period from July 1, 2012 to June 30, 2013.
[49] *Id.*

upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[50]

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[51] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.[52] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[53]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[54] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

d. Ascension Borgess Hospital v. Becerra

Even more recently, the D.C. Circuit revisited, once again, the judicial and administrative bar on review of uncompensated care DSH payments again in *Ascension Borgess Hospital v. Becerra* ("*Ascension*").[55] In *Ascension*, the providers sought an order declaring the Worksheet S-10 audit protocol was unlawful, vacating the payments based on the Worksheet S-10 audit, requiring the Secretary to recalculate those payments, and setting aside the Board decisions refusing to exercise jurisdiction over their appeals.[56] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the providers claims. In making this finding, the D.C.

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

Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."[57] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[58] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[59]

The Board concludes that the same findings are applicable to the Provider's challenge to their FFY 2017 UCC payments. The Provider is challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2017. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review.

* * * * *

Based on the foregoing, the Board has dismissed the two (2) remaining issues in this case – (Issues 1 and 8). As no issues remain, the Board hereby closes Case No. 19-0156 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

5/23/2024

X Kevin D. Smith, CPA

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

cc: Michael Redmond, Novitas Solutions, Inc. (J-H)

[57] *Id.* at *9.
[58] 139 S. Ct. 1804 (2019).
[59] A*scension* at *8 (bold italics emphasis added).

Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Board Decision* – SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**
Martin General Hospital (Provider Number 34-0133)
FYE: 04/30/2019
Case Number: 23-1001

Dear Mr. Ravindran and Mr. Lamprecht,

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

Background:

A. *Procedural History for Case No. 23-1001*

On **September 2, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end April 30, 2019.

On **February 21, 2023**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained six (6) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Unduly Narrow Definition of SSI Entitlement[1]
3. DSH Payment – Medicaid Eligible Days
4. DSH Payment – Medicare/SSI and Medicaid Fractions – Medicare Managed Care Part C Days[2]
5. DSH Payment – SSI/Medicare and Medicaid Fractions – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[3]
6. Standardized Payment Amount[4]

[1] On October 4, 2023, this issue was transferred to PRRB Case No. 24-0006GC.
[2] On October 4, 2023, this issue was transferred to PRRB Case No. 24-0007GC.
[3] On October 4, 2023, this issue was transferred to PRRB Case No. 24-0010GC.
[4] The issue was withdrawn on October 4, 2023.

The Provider is commonly owned/controlled by Quorum Health and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **October 4, 2023**, the Provider transferred Issues 2, 4, and 5 to Quorum Health groups. After the withdrawal of Issue 6, there are two (2) remaining issues in this appeal: Issue 1 (DSH Payment/SSI Percentage (Provider Specific)) and Issue 3 (DSH Payment – Medicaid Eligible Days).

On **February 23, 2023**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[5]

On **October 17, 2023**, the Provider timely filed its preliminary position paper.

On **January 16, 2024**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 3.

On **February 14, 2024**, the Medicare Contractor timely filed its preliminary position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 24-0006GC

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

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

[5] (Emphasis added).

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

The group issue statement in Case No. 24-0006GC, Quorum Health CY 2019 DSH SSI Unduly Narrow Definition of SSI Entitlement CIRP Group, to which the Provider transferred Issue 2 reads, in part:

> **Statement of the Issue:**
>
> The Provider(s) protest(s) CMS's policy of excluding unpaid SSI days from the numerator of the Medicare fraction. Despite CMS's seemingly contrary policy of treating unpaid Part A days as days entitled to benefits under Part A, CMS requires that a beneficiary be paid SSI benefits (or "covered" by SSI) during the period of his or her hospital stay in order for such days to be considered "entitled to supplemental security income benefits" and included in the numerator of the SSI fraction.
>
> CMS does not include days in the numerator of the SSI fraction when individuals were eligible for SSI but did not receive a SSI payment during their hospitalization for such reasons as failure of the beneficiary to have a valid address, representative payee problems, Medicaid paying for more than 50 percent of the cost of care in a medical facility, or the period of hospitalization is during the first month of eligibility before a cash payment is made. None of these reasons affect the patient's indigency.
>
> CMS's policy of applying different interpretations to the same term, "entitled," used in the same sentence of the statute is the epitome of arbitrary and capricious agency action and must be reversed. *See Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 20 n.1 (D.C. Cir. 2011) (Kavanaugh, J. concurring) ("HHS thus interprets the word 'entitled' differently within the same sentence of the statute. The only thing that unifies the Government's inconsistent definitions of this term is its apparent policy of paying out as little money as possible. I appreciate the desire for frugality, but not in derogation of law."); *see also Walter O. Boswell Mem'l Hosp. v. Heckler*, 749 F.2d 788, 799 (D.C. Cir. 1984) ("It would be arbitrary and capricious for [the Secretary] to bring varying interpretations of the statute to bear, depending upon whether the result helps or hurts Medicare's balance sheets. . . .").

[6] Issue Statement at 1 (Feb. 21, 2023).

> In rulemaking, commenters specifically requested that CMS include other payment codes that identified "entitled" individuals, but the Secretary nonetheless adopted a policy of including only codes that identify people receiving actual SSI cash payment. Id. For example, commenters requested that codes S06 (suspended payment because recipients' whereabouts are unknown based on "undeliverable checks, mail, reports of change or a change of address") and S07 ("checks returned for reasons that are unclear or for reasons other than address or a representative payee problem") be included. CMS refused the suggestion.
>
> Because CMS's treatment of unpaid Part A days as "days entitled to benefits under part A" was upheld by the Supreme Court in *Becerra v. Empire Health Found., for Valley Hosp. Med. Ctr.*, 597 S.Ct. June 24, 2022 WL 227680 (2022), CMS must apply the same interpretation of the word "entitled" in the context of "entitled to supplemental security income benefits." By doing so, CMS will necessarily have to widen the number of SSI status codes it treats as being "entitled to SSI benefits" to encompass not just the three codes CMS currently includes, but all codes that reflect *eligibility* for SSI benefits.[7]

The amount in controversy listed for both Issue 1 in the instant appeal and for the Provider as a participant in PRRB Case No. 24-0006GC is $6,346.

On October 17, 2023, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Issue #1: Provider Specific**
>
> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination 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

[7] Group Issue Statement, Case No. 24-0006GC.

> SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[8]

C. Description of Issue 3 in the Appeal Request

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

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 5,8,10,S-D.
>
> Estimated Reimbursement Amount: $17,366[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

[8] Provider's Preliminary Position Paper at 8-9 (Oct. 17, 2023).
[9] Appeal Request at Issue 3.
[10] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).

by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[11] The Provider then, for the first time in this appeal, states it is seeking reimbursement for section 1115 waiver days as a part of the Medicaid eligible day issue. Specifically, the Provider states:

> [M]edicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days) are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).[12]

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue. First, the MAC argues that the Provider has abandoned the SSI realignment sub-issue: "the Provider has abandoned the issue of SSI realignment and, therefore, it should be considered withdrawn. The Provider did not brief this issue within its preliminary position paper. . ."[13] The MAC also argues the appeal is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[14]

[11] Provider's Preliminary Position Paper at 9.
[12] *Id.* at 9-10.
[13] Jurisdictional Challenge at 6 (Jan. 16, 2024).
[14] *Id*. at 6-7.

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH/SSI Unduly Narrow Definition of SSI Entitlement issue in PRRB Case No. 24-0006GC are considered the same issue by the Board.[15]

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

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC contends that the Provider is attempting to untimely and improperly add the issue of Section 1115 waiver days as a sub-issue via its preliminary position paper, filed on October 17, 2023.[18] The MAC asserts that prior to the preliminary position paper, the Provider had not formally added the dispute to the appeal, nor had it otherwise raised the issue of section 1115 waiver days.[19] The MAC contends that the Provider's attempt to add the issue within its preliminary position paper is improper and untimely, citing 42 C.F.R. § 405.1835(e), which governs when specific Medicare payment issues may be added to the original hearing request, including a timeframe of no later than 60 days after the expiration of the applicable 180-day deadline to file an appeal.[20]

The MAC contends that the section 1115 waiver days issue is one component of the DSH issue. The MAC references Board Rule 8 (version 3.1), which lists Section 1115 waiver days (program/waiver specific) as a common example of issues with multiple components for which "each contested component must be appealed as a separate issue and described as narrowly as possible."[21] The MAC contends that the Board Rules support the argument that section 1115 waiver days issue is a component of DSH different from the generic Medicaid eligible days issue and must be identified and appealed separately.[22]

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

> The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain

[15] *Id*. at 4-5.
[16] *Id*. at 7.
[17] *Id*. at 9.
[18] *Id*. at 14.
[19] *Id*. at 15.
[20] *Id*. at 13-14.
[21] *Id*. at 15.
[22] *Id*.

> unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.
>
> Within its Provider's preliminary position paper, the Provider makes the broad allegation, ". . . the Provider contends that the total number of days reflected in its 2019 cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats their appeal request.[23]

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

Board Analysis and Decision:

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

A. DSH Payment/SSI Percentage (Provider Specific)

The analysis for Issue 1 has several two 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. As set forth below, the Board should dismiss all aspects of Issue 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

[23] *Id*. at 11.
[24] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

duplicative of the DSH/SSI Unduly Narrow Definition of SSI Entitlement issue that was appealed in PRRB Case No. 24-0006GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[25] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[26] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[27]

The Provider's DSH/SSI Unduly Narrow Definition of SSI Entitlement issue in group Case No. 24-0006GC 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 definition of "entitled" as it relates to social security income payments. Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Unduly Narrow Definition of SSI Entitlement issue in Case No. 24-0006GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6,[28] the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations, and to that end, the Provider is pursuing that issue as part of the group under Case No. 24-0006GC, 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.[29] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 24-0006GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from

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[25] Issue Statement at 1.
[26] *Id.*
[27] *Id.*
[28] PRRB Rules v. 3.1 (Nov. 2021).
[29] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

the SSI issue in Case No. 24-0006GC, but instead refers to the *Baystate* case and again addresses entitlement to SSI payments, similar to the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[30]

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

[30] (Emphasis added).

> set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year.

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

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh. [31]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[32]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.

Accordingly, the Board finds that issue #1 in the instant appeal and the group issue from Group Case 24-0006GC are the same issue.[33] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board dismisses this aspect of the appeal.

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[31] Last accessed May 20, 2024.
[32] Emphasis added.
[33] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Quorum Health CIRP group per 42 C.F.R. § 405.1837(b)(1).

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 February of 2023 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) how and why the provider believes Medicare payment must be determined differently for each disputed item…[34]

Board Rule 7.2.1 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 relevant adjustment(s), including the adjustment number(s),
> - the controlling authority (e.g., specific regulation, Federal Register issuance, manual provision, or Ruling),
> - why the adjustment(s) is incorrect,
> - how the payment should be determined differently,

[34] 42 C.F.R. § 405.1835(b).

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

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

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include, but are not limited to:
>
> …
>
> - ***Section 1115 waiver days (program/waiver specific)***[35]

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.[36]
42 C.F.R. § 405.1835(e) provides in relevant part:

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

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

In this regard, the Board notes that section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[37] 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

[35] (Bold and italic emphasis added).
[36] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[37] 65 FR 47054, 47087 (Aug. 1, 2000).

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) (2022) states in pertinent part:

> (4)*Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(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*

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

> **Statement of 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.[38]

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

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[39]

Board Rule 7.3.1.2 states:

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

[38] Individual Appeal Request, Issue 3.
[39] Provider's Preliminary Position Paper at 10.

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.[40]

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[41]

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

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

Similarly, with regard to position papers,[42] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[43] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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

[41] (Emphasis added).

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

[43] (Emphasis added).

Similarly, consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[44]

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility *for each Medicaid patient day claimed* under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.[45]

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

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

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

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

[44] (Emphasis added).
[45] (Emphasis added).

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled, consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[46] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it, consistent with Board Rule 25.2.2. Indeed, without any days identified in the position paper filing, the Board assumes that there are no days or amount in dispute for this issue.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.[47]

Accordingly, the DSH Payment – Medicaid Eligible Days issue is dismissed.

****

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. 24-0006GC 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. 23-1001 and removes it from the Board's docket.

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

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

Board Members Participating:

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

For the Board:

5/23/2024

X Kevin D. Smith, CPA

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

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

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RE: ***Board Decision*** **– Medicaid Eligible Days Issue**
Hillcrest Baptist Medical Center (Prov. No. 45-0101)
FYE 08/31/2015
Case No. 19-0140

Dear Messrs. Ravindran and Redmond,

The Provider Reimbursement Review Board ("Board") has reviewed the record in the above-referenced appeal involving Hillcrest Baptist Medical Center ("Provider") which is commonly owned by Baylor Scott & White Health ("BS&W"). The Provider's designate representative is Quality Reimbursement Services, Inc. ("QRS") The decision of the Board is set forth below.

