DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Norwalk Hospital Association (Provider Number 07-0034)
FYE: 09/30/2016
Case Number: 19-2437

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-2437. Set forth below is the decision of the Board to dismiss the only remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) payments.

Background:

A. *Procedural History for Case No. 19-2437*

On **February 14, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2016. The Provider is commonly owned by Nuvance Health. ("Nuvance").

On **August 15, 2019**, Provider's Representative, Quality Reimbursement Services ("QRS"), 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 – Medicaid Eligible Days[2]
4. DSH SSI Fraction / Medicare Managed Care Part C Days[3]

[1] On March 23, 2020, this issue was transferred to Case No. 20-1324GC.
[2] On May 10, 2024, the Provider withdrew this issue from the appeal.
[3] On March 23, 2020, this issue was transferred to Case No. 20-1325GC.

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

As the Provider is commonly owned/controlled by Nuvance Health, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **March 23, 2020**, the Provider transferred Issues 2, 4, 5, 6, 7, 8 and 9 to Nuvance CIRP groups. On **May 10, 2024**, the Provider withdrew Issue 3 from the appeal.

As a result of the case transfers and withdrawn issue, the only issue remaining in the appeal is Issue 1 (DSH – SSI Percentage Provider Specific).

On **May 28, 2020**, the Medicare Contractor filed a Jurisdictional Challenge[9] with the Board over Issue 1 requesting that the Board dismiss this issue.

On **November 10, 2022**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **December 7, 2022**, the Board sent a Notice of Case Acknowledgement and Critical Due Dates, providing the filing deadline of **March 14, 2023** for Provider's preliminary position paper. 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

[4] On March 23, 2020, this issue was transferred to Case No. 20-1326GC.
[5] On March 23, 2020, this issue was transferred to Case No. 20-1330GC.
[6] On March 23, 2020, this issue was transferred to Case No. 20-1328GC.
[7] On March 23, 2020, this issue was transferred to Case No. 20-1329GC.
[8] On March 23, 2020, this issue was transferred to Case No. 20-1331GC.
[9] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

> 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 **December 9, 2022**, the Board sent a separate Critical Due Dates Notice to inform the Provider that their deadline to respond to the Medicare Contractor's Jurisdictional Challenge was **February 7, 2023**. The Medicare Contractor originally filed its Jurisdictional Challenge on **May 28, 2020**.

On **February 7, 2023**, the Provider filed its response to the Medicare Contractor's Jurisdictional Challenge.

On **March 7, 2023**, the Provider filed its preliminary position paper within the deadline issued to Provider in the Critical Due Dates Notice dated December 7, 2022.

On **February 28, 2024**, the Provider filed its final position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20 -1324GC – Nuvance Health CY 2016 DSH SSI Percentage CIRP Group

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

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

[10] (Emphasis added.)

> 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. 20-1324GC, to which the Provider transferred Issue No. 2, reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[12]

[11] Provider's Issue Statement – Issue 1 (Aug. 15, 2019).
[12] Group Appeal Issue Statement in Case No. 20-1324GC.

On March 21, 2024, the Board received the Provider's final position paper in Case No. 19-2437. 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 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).[13]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $92,000.

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:

> The MAC contends that Issue 1 has three sub-issues. Sub-issues 1 and 3 are duplicative of Issue 2. In sub-issues 1 and 3, the Provider states:

[13] Provider's Final Position Paper at 8-9 (Mar. 21, 2024).

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

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

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 that were transferred to Group Case No. 20-1324GC. The Provider states in Issue 2:

> The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] incorporates 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:
>
> 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.

The MAC contends that the above argument is duplicative 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 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 the above argument is duplicate of sub-issue 3 of Issue 1.

The MAC contends that the Provider is arguing the same issues in both the instant case and the Group Case; that is, that the SSI percentage is flawed. See the Group issue statement at Exhibit C-5. Therefore, portions of Issue 1 related to SSI data accuracy and SSI payment are duplicative of Issue 2, which was transferred to Group Case No. 20-1324GC.