Background:

A. *Procedural History for Case No. 19-0140*

On **April 10, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end August 31, 2015 ("FY 2015"). On **October 12, 2018**, the Provider filed its individual appeal request appealing the FY 2015 NPR. The initial Individual Appeal Request contained ten (10) issues:

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

[1] Following a September 11, 2019 Jurisdictional Challenge, the Board dismissed Issue 1 on January 8, 2024.
[2] On May 30, 2019, this issue was transferred to PRRB Case No. 18-1276GC.
[3] On May 30, 2019, this issue was transferred to PRRB Case No. 18-1279GC.
[4] On May 30, 2019, this issue was transferred to PRRB Case No. 18-1281GC.
[5] On May 30, 2019, this issue was transferred to PRRB Case No. 18-1277GC.
[6] On May 30, 2019, this issue was transferred to PRRB Case No. 18-1280GC.

8. UCC Distribution Pool[7]
9. 2 Midnight Census IPPS Payment Reduction[8]
10. Standardized Payment Amount[9]

Following the transfer of Issues 2 to 4, 6 and 7 to BS&W CIRP groups and the Board's dismissal of Issue 1, there remains *only* one issue – Issue 5 (DSH Payment – Medicaid Eligible Days).

On **October 29, 2018**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[10]

On **June 5, 2019**, the Provider timely filed its preliminary position paper. Significantly, for Issue 5, the Provider stated that an eligibility listing was "NOT INCLUDED – BEING SENT UNDER SEPARATE COVER."

On **October 3, 2019**, the Medicare Contractor timely filed its preliminary position paper. With respect to Issue 5, the Medicare Contractor noted that, to resolve this issue, the Provider must supply all required documentation; however, to date, the Provider has not supplied a listing of Medicaid eligible days notwithstanding the Provider's statement in its preliminary position paper that such a listing was being sent under separate cover.[11]

On **May 5, 2023**, the Board issued a Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' *optional* 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***

[7] On May 30, 2019, this issue was transferred to PRRB Case No. 18-1282GC.
[8] On May 30, 2019, this issue was transferred to PRRB Case No. 18-1275GC.
[9] On May 30, 2019, this issue was transferred to PRRB Case No. 19-1717GC.
[10] (Emphasis added).
[11] Medicare Contractor's Preliminary Position Paper at 17 (Oct. 3, 2019).

> *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.[12]

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

The Provider's deadline to file its *optional* final position paper was **November 23, 2023**; however, the Provider apparently decided not to file one as QRS failed to make any such filing by the November 23, 2023 filing deadline. As such, the Provider chose to rely on its preliminary position paper.

On **December 18, 2023**, the Medicare Contractor timely filed its *optional* final position paper. With respect to Issue 5, the Medicare Contractor again noted that, to resolve this issue, the Provider must supply all required documentation; however, to date, the Provider has not supplied a listing of Medicaid eligible days notwithstanding the Provider's statement in its preliminary position paper that such a listing was being sent under separate cover.[13]

On **January 22, 2024**, QRS filed a Supplement to Position Paper/Redacted Medicaid Eligible Days listing. QRS' filing did not explain why the listing of so many days was being submitted at this late date (***over 8 years after the fiscal year at issue had closed***).

Also on **January 22, 2024**, QRS filed what it identified as a "Supplemental Position Paper/Redacted Medicaid Eligible Days Lising Submission." QRS' cover letter to the filing stated that it was attaching "redacted copy of the additional Medicaid Eligible Days listing for the record of the case." However, the attachments consisted of four (4) redacted listings:

1. A listing entitled "Medicare DSH – Medicaid NPR Days" totaling 16,511 days which appears to be the listing associated with the settled cost report for FY 2015.
2. A listing entitled "Additional Medicaid Days – High Strata" totaling 98 days.
3. A listing entitled "Additional Medicaid Days – Low Strata" totaling 68 days.
4. A listing entitled "1115 Waiver Days" totaling 5818 days.

Significantly, QRS failed to explain why the listing was being *belatedly/untimely* filed as an alleged "supplement" to the Provider's preliminary position paper filed ***more than 6 years ago*** on June 5, 2019.

On **February 8, 2024**, the Medicare Contractor filed a Motion to Exclude, requesting that the Provider's filings on January 22, 2024, violated Board Rules and that they, therefore, be excluded from the record. The Medicare Contractor also stated that it planned to file a

[12] (Emphasis added).
[13] Medicare Contractor's Final Position Paper at 17 (Dec. 18, 2023).

Jurisdictional Challenge to request dismissal of a new improperly-added sub-issue to Issue 5 that is identified as the § 1115 waiver days sub-issue.

On **February 16, 2024**, the Board issued a Show Cause Order. In it, the Board orders that, no later than March 4, 2024,[14] the Provider show cause as to why the case should not be dismissed based on the following Board findings:

> 1. The failure of the Provider in include in its June 5, 2019 preliminary position paper the material facts for Issue 5 (*e.g.*, the number of eligible days at issue) and include a listing identifying those specific days at issue as part of that position paper filing. *See* 42 C.F.R. §§ 405.1853(b)(2)-(3), 412.106(b)(4)(iv); Board Rules 25 and 35.3.
>
> 2. The failure of the Provider to include the § 1115 waiver days issue in its appeal request and failure to develop that issue as part of the preliminary position paper filing (both identifying the material facts for the issue and providing a listing identifying the specific days at issue). *See* 42 C.F.R. §§ 405.1835(b), 405.1853(b)(2)-(3), 412.106(b)(4)(iv); Board Rules 8 and 25. In this regard, the Board notes that the listing filed includes 5818 days, which is exponentially larger than the original "estimated impact" included in the October 12, 2018 appeal request for this issue – an estimated additional 150 Medicaid eligible days with a net estimate impact of $68,567. Accordingly, the Board also requires that the provider explain why the § 1115 waiver days at issue were not claimed or included on the as-filed cost report for FY 2015. In asking the Provider to address this question, 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 advertence from the as-filed cost report, then that class of days is an unclaimed cost for which the Board would lack jurisdiction under 42 U.S.C. § 1395oo(a) consistent with CMS Ruling 1727-R.

On **March 4, 2024**, QRS timely filed a response to the MAC's Motion to Exclude and the Board's Show Cause Order, asserting that: (1) the 1115 waiver day sub-issue was properly part of the appeal and "providers are not required to identify specific section 1115 waiver days on its cost report or in its appeal filing"; and (2) the January 22, 2024 filing was a supplement to its preliminary position paper; (3) the Medicare Contractor "is required by specific command of CMS to accept and audit the Provider's section 1115 waiver days" consistent with CMS Change Request 12669, Transmittal No. 11912 (Mar. 16, 2023); and (4) there is no prejudice to the Medicare Contractor for the Board to accept the late-filed exhibit listing because "The Board must balance the Provider's non-compliance with the technical requirements of the Board's rules

[14] The Board also required that the Medicare Contractor file a reply brief by March 15, 2024.

of position paper filings with the reality that the Provider has submitted a listing of its section 1115 waiver days in advance of the hearing, and the MAC can simply audit them."

Finally, on **March 15, 2024**, the Medicare Contractor timely filed a reply brief to the Board's Show Cause Order and continued to request Board exclusion of the Provider's January 22, 2024 filing and dismissal of Issue 5 in its entirety, including the § 1115 waiver days issue.

The deadline for the parties to file witness lists in this case was **April 29, 2024**. However, neither party filed a witness list. Accordingly, parties are relying on the evidentiary record in this case.

B. Description of Issue 5 in the Appeal Request

According to its October 12, 2018 Appeal Request, the Provider asserts in Issue 5 that all Medicaid eligible days were not included in the calculations of the DSH calculations. Specifically, the Provider describes Issue 5 as:

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 5,37,S-D *See* Tab. 4
> Estimated Reimbursement Amount: $68,000 *See* Tab. 5[15]

Significantly, the issue statement does not reference or discuss § 1115 waiver days as an issue. At Tab 4, the Provider included a description of the "Estimated Impact" of Issue 5 explaining that the "Estimated Impact" is $68,567 based on an estimated 150 "additional Secondary Medicaid eligible Days."

[15] Appeal Request at Issue 5.

Regarding the Medicaid eligible days issue, the Provider argues in its June 5, 2019 Preliminary Position Paper that pursuant to the *Jewish Hospita*l 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] for Issue 5, the Provider stated that an eligibility listing was "NOT INCLUDED – BEING SENT UNDER SEPARATE COVER." Further, the Provider again attached (as part of Exhibit 2 to the position paper) the same original "Estimated Impact" of $68,567 for Issue 5 based on an estimated 150 "additional Secondary Medicaid eligible Days."

On **January 22, 2024**, the Provider files what it identifies as a "Responsive Final Position Paper" in response to the arguments and evidence submitted in the Medicare Contractor's final position paper. However, in its response, the Provider does not respond to the Medicare Contractor's final position paper; but rather simply restates verbatim the arguments stated in its preliminary position paper with the only change being the addition of references to § 1115 waiver days in parentheticals or asides. As a result, the Provider, for the first time in this appeal, states ***in parentheticals*** that it is seeking reimbursement for § 1115 waiver days as a part of the Medicaid eligible day issue:

> Medicaid eligible days (*including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days*) are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (*including section 1115 waiver days*).[18]

The Provider then adds a new paragraph directly addressing § 1115 waiver days (which was not ever mentioned by the Medicare Contractor in its final position paper) making general assertions about § 1115 waiver days but without ever explaining how they relate to the § 1115 days being raised in this case for the first time:

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

[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 (June 5, 2019).
[18] *Id.* at 9.

> the plain meaning of its own regulations (which regulations represent the official policy of CMS all along). *See* CMS Manual Instructions System, Change Request 12669, Transmittal No. 11912 (March 16, 2023) ("Transmittal 11912"), attached as Exhibit P-3.

Significantly, *by only referring to § 1115 waiver days in passing as part of parentheticals or asides*, the Provider's January 22, 2024 responsive brief does not identify what specific state § 1115 waiver program(s) are at issue, much less how such program(s) would or would not qualify under 42 C.F.R. § 412.106(b)(4) for inclusion in the numerator of the DSH Medicaid fraction. Curiously, the responsive brief continues to list the "Estimated Medicare Reimbursement Effect" for Issue 5 as $67,657 and again attaches as Exhibit P-2 the original "Estimated Impact" supporting that number based on an estimated 150 "additional Secondary Medicaid eligible Days."

Additionally, on **January 22, 2024**, in a separate filing but ***without explanation***, the Provider *belatedly* files a "supplement" to its preliminary position paper ***more than 6 years*** *after that position paper was filed* and ***more than 8 years*** *after the Provider's FY 2015 had ended*. The supplement includes listings for 166 "additional Medicaid days" and 5818 "1115 waiver days."

Provider's Response to Motion to Exclude and Show Cause Order

The Provider argues that "the MAC has an independent legal duty to accept the Provider's list of [§] 1115 days and audit them."[19] Further, the Provider contends that "[t]his duty is not dependent upon the Provider 'timely' providing the MAC with a listing of [§] section 1115 waiver days, or specifically mentioning [§] 1115 waiver days in a preliminary or final position paper."[20] They acknowledge that the listing was late-filed but argue the timing of the listing does not prejudice the Medicare Contractor.[21]

The Provider also argues that "the June 25, 2004 proposed rule (69 Fed. Reg. 35716) and the May 23, 2008 final rule (73 Fed. Reg. 30190) indicate that an 'issue' is encapsulated by a specific cost report adjustment."[22] The Provider goes on to argue that an "issue" should not be "slice[d] and dice[d] . . . into component parts, including the specific reason why Medicaid eligible days were not counted in the numerator of the Medicaid Fraction of the Disproportionate Payment Percentage."[23]

Finally, the Provider contends that their Supplemental Position Paper filing on January 22, 2024, was a supplementary to the preliminary position paper, and the filing of a final position paper was optional.[24]

---

[19] Provider's Response to Motion to Exclude & Show Cause Order at 3 (Mar. 4, 2024).
[20] *Id*. at 2.
[21] *Id*. at 3.
[22] *Id*. at 1.
[23] *Id*.
[24] *Id*. at 2.

MAC's Responsive Brief

The Medicare Contractor replied first by pointing out that "The Board's Order at footnote 3 identifies no less than five (5) decisions addressing § 1115 waiver days, and each decision was issued prior to the Provider's filing of this appeal"; and that "[t]hese cited decisions represent a compelling list of examples of the uniqueness of § 1115 waiver days appeals."[25] Accordingly, the Medicare Contractor concludes that clearly the § 1115 waiver days are a unique class or component of the Medicaid eligible days issue.