In accordance with PRRB Rule 4.6.1, "A provider may not appeal an issue from a single final determination in more than one appeal." Consistent with the Board's previous jurisdictional decisions, the MAC respectfully requests the Board dismiss the

> portions of Issue 1 concerning data accuracy and individuals who are eligible for SSI but did not receive SSI payment.[14]

The MAC also argues that the Provider has abandoned the issue of SSI realignment, and states:

> Issue 1 also includes the Provider's attempt at a subsidiary appeal over SSI realignment. The Provider states in its appeal request:
>
> > 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.[15]

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:

> Even if the Board finds that the SSI realignment portion of Issue 1 is still active, it should still be dismissed. The Board has consistently ruled that a provider's appeal of the SSI issue to preserve its right to a recalculation is not a valid issue. The appeal regulations do not allow providers to file an appeal to preserve future appeal rights. 42 C.F.R. § 412.106(b)(3) allows a hospital to request that CMS calculate its SSI percentage based on its cost reporting period instead of the Federal fiscal year end. Realignment can be performed once per hospital per cost reporting period and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period, regardless of if the result is advantageous to the hospital or not. The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election and not a final MAC determination.

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[14] Jurisdictional Challenge at 5-6 (May 28, 2020).
[15] *Id.* at 7.

> The regulations at 42 C.F.R. § 405.1835 set forth the criteria for a Provider's right to a PRRB hearing:
>
> > A provider . . . has a right to a Board hearing, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination[.] (Emphasis added).
>
> …
>
> 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 other jurisdictional decisions.[16]

Provider's Jurisdictional Response:

The Provider filed its response the Medicare Contractor's jurisdictional challenge on February 7, 2023. In the 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 – SSI Systemic issue that was transferred on March 23, 2020 to Group Case No. 20-1324GC. Provider contends each of the appealed SSI issues are separate and distinct issues, and that the Board should find jurisdiction over PRRB Case Number 19-2437.
>
> 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 issues represent different aspects/components of the SSI issue, Provider contends the Board should find jurisdiction over both the SSI Systemic and Provider Specific/Realignment issues.

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

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

> SSI ratio. Therefore, the Board should find jurisdiction over the SSI provider specific issue in the instant appeal.
>
> Accordingly, this is an appealable item because the MAC specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2016, resulting from its understated SSI percentage due to errors of omission and commission.
>
> The Provider is entitled to appeal an item with which it is dissatisfied. Further, the Centers for Medicare & Medicaid Services ("CMS") in *Northeast Hospital Corporation v. Sebelius*, 657 F.3d 1 (D.C. Cir. 2011) specifically abandoned the CMS Administrator's December 1, 2008 decision that the SSI ratio cannot be revised based upon updated data after it has been calculated by CMS. Accordingly, the Provider has specifically identified patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS, due to errors that are or may be specific to the Provider, but in any case, are not the systemic errors that have been previously identified in the *Baystate* litigation. See *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008). Once these patients are identified, the Provider contends that it will be entitled to a correction of these errors of omission to its SSI percentage.
>
> The DSH/SSI percentage was adjusted on the Provider's cost report. Accordingly, Provider requests the Board find that it has jurisdiction over the DSH/SSI provider-specific issue.[17]

Decision of the Board:

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

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

[17] Provider's Jurisdictional Response at 2-3 (Feb. 7, 2023).

DSH Payment/SSI Percentage (Provider Specific)

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

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Case No. 20-1324GC.

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

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-1324GC 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. 19-2437 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-1324GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[21], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may

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

impact the SSI percentage for each provider differently.[22] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors are specific to this provider.

To this end, the Board also reviewed the Provider's Preliminary 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. 20-1324GC, but instead referred to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's position papers failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Aug. 29, 2018), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

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

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

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

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

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

> *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*, 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. 20-1324GC.

Accordingly, *based on the record before it*, the Board finds that the SSI Provider Specific issue in Case No. 19-2437 and the group issue from the CIRP group under Case No. 20-1324GC 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

[24] Last accessed June 3, 2024.
[25] Emphasis added.

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 Provider's cost reporting period ends on 9/30, and is therefore congruent with the Federal fiscal year. As such, realignment of the SSI percentage would have no effect on reimbursement whatsoever. Therefore, the Board dismisses this aspect of the appeal.