The Medicare Contractor documents how the Provider is disingenuous in arguing that the days included in the numerator of the Medicaid fraction may not have multiple component issues. It is disingenuous because the Provider had argued the opposite position in connection with the Issue 1, by arguing that each of the appealed SSI issues are separate and distinct and, in support, pointing to Board Rule 8.1 which confirms that some issues may have multiple components and each component must be appealed as a separate issue.[26]

Indeed, the Medicare Contractor points out that, if § 1115 waiver days were indistinguishable from traditional Medicaid eligible days as maintained by the Provider, then there would be no need to rely on the issuance of CMS Change Request 12669, Transmittal No. 11912 to support inclusion of the 1115 waiver days in the numerator of the Medicaid fraction. Rather, the Provider should be able to rely on HCFA Ruling 97-2.

The Medicare Contractor also argues Board rules do not allow for supplemental position papers to present either new arguments, new issues, or new evidence. However, the Provider's supplemental filing introduces § 1115 waiver days for the first time and then concurrently filed new evidence.[27] Indeed, the Medicare Contractor points out that it is unclear why at this late date, the supplemental filing contains nearly 40 time the number of days estimated in the appeal request. However, *the Provider failed to explain* why this late-filed list is exponentially larger than the estimated 150 days that served as the basis for the appeal request.

Finally, the Medicare Contractor posits that, even if the supplemental filing was proper (which it was not), it fails to include any documentation of the applicable § 1115 waiver program or how the claimed days qualify as § 1115 waiver days pursuant to that program. Further, the Provider's response "fails to address or explain the absence of § 1115 waiver days from its cost report for fiscal year end 08/15/2015".[28]

Board Decision

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

[25] Medicare Contractor's Response to Show Cause Order at 1-2 (Mar. 15, 2024).
[26] *Id*. at 2.
[27] *Id*. at 3-4.
[28] *Id*. at 5.

$10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. Dismissal of the Improperly-Added Sub-Issue for § 1115 Waiver Days and Granting Medicare Contractor's Motion To Strike the January 22, 2024 "Supplemental" Exhibits

The Board finds that the § 1115 Waiver days sub-issue is not a part of Issue 5 or this appeal because it was not properly part of the original appeal request and it was not timely and properly added to this appeal. The Provider failed to include § 1115 Waiver days as a cost issue in its October 12, 2018 appeal request (whether as part of Issue 5 or any other issue[29]) and failed to timely and properly add this additional issue to the appeal. While the Provider's appeal included the Medicaid eligible days issue at Issue 5, this issue is separate and distinct from the § 1115 Waiver days. as set forth in Board Rule 8 (Aug. 2018) which reflected multiple Board, Administrator and Court decisions on this issue[30] (most of which had been issued prior to the Provider's December 11, 2018 deadline for adding issues to this appeal[31]). Moreover, even if the § 1115 waiver days issue were properly part of this appeal (which it was not), the Provider failed to properly develop the merits of the § 1115 waiver days issue in its preliminary position paper (and opted not to file the *optional* final position paper) as required under 42 C.F.R. §§ 412.106(b)(4)(iv)[32] and 405.1853(b)(2)-(3), Board Rules 25 and 27, and the instructions in the Notices setting the deadlines for the position paper filings. This would be an independent basis to dismiss the § 1115 waiver days issue. Finally, there are unresolved jurisdictional issues under 42 C.F.R. § 405.1835(a)(1)(i)-(ii) (2012) as clarified by CMS Ruling 1727-R that would serve as yet another independent basis for dismissal (*e.g.*, why the Provider could not otherwise claim or protest any of the ***5818*** § 1115 waiver days on the as-filed FY 2015 cost report). On a separate

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[29] The Board notes that Issues 2, 3, 4, 6, and 7 were all transferred to CIRP groups on May 30, 2019 prior to the Provider filing its preliminary position paper on June 5, 2019. As such, to the extent the § 1115 wavier day issue could have been part of any of those issues, it was transferred out of the individual appeal and the § 1115 wavier day issue would have needed to have been briefed in its preliminary position paper. Finally, the Board notes that it dismissed Issue 1 in its entirety on September 11, 2019, and that issue had nothing to do with § 1115 wavier day issue since it related only to the DSH SSI fraction.

[30] *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. Ci;r. 2020).

[31] The NPR at issue was issued on April 10, 2018 and the Provider had until Friday, October 12, 2018 to file this appeal. Thus, the deadline to add issues is 60 days beyond that date, *i.e*., by Tuesday, December 11, 2018.

[32] Note this regulatory provision was previously located at 42 C.F.R. § 412.106(b)(4)(iii) but was redesignated as subparagraph (iv) as a result of the FY 2024 IPPS Final Rule, 88 Fed. Reg. 58640, 59332 (Aug. 28, 2023).

basis, the Board agrees with and grants the Medicare Contractor's Motion to strike the January 22, 2024 "Supplemental" Exhibits from the record in this case.

The appeal was filed with the Board in October of 2018 and the regulations at 42 C.F.R. § 405.1835(b) required the following content to be included in the appeal request:

> (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.
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final contractor or Secretary determination under appeal, including an account of all of the following:
>
> (i) why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) how and why the provider believes Medicare payment must be determined differently for each disputed item.
>
> (iii) If the provider self-disallows a specific item (as specified in §413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.
>
> (3) A copy of the final contractor or Secretary determination under appeal and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section.[33]

Board Rule 7[34] elaborated on this regulatory requirement instructing providers and *specifically* cross-references Board Rule 8 for "special instructions regarding multi-component disputes":

[33] 42 C.F.R. § 405.1835(b) (bold and underline emphasis added).
[34] v. 2 (Aug. 2018).

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

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

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

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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:
  - 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). . . .

7.3 Self-Disallowed Items (Applies to Cost Reporting Periods Ending On or Before 12/31/15)

7.3.1 Authority Requires Disallowance

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

- a concise 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).

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[35] (as referenced in Board Rule 7) explains that when framing issues for adjustments involving multiple components, that providers must ***specifically*** identify *each* item

[35] *Id*.

in dispute, and "…each contested component must be appealed as a separate issue and described as ***narrowly*** *as possible*…".[36] Specifically, Board Rule 8 states:

> **Rule 8 – Framing Issues for Adjustments Involving Multiple Components**
>
> **8.1 – General**
>
> Some issues may have multiple components. To comply with the regulatory requirement to *specifically identify* the items in dispute, *each contested component must* be appealed as a separate issue and *described as narrowly as possible* using the applicable format outlined in Rule 7. 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.
>
> **B. Bad Debts**
>
> Common examples include: crossover bad debts, collection effort, use of collection agency, 120-day presumption, and 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[37]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect ***to limit*** the time frame in which issues may be added to appeals.[38] 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

[36] (Emphasis added.)
[37] (Emphasis added).
[38] *See* 73 Fed. Reg. 30190 (May 23, 2008).