* * * * *

Based on the foregoing, the Board dismisses the remaining issue in this case – Issue 1. As no issues remain, the Board hereby closes Case No. 19-2437 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

6/4/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

June 7, 2024

Via Electronic Delivery

Lindsay Pelletier
Silver Oaks Behavioral Hospital
1004 Pawlak Parkway
New Lenox, IL 60451-9401

Pamela VanArsdale
National Government Services, Inc. (J-6)
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

Re: ***Dismissal for Untimely Response to Request for Required Information***
Case No. 24-1791 – Silver Oaks Behavioral Hospital, Prov. No. 14-4041, FYE 12/31/2023

Dear Ms. Pelletier and Ms. VanArsdale:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced appeal and after review of the facts outlined below, has determined that the appeal must be dismissed pursuant to 42 C.F.R. § 405.1868 for failure to follow Board Rules. The pertinent facts of the case and the Board determination are set forth below.

Pertinent Facts:

On **April 25, 2024**, Silver Oaks Behavioral Hospital (the "Provider") filed an appeal with the Board to establish Case No. 24-1791. The appeal was filed from a determination entitled "Notice of Quality Reporting Program Noncompliance Decision Upheld" ("Quality Reporting Determination") dated February 20, 2024.

As its issue statement, the Provider uploaded a document labeled "NHSN Appeal Letter1.doc" and copies of various emails to demonstrate its attempts to gain access to the CDC's National Healthcare Safety Network ("NHSN") reporting site to file its compliance data. Unfortunately, these submissions do not meet the requirements of an issue statement, nor did they include any calculation support. In place of the required representation letter, the Provider uploaded a copy of the initial September 29, 2023 Quality Reporting Denial.

In its initial review of the appeal, the Board found that the Provider's appeal request did not include:

- a proper issue statement (Board Rule 7.2);[1]

[1] All Provider Reimbursement Review Board Rules cited herein are from Version 3.2 (Dec 15, 2023).

- a calculation of the amount in controversy with supporting documentation ("calculation support") (Board Rule 6.4); and
- a representation letter (Board Rule 5.4).

On **April 26, 2024**, the Board issued an Acknowledgement and Critical Due Dates Notice in which it set a briefing schedule for the Parties to file preliminary position papers and required the Provider to file a proper issue statement, calculation support, and a representation letter. The deadline for the required support documents was set for **May 13, 2024**. The letter clearly states, "If the Provider misses any of its due dates, the Board will dismiss the appeal."

On **May 14, 2024**, after the Provider failed to respond to the initial request for required support documents, the Board issued a final Request for Information ("RFI"), giving the Provider a new deadline of **May 24, 2024** to submit the documentation required by Board Rules 7.2, 6.4, and 5.4. The letter closes with the statement, "If the necessary documentation is not submitted by the deadline, the Board will take action in accordance with 42 C.F.R. § 405.1868."

On **May 28, 2024,** the Provider responded to the RFI and simultaneously filed a request for reconsideration in which it asked the Board to continue reviewing its appeal (*rather than dismissing the case*). The Provider explained that it checked the OH CDMS website for updates, but noted it was not until May 23, 2024 when it checked its email "SPAM Folder" that it noticed the three (3) emails from the Board with requests for the updated information. The Provider contends that it immediately responded, and at the earliest time, on May 28, 2024, it facilitated a meeting with the Medicare Contractor.

Rules/Regulations:

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

The required contents for an appeal request – as set forth in 42 C.F.R. § 405.1835(b) – are:

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

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

Board Rules 6 (Initial Filing), 7 (Support for Appealed Final Determination, Availability of Issue-Related Information and Basis for Dissatisfaction), and 8 (Framing Issues for Adjustments Involving Multiple Components) further address individual appeal requirements and support for the appealed final determination, availability of issue-related information, and the basis for dissatisfaction. Specifically, Board Rule 6.1.1 (Request and Supporting Documentation), advises that the Board will *dismiss* appeal requests that do not meet the *minimum* filing requirements as identified in 42 C.F.R. § 405.1835(b).

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

Finally, Board Rule 9 (Board Acknowledgement of Appeals) discusses that the fact that the Board's Acknowledgement letter and subsequent correspondence will establish various deadlines and due dates, and that the Parties' failure to comply with such deadlines may result in the Board

[2] 42 C.F.R. § 405.1835(b) (emphasis added).

taking any of the actions described in 42 C.F.R. § 405.1868 (*i.e.*, dismiss the appeal with prejudice; issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or take any other remedial action it considers appropriate).[3]

Board Determination:

After a review, the Board has determined that the Provider's appeal request, as initially filed, was fatally flawed as it was not filed in accordance with the regulations at 42 C.FR. § 405.1835(b). Further, the Board finds that the Provider's response to the Board's Request for Information to cure the deficiencies was untimely filed.

The Provider's appeal request failed to meet the requirements of 42 C.FR. § 405.1835(b).

In its initial review, the Board found that the initial submission did not constitute an issue statement consistent with the appeal content requirements in Board Rule 7.2 (Issue-Related Information) and 42 C.F.R. § 405.1835(b). The regulation requires an "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."[4] Board Rule 7.2 is consistent with 42 C.F.R. § 405.1835(b) and requires, among other things, that the supporting documentation submitted for each issue raised in the appeal request describe the controlling authority (*e.g.*, specific regulation, manual provision, or Ruling), why the adjustment(s) is incorrect, how it should be determined differently, and an identification of the reimbursement effect. As previously noted, the document labeled by the Provider as an "Issue Statement" in the initial appeal was really a timeline of the events, describing the Provider's efforts to gain access to the NHSN reporting site prior to the deadline to submit its COVID vaccine information, which had been filed late. The Provider included copies of various emails which it uploaded as "other issue support" to demonstrate its attempts to gain access to the reporting site to file the compliance data. None of the documents submitted provide controlling authority, an explanation of why the adjustment is incorrect, or even why the Provider is dissatisfied with the specific aspects of the final contractor or Secretary determination. Further, the Provider's appeal request failed to identify a reimbursement effect and failed to include calculation support of the amount in controversy as required under 42 C.F.R. § 405.1835(a)(2) and Board Rule 6.4 (Amount in Controversy). To be clear, the initial appeal request left the "Amount in Controversy" field empty; it was not until the twice-late response on May 28, 2024 that the Provider first offered an estimate at an amount in controversy.

A representation letter is required for all appeals in accordance with Board Rule 5.4 (Representation Letter). The representation letter must designate the case representative and must be on the provider's letterhead. In addition, it must reference the provider's name, number, and fiscal year under appeal, along with certain contact information for the case representative. The Provider uploaded a copy of a CMS notification letter, but that document failed to meet the

[3] 42 C.F.R. § 405.1868(b).
[4] 42 C.F.R. § 405.1835(b)(2).

requirements of Board Rule 5.4 as it was not on the Provider's letterhead and did not include an authorization by the Provider.

Provider's response to the Board's Request for Information to cure the deficiencies was untimely filed.

The Provider was afforded **two (2)** separate opportunities to cure the noted deficiencies in this case. The Provider failed to respond to the Board's initial April 26, 2024 request, and although the Provider responded to the Board's second, May 14, 2024 request, it did not do so by the May 24, 2024 deadline. Instead, the Provider waited until May 28, 2024 (*i.e.*, four (4) days after the expiration of the deadline) and simultaneously requested a "reconsideration," asking that the Board continue its review.

In its May 28, 2024 response, the Provider indicated that it "immediately responded" after it discovered the email requests in the SPAM Folder May 23, 2024. The Board finds this explanation to be curious in that the Provider admits it discovered the deadlines on **May 23, 2024** (which expired on the following day, May 24), but elected to wait until **May 28, 2024** to submit the required documentation. Further, if the Provider had checked OH CDMS as it indicates, it would have seen the "Respond" buttons on the Case Actions Table showing the Document Types Requested (in this case an Issue Statement, Calculation Support, and Representation Letter) and the corresponding due dates.[5]

Board Determination.

Accordingly, the Board hereby dismisses Case No. 24-1791 for the Provider's failure to timely cure the deficiencies in the appeal. The Board closes this case and removes it from its docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 105.1877.

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

For the Board: 6/7/2024

X Nicole E. Musgrave

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

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

[5] *See* Office of Hearings Case and Document Management System ("OH CDMS") Provider Reimbursement Review Board ("PRRB") Module External User Manual (Version 1.0) (August 22, 2018) at Section 3.3.4.1 (Case Actions Table) *available at* https://www.cms.gov/regulations-and-guidance/review-boards/prrbreview/downloads/oh-cdms-prrb-external-user-manual-v-10.pdf (accessed June 6, 2024). ("The case actions table displays notifications from the PRRB, including the date requested, notification type, document requested, owner, and the due date.").