> the original hearing request by submitting a written request to the Board, only if –
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> ****
>
> (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 (which is presumed to be 5 days after issuance per the definition of "date of receipt" in 42 C.F.R. § 405.1801(a)). Specifically, as the NPR at issue was issued on April 10, 2018 and the Provider had 185 days after that to file the appeal (*i.e*., until Friday, October 12, 2018), the deadline to add issues was 60 days after October 12, 2018 (*i.e*., by Tuesday, December 11, 2018). However, there is no evidence in the record to indicate the Provider added the § 1115 waiver days issue to the case properly or timely.

Accordingly, the only way in which the 1115 wavier day issue could be properly part of this appeal is if it was included in the original appeal request. The Board finds that it was not as set forth below.

First, as a preliminary matter, the Board notes that § 1115 Waiver days are *not* traditional Medicaid eligible days and that the burden of proof relative to 1115 waiver days (both factually and legally) is materially different from that for traditional Medicaid eligible days. In this regard, 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 be included in the DSH calculation and that she exercised her discretion to include only certain such days).[39] 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 § 1115 waiver days. Specifically, § 412.106(b)(4) *as it existed in 2015* (and before the revisions made in the FY 2024 IPPS Final Rule[40]) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the

[39] 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).").

[40] *See supra* note 32 discussing how the FY 2024 IPPS Final Rule redesignated 42 C.F.R. § 412.106(b)(4)(iii) as was redesignated as § 412.106(b)(4)(iv).

> 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.

*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**.*[41] 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[42] and not every inpatient day associated with beneficiary enrolled in such a § 1115 waiver program qualifies to be included in the numerator of the DSH Medicaid fraction.[43] In contrast, every state has a Medicaid state plan;

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[41] 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.

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

[43] 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

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.[44]

Notwithstanding the fact that § 1115 waiver days are handled differently from regular Medicaid eligibility under a State plan, the appeal request only *generically* references Medicaid eligible days and includes an "Estimated Impact" of only 150 days (*exponentially different than the* ***5818*** *§ 1115 waiver days claimed on January 22, 2024* ***without explanation and*** *more 4 years than after the Provider's June 5, 2019 filing of its preliminary position paper*). In this regard, documentation needed to verify eligibility for a § 1115 waiver day is *materially* different than that for a traditional Medicaid eligible day[45] and, similarly, it is not a given that *all* § 1115 waiver days (even those

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

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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.

[44] (Emphasis added.)

[45] In addition to providing proof that the patient at issue was eligible for the § 1115 waiver program for each day

under a program receiving Title XIX matching payments) necessarily would qualify under § 412.106(b)(4) as demonstrated by Board decisions and case law.[46] Here, 42 C.F.R. § 405.1835(b) and Board Rules 7 and 8 required each separate issue to be identified, and Board Rule 8 ***specifically*** *identified § 1115 waiver days is a separate and distinct issue*. Yet, the Provider failed to identify *§ 1115 waiver days* as a separate issue.[47] Accordingly, the Board dismisses it from this appeal because Issue 5 (the DSH Medicaid Eligible Days issue) as stated in the original appeal request did not specifically include the § 1115 waiver days issue consistent with the appeal request *content* requirements at 42 C.F.R. § 405.1835(b) and Board Rules 7 and 8, and because the § 1115 waiver days was not timely added to the appeal consistent with 42 C.F.R. § 405.1835(e).

Regardless, of whether the Provider *properly* included the § 1115 waiver days issue in its appeal request (which it did not), QRS failed to properly develop the merits of § 1115 waiver day issue in any of the Provider's preliminary position paper filing (and then failed to even file an *optional* final position paper by the November 23, 2023 filing deadline). This is an independent basis for dismissal of the § 1115 waiver day issue. Specifically, the material facts and legal arguments need to establish the merits of the Provider's claims regarding the § 1115 waiver days issue along with the relevant supporting documentation were not properly briefed and included in the preliminary position paper filing.

First, the Provider's June 5, 2019 preliminary position paper does not mention or discuss the § 1115 waiver day issue, much less:

(1) Identify the material facts (*e.g.*, identify the total number of § 1115 waiver days at issue, the each of the specific days at issue, and the State § 1115 waiver program(s) at issue);

(2) Present the legal arguments in support of its position (*e.g.*, explain how the relevant State 1115 waiver program(s) identified in No. 1 above met the requirements of 42 C.F.R. § 412.106(b)(4) to have days associated with such program(s) to be included in numerator of the Medicaid program); and

(3) Include the relevant supporting document (*e.g.*, documentation verifying eligibility of the relevant patients underlying each of the § 1115 waiver days).

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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 43 and litigation in *supra* note 30.

[46] *See* litigation in *supra* note 30.

[47] 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. This is made clear by Board Rule 8 (Aug. 2018) which specifically identified § 1115 waiver days as a distinct issue.

42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25 (Aug. 2018) required a ***fully***-developed preliminary position paper that include 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). As specifically noted in Board Rule 8, § 1115 waiver days is a separate and distinct issue. As it was not briefed in the preliminary position paper, it is "considered withdrawn" to the extent it was ever part of this appeal as made clear by Board Rule 25.3 (Aug. 2018): "Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn." Indeed, the Board agrees with the Medicare Contractor that the Provider's assertion that § 1115 waiver days issue is part and parcel part of the Medicaid eligible days issue is disingenuous given that it points to the very litigation and CMS Transmittal that make it clear that it is a separate and distinct issue.

Even if it had not been effectively abandoned/withdrawn in the preliminary position paper and the Board had accepted the January 22, 2024 responsive brief, the Provider would fare no better because that responsive brief is fatally flawed. More specifically, it failed to properly develop the § 1115 waiver days issue because it was a *perfunctory* and flawed filing and only made generic unsupported conclusory assertions regarding the § 1115 waiver day issue in the argument section for Issue 5. First, it only generically references § 1115 waiver days and ***fails*** *to identify* the specific state § 1115 waiver program(s) at issue (whether 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. The responsive brief failed to explain why a listing had not been provided earlier with the preliminary position paper (or even during the intervening 6+ years between the June 5, 2019 position paper filing and January 22, 2024 responsive brief filing), and what efforts had been made to obtain the listing prior to January 22, 2024.

The Board recognizes that, on January 22, 2024, the Provider filed a listing of § 1115 waiver days with the Board. However, consistent with its authority under 42 C.F.R. §§ 405.1868 and 405.1853(b)(2)-(3) and Board Rules 25.2 and 35.3, the Board finds the listing was excessively untimely and **declines** to accept this late-filed listing into the record for this case since it was filed outside the only position paper the Provider filed on June 5, 2019 and no explanation was given consistent with Board Rule 25.2.2 explaining why it was being filed outside this process and what efforts had been expended to obtain this information prior to January 22, 2024. Indeed, the Secretary has stated that 17 months following the close of a fiscal year is ample time to identify any additional days missed in the as-filed cost report which here would have been by February 1, 2017 (*i.e.*, ***before*** this appeal was filed).[48] 42. C.F.R. § 412.106(b)(4)(iv) make clear the Provider has the "burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and ***of verifying with the State*** *that a patient was eligible for Medicaid during each*

[48] In this regard, the Board notes that the Secretary stated in the final rule published on November 13, 2015 that generally 17 months after the close of a provider's fiscal year (the filing of the cost report is due the last day of the 5th month after the close of the fiscal year) is *sufficient time* for the provider to identify any additional Medicaid eligible days missed in the as-filed cost report:

> In our experience, we believe an additional 12 months [after the filing of the cost report on the last day of the 5th month following the end of the fiscal year] is sufficient time for States to make Medicaid eligibility determinations and for hospitals to revise its number of Medicaid-eligible patient days in order to make an appropriate cost report claim for a DSH payment adjustment.

80 Fed. Reg. 70298, 70564 (Nov. 13, 2015).

claimed patient hospital stay."[49] Here, the Provider had more than ample opportunity to comply with its burden of proof but failed to timely and properly do so. Indeed, the Provider admits in its response to the Board's Show Cause Order that the listing should have been included with its preliminary position paper and was late-filed. Accordingly, the Board grants the Medicare Contractor Motion to strike the late-filed January 22, 2024 listings and further strikes the January 22, 2024 responsive brief because that responsive brief is otherwise perfunctory and repetitive of the June 5, 2019 preliminary position paper, *once the § 1115 waiver day sub-issue is stricken from that filing consistent with the Board's above dismissal of that improper and late-filed sub-issue*.

Additionally, as previously discussed, the hearing is currently scheduled for Friday, May 29, 2024 and the Provider designated ***no*** *witnesses* under the time allotted under Board Rule 28 and in the Notices of Hearing issued in this case. *As a result, the Provider is* ***solely*** *relying on the documentary record in this case and, as discussed above, the record is* ***wholly*** *insufficient as a threshold matter relative to the Provider's burden of proof under 42 C.F.R. § 412.106(b)(4)(iv).*

Finally, even if the Board had accepted the late-filed listing, there is no indication that any of the late-filed 5818 § 1115 waiver days 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). The fact that the Provider is claiming *a* ***materially*** *large number of days* (5818 days) suggests that they may be an unclaimed cost for which the Board would lack jurisdiction under 42 C.F.R. § 405.1835(a)(1)(i)-(ii) (2012) as clarified by CMS Ruling 1727-R, and that the Provider failed to address the Board's jurisdiction over the § 1115 waiver days issue in its preliminary position paper consistent with § 405.1853(b)(2) and Board Rule 25. 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 advertence from the as-filed cost report,[50] 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.[51] The Provider's briefings do not discuss this jurisdictional issue even though 42 C.F.R. § 405.1853(b)(2) requires position papers to address the Board's jurisdiction over each issue. In particular, QRS fails to address whether, pursuant to CMS Ruling 1727-R, "***the provider 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***

[49] (Emphasis added.)

[50] 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.)

[51] *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 06-1852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days because no days were claimed with the as-filed cost report due to choice, error and/or inadvertence and, as such, the practical impediment standard or futility concept in the *Norwalk* and *Danbury* decisions under PRRB Dec. Nos. 2012-D14 and 2014-D03 is not applicable (available at: https://www.cms.gov/regulations-andguidance/review-boards/prrbreview/downloads/jd-2017-11.pdf (last accessed Dec. 15, 2023)).

the manner sought by the provider."[52] Here, the Provider in its January 22, 2024 responsive brief appears to claim that the Medicare Contractor was *required* to include these § 1115 days in the numerator of the DSH Medicaid fraction and, thus, would appear ***not*** to qualify under CMS Ruling 1727-R for jurisdiction (*i.e*., there would be no basis for jurisdiction under Ruling 1727-R). This is an independent basis for the Board to dismiss the § 1115 waiver days issue (*i.e*., in addition to and independent from dismissal for failure to properly include the issue in its appeal request).

In summary, the Board finds that: (1) the § 1115 waiver days sub-issue to Issue 5 is a separate issue as set forth in Board Rule 8 (Aug. 2018) and it is not a part of this appeal because it was not properly or timely added;[53] and (2) even if it were an issue in this appeal (which it is not), the Provider effectively abandoned it by failing to develop the merits of its case in its preliminary position paper and failing to the material facts and all relevant available documentation without explaining why it has been unable to do so as required under Board Rule 25.2.2. Finally, the Board grants the Medicare Contractor's motion to strike the January 22, 2024 listings from the record. Accordingly, for the multiple and independent bases, the Board dismisses the § 1115 waiver day sub-issue from this appeal.

B. Dismissal of the Original Medicaid Eligible Days Issue

In its October 12, 2018 Appeal Request, the Provider asserts that all Medicaid Eligible Days were not included in the calculations of the DSH calculation. The Provider states Issue 5 as:

> **Statement of 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

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

[53] The fact that, as a result of the *Bethesda and Forrest General* decisions, the Secretary may ***now*** (well after the appeal request was filed) have changed its stance on how ***certain*** § 1115 waiver days may or may not be included in the numerator of the Medicaid fraction does *not* otherwise alter the base requirement that the Provider must have a claim for that issue *properly* pending in an appeal in the first instance. Moreover, CMS Transmittal No. 11912 at 5 (Mar. 16, 2023) does reference the requirement that a Provider have a properly pending appeal of the issue: "jurisdictionally valid pending Section 1115 Bethesda-like appeals." As such, the Board finds that Medicare Contractors are ***not*** obligated to accept or review any and all claims for § 1115 waiver days but rather only those where a "Section 1115 Bethesda-like appeal" is *properly* pending before the Board. Indeed, this is a basic mantra of CMS included in CMS Rulings generally. *See, e.g*., CMS Ruling 1498-R (Apr. 28, 2010) ("In accordance with the foregoing history and determination, CMS and the Medicare contractors will resolve each properly pending DSH appeal of the SSI fraction data matching process issue, by applying…."); CMS Ruling 1739-R (Aug. 17, 2020) ("First, it is CMS's Ruling that the agency and the Medicare contractors will resolve each properly pending claim in a DSH appeal in which a provider alleges that . . . ."). Regardless, that Transmittal is not directed to the Board itself or Board proceedings and, to this end, does not give any guidance or instruction *to the Board*.