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

Robert Roth
Hooper, Lundy & Bookman, P.C.
401 9th Street, N.W., Suite 550
Washington, DC 20004

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

RE: ***Board Decision***
HLB FFY 2014 UC DSH Merged Hospital Group
Case Number: 18-1346G

Dear Mr. Roth and Mr. Redmond,

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

Background

The Providers in the above-referenced optional group all filed their appeal requests from the Final Rule issued in the Federal Register on August 19, 2013: the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates.

The issue statement in the Notice of Formation reads:

> Whether the Hospitals' FFY 2014 UC DSH payments were improperly low because [CMS] calculated them by unlawfully excluding data from hospitals that had merged into the Hospitals before the beginning of FFY 2014, using a policy for which CMS did not provide either notice or an opportunity to comment, as required by the Administrative Procedure Act ("the APA"), 5 U.S.C. § 551 *et seq*., the Medicare Act at 42 U.S.C. § 1395hh(a)(1) and (2), and which was otherwise unlawful.

MAC's Contentions

The MAC argues "that the Board does not have jurisdiction over the UCC DSH payment issue because of the preclusion on administrative and judicial review by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2)."[1]

[1] Jurisdictional Challenge at 4 (Jun. 22, 2020).

Provider's Jurisdictional Response

The Jurisdictional Challenge was filed on June 22, 2020. *Prior to* the filing of the Jurisdictional Challenge in the instant optional group case, the Providers' Representative filed a "Jurisdictional Response" titled "The Hospitals' Combined Second Supplemental Response to MACS' Jurisdictional Challenges."[2] Included with this filing, as exhibits, were timely filed responses to Jurisdictional Challenges from the individual appeals of the participants which were transferred to the optional group case.[3] The stated purpose of this filing was to "inform Novitas Solutions, Inc., the Lead MAC for this Group Appeal, as it responds to the Board's June 8, 2018 request that the Lead MAC address 'whether the group meets the jurisdictional requirements (with the exception of the amount in controversy).'"[4] On September 13, 2019, "The Hospitals' Combined Third Supplemental Response to MACS' Jurisdictional Challenges" was presented to "advise the [Board] of the recent decision in *Yale New Haven Hospital v. Azar*. . ."[5]

Firstly, the Providers' Representative argues the 2014 Merged Hospital Policy that resulted in exclusion of merged hospital data for the participants was a departure from long-standing CMS policy and for the following year, CMS realized its error and reversed this policy for the following years and since.[6] Further, they argue the FFY 2014 Merged Hospital Policy must be set aside "because it violates, *inter alia*, 42 U.S.C. § 1395ww(r)"[7] and "is invalid procedurally under the Medicare Act and the APA."[8]

Finally, the argument is presented that the participants' appeals are not precluded by 42 U.S.C. § 1395oo(a) because:

> First, the plain reading of the Preclusion Statute shows that it does not apply to the agency action at issue. Second, the Preclusion Statute does not apply because the Hospitals here are challenging the lawfulness of the establishment of the FFY 2014 Merged Hospital Policy, and not the estimate of the Hospitals' FFY 2014 UC DSH payments. Third, the Preclusion Statute could not, did not, and cannot be interpreted to, shield CMS's *ultra vires* action from administrative and judicial review."[9]

In the third supplement, the Providers' Representative argues that the *Yale* court found that judicial review was jurisdictionally valid under a procedural claim of the FFY 2014 Merged

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[2] (Aug. 27, 2018).
[3] *See* Ex. P-3 and P-4. The content of the Jurisdictional Challenges in the individual appeals is essentially identical to the arguments by the MAC in the current Jurisdictional Challenge.
[4] Hospitals' Combined Second Supplemental Response to the MACS' Jurisdictional Challenges at 2. The Board Request addressed was a part of the Board's Case Acknowledgement and Critical Due Dates Notification.
[5] Hospitals' Combined Third Supplemental Response to MACS' Jurisdictional Challenges at 1 (Sept. 13, 2019), citing No. 18-cv-01230, 2019 U.S. Dist. LEXIS 124628 (D. Conn. July 25, 2019).
[6] The Hospitals' Combined Second Supplemental Response to MACS' Jurisdictional Challenges at 4-6 (Aug. 27, 2019).
[7] *Id*. at 6.
[8] *Id*. at 11.
[9] *Id*. at 13.

Hospital Policy.[10] Further, the Court's conclusion should also apply to administrative review, as that question was not before the *Yale* court, because "(a) jurisdiction for both administrative (*i.e.*, Board) and judicial review arises under 42 U.S.C. § 1395oo and (b) the Court in *Yale* explicitly held that it had jurisdiction "pursuant to section 1395oo of title 42 of the United States Code" (Exhibit P-29 at 8), which also governs Board jurisdiction."[11] Finally, they argue the procedural challenge in *Yale* is substantively identical to the procedural challenge brought forward by the Group Representative in Second Supplemental Response and their Preliminary Position Paper.[12]

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 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).[13]
>
> (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*

[10] The Hospitals' Combined Third Supplemental Response to MACS' Jurisdictional Challenges at 3.
[11] *Id*. at 4.
[12] *Id*. at 5.
[13] 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.

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs*. ("*Tampa General*"),[14] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[15] 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."[16] 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.[17]

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.[18]

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*").[19] 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."[20] 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

[14] 830 F.3d 515 (D.C. Cir. 2016).
[15] 89 F. Supp. 3d 121 (D.D.C. 2015).
[16] 830 F.3d 515, 517.
[17] *Id.* at 519.
[18] *Id.* at 521-22.
[19] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[20] *Id.* at 506.

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.[21]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[22] 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.[23] 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.[24] 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.[25] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[26]

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.[27]

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

[21] *Id.* at 507.
[22] 514 F. Supp. 3d 249 (D.D.C. 2021).
[23] *Id.* at 255-56.
[24] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[25] *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.
[26] *Id.*
[27] *Id.* at 262-64.

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

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.[31] 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*").[32] 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.[33] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the provider's claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a 'functional approach' focused on whether the challenged action was 'inextricably intertwined' with the unreviewable estimate itself' and eschewing 'categorical distinction between inputs and outputs.'"[34] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[35] 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***."[36]

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[28] *Id.* at 264.
[29] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[30] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[31] *Id.* at 264-65 (quoting *DCH v. Azar*, 925 F.3d at 509).
[32] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[33] *Id*. at *127.
[34] *Id.* at *134.
[35] 139 S. Ct. 1804 (2019).
[36] *Ascension* at *132 (bold italics emphasis added).

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 center 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.

e. Yale New Haven Hospital v. Becerra

The participants in the instant appeal have referenced the decision in *Yale New Haven Hospital v. Azar*, a decision in which the District Court of Connecticut found in the Provider's favor that a procedural challenge to the FFY 2014 Merged Hospital Policy was not precluded from judicial review by 42 U.S.C. § 1395.[37] In the Providers' third Supplemental Jurisdictional Response, the Providers' Representative also argued for applying that holding to the statute's bar on administrative review.[38] However, the Board need not consider the July 25, 2019 holding by the District Court of Connecticut because it was subsequently reversed by the United States Court of Appeals for the Second Circuit.[39]

In this decision, the Second Circuit rejected Yale New Haven Hospital's argument that the review-preclusion provision applies only to the Secretary's "bottom-line estimates of each qualifying hospital's "DSH Payment" but also to "underlying data."[40] The Second Circuit went on to say "the Secretary's estimate of [the Provider's] amount of uncompensated care for FFY 2014 is not just "underlying data" for the relevant "estimate" – it *is* the "estimate."[41]

Regarding specifically the "Merged Hospital Policy", the Second Circuit found that the "the 'Merged Hospital Policy' amounts to nothing more than the Secretary's choice to 'exclude[]' (i.e., to *not use*) 'the uncompensated [-] care data from [the merged hospital]'…At bottom, then, what [the Provider] calls 'the FFY 2014 Merged Hospital Policy,' is really just the estimate of the Secretary as contemplated by the statute."[42]

The Court also considered whether the bar on judicial review extends to procedural questions. The Court held "that section 1395ww(r)(3)(A) plainly and explicitly strips us – and the district

[37] *Supra* n. 11.
[38] *Supra* n. 12.
[39] *See* 56 F.4th 9 (2nd Cir., Dec. 19, 2022).
[40] *Id*. at 18.
[41] *Id*. (Emphasis included).
[42] *Id*. at 19. (Emphasis included).