> 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.[54]

The Provider did not include a list of additional Medicaid eligible days they expect to be included in their Medicaid percentage and DSH computations, with their appeal request, notwithstanding the fact that it had been more than 3 years since the close of its FY 2015. Rather, the Provider stated that Issue 5 involved an estimated 150 additional Medicaid eligible days.

The Provider's June 5, 2019 preliminary position paper similarly did not include a listing of additional Medicaid eligible days. Rather it stated that it would be sending the eligibility listing under separate cover[55] and continued to represent that Issue 5 involved an estimated 150 additional Medicaid eligible days. Significantly, *even though it had been more than 3½ years after the Provider's FY 2015 had closed*, the Provider's June 5, 2019 preliminary position paper did not comply with Board Rule 25.2.2 as it did not explain why the listing was not included, what efforts had been made to obtain the listing, or when it would become available.

Board Rule 7.3.2[56] 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.

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.[57]

The Provider did not submit a listing of Medicaid Eligible Days until February 27, 2024, ***over 6 years after the appeal was filed and over 8 years after the Provider's FY 2015 had closed***. In its response to the Board's Show Cause Order, the Provider admits the listing was late-filed and

[54] Individual Appeal Request, Issue 5.
[55] Provider's Preliminary Position Paper at 8.
[56] v. 2 (Aug. 2018).
[57] *Id*.

should have been included with its October 3, 2019 preliminary position paper; however, the Provider fails to explain why that listing of 166 "additional Medicaid days" was late-filed ***more than 4 years after its preliminary position paper***. As discussed *infra*, the Secretary maintains that 17 months following a provider's cost reporting period is sufficient time to identify any additional Medicaid eligible days relevant to that cost reporting period. Here, 17 months following the close of the Provider's FY 2015 was February 1, 2017. As a result, by this standard, the Provider had more than ample opportunity to identify the 166 Medicaid eligible days belatedly identified as being at issue before it filed its preliminary position paper on June 5, 2019 (*2 years and 5 months after the February 1, 2017 mark*). Accordingly, as discussed *supra*, the Board has declined to accept the late-filed January 22, 2024 listings/exhibit in the record and finds the Provider has essentially abandoned the issue by failing to *properly* ***and*** *timely* develop its arguments and material facts in its preliminary position paper and to provide all available supporting documents with that filing or, in the alternative, explain why it could not timely produce those documents, as required by the regulations at 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iv), Board Rule 25 (including in particular 25.2.1 and 25.2.2) and the instructions in the Board's October 29, 2018 Notice of Case Acknowledgement and Critical Due Dates.[58]

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[59]

Similarly, with regard to position papers,[60] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[61] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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[58] *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.

[59] (Emphasis added).

[60] The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. *See* Board Rule 27.2.

[61] (Emphasis added).

Similarly, consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[62]

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iv) places the burden of production on the provider, stating:

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

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

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

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

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

[62] (Emphasis added).

The Board concurs with the Medicare Contractor that the Provider is required to timely identify and provide documentation with its preliminary position paper to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. The Provider had more than ample time prior to the filing of its preliminary position paper to identify and gather the supporting documentation but it failed to do so and then failed to explain why it did not do so in compliance with Board Rule 25.2.2. Indeed, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[63] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider failed to timely provide a listing or other supporting documentation for the Medicaid Eligible Days issue with its preliminary position paper as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what caused the delay with Board Rule 25.2.2. Indeed, based on these facts, the Board must assume that the Provider has abandoned this issue and, as described above, the Board declines to accept into the record the late-filed January 22, 2024 exhibit and strikes it from the record.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25 (as well as the instructions in the Board's October 29, 2018 Notice) related to timely identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[64] Accordingly, the Board dismisses the original DSH Payment – Medicaid Eligible Days issue filed as Issue 5.

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In summary, the Board further dismisses Issue 5 (the DSH Payment - Medicaid Eligible Days issue) *in its entirety* because: (1) the § 1115 waiver days sub-issue is not properly part of Issue 5 (or this appeal in general) since it was not included in the appeal request consistent with 42 C.F.R. § 405.1835(a)-(b) and Board Rules 7 and 8 (Jul. 2015) and was not timely added pursuant to 42 C.F.R. § 405.1835(e); (2) the Provider failed to properly develop the merits of both the original Medicaid eligible days and the improperly-added § 1115 waiver days sub-issue in its preliminary position paper (and then opted not to file an optional final position paper) as required under 42 C.F.R. §§ 412.106(b)(4)(iv)[65] and 405.1853(b)(2)-(3), Board Rules 25 and 27, and the instructions in the Notices setting the deadlines for the position paper filings; and (3) grants the Medicare Contractor's motion to strike the January 22, 2024 listings from the record and further strikes the January 22, 2024 responsive brief from the record as the filing is not a responsive brief but rather is the same as the Provider's preliminary position paper *once the § 1115 waiver day sub-issue is stricken from that filing consistent with the Board's above dismissal of that*

[63] (Emphasis added).
[64] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is also applicable to final position papers via Board Rule 27.2.
[65] Note this regulatory provision was previously located at 42 C.F.R. § 412.106(b)(4)(iii) but was redesignated as subparagraph (iv) as a result of the FY 2024 IPPS Final Rule, 88 Fed. Reg. 58640, 59332 (Aug. 28, 2023).

improper and late-filed sub-issue. The Board takes administrative notice that it has made similar dismissal in other cases in which QRS was the designated representative.[66] As no issues remain pending, the Board hereby closes Case No. 19-0152 and removes it from the Board's docket.

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

Board Members Participating:

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For the Board:

5/24/2024

X Clayton J. Nix

Clayton J. Nix, Esq.
Board Chair
Signed by: PIV

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

[66] Examples of cases in which QRS was the designated representative and which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days at issue include, but are not limited to: Case No. 14-2674 (by Board letter dated 5/5/2022); Case No. 16-2521 (by Board letter dated 5/5/2022); Case No. 16-0054 (by Board letter dated 5/5/2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, 16-1712 (by Board letter dated 9/30/2022). Moreover, in Case Nos. 13-3022, 13-3211, 14-2506, and 14-4313, the Board's attention to the filing deficiency was brought to the Board's attention via a motion to dismiss filed by the Medicare Contractor in its position paper (on December 10, 2020, December 11, 2020, March 12, 2021, March 12, 2021 respectively). *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.