court below – of subject-matter jurisdiction to consider the merits of [Provider's] challenge here."[43] The Court also rejected *ultra-vires* jurisdiction as the statutory preclusion of review is express rather than implied in section 1395ww(r)(3).[44]

****

In summary, the Board hereby dismisses the UCC Distribution Pool issue as the Board does not have jurisdiction because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation. The Board hereby closes Case No. 18-1346G and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

6/12/2024

X Kevin D. Smith, CPA

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

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

[43] *Id*. at 26.
[44] *Id*. at 26-27.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

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

RE: ***Board Decision* – Medicaid Eligible Days Issue**
University Medical Center (Provider Number 45-0686)
FYE: 12/31/2013
Case Number: 19-0078

Dear Messrs. Ravindran and Redmond,

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

Background:

A. *Procedural History for Case No. 19-0078*

On **April 9, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2013.

On **October 5, 2018**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained seven (7) issues:

Issue 1: Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage- Provider Specific[1]
Issue 2: DSH- SSI Percentage[2]
Issue 3: DSH SSI Fraction/Medicare Managed Care Part C Days[3]
Issue 4: DSH- SSI Fraction/Dual Eligible Days[4]
Issue 5: DSH-Medicaid Eligible Days
Issue 6: DSH – Medicaid Fraction/Medicare Managed Care Part C Days[5]
Issue 7: DSH- Medicaid Fraction/Dual Eligible Days[6]

[1] The Board dismissed on August 10, 2022.
[2] On October 18, 2019, the Provider transferred this issue to PRRB Case No. 20-0106G.
[3] On October 18, 2019, the Provider transferred this issue to PRRB Case No. 20-0110G.
[4] On October 18, 2019, the Provider transferred this issue to PRRB Case No. 20-0107G.
[5] On October 18, 2019, the Provider transferred this issue to PRRB Case No. 20-0111G.
[6] On October 18, 2019, the Provider transferred this issue to PRRB Case No. 20-0112G.

There is one remaining issue in the appeal: Issue 5 (DSH Payment – Medicaid Eligible Days).

On **October 22, 2018**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[7]

On **March 5, 2019**, the Medicare contractor filed a Jurisdictional Challenge over Issue 1- DSH SSI Provider Specific. The Provider did not file a response. On **August 10, 2022**, the Board dismissed Issue 1.

On **May 31, 2019**, the Provider timely filed its preliminary position paper.

On **September 23, 2019**, the Medicare Contractor timely filed its preliminary position paper. With respect to Issue 5, the Medicare contractor requested from the Provider all documentation necessary to resolve the issue in dispute.[8]

On **January 5, 2022**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **November 14, 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.[9]

---

[7] (Emphasis added).
[8] Medicare Contractor's Preliminary Position Paper at 30.
[9] (Emphasis added).

On **March 21, 2024**, the Provider timely filed its final position paper.

On **April 17, 2024,** the Medicare Contractor filed a Jurisdictional Challenge over the remaining issue, Issue 5: Medicaid Eligible Days. On **May 22, 2024**, the Provider filed an *untimely* Jurisdictional Response.

On **April 18, 2024**, the Medicare Contractor timely filed its final position paper.

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 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): 8, 24, 27, S-D
> Estimated Reimbursement Amount: $54,000[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 payment adjustment.[12] This argument was repeated verbatim in the Provider's March 21,

[10] Appeal Request at Issue 5.
[11] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[12] Provider's Preliminary Position Paper at 7.

2024 filing.[13]

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:

> Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover directly to the MAC (a redacted copy is attached), including Section 1115 waiver days, the Provider contends that the total number of days reflected in its 2013 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.
>
> With respect to section 1115 waiver days, the courts have firmly rejected CMS's interpretation of its regulations, holding instead that the plain language of the statute and the regulations require inclusion in the Medicaid Fraction of the days belonging to individuals who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool. *See Forrest General Hospital*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43(D.D.C. 2018); *Bethesda Health Inc., v. Azar*, 389 F. Supp. 3d 32, (D.D.C. 2019), *aff'd*, 980 F.3d 121 (D.C. Cir. 2020). CMS has acquiesced in *Bethesda* and is now following the statute and the plain meaning of its own regulations (which regulations represent the official policy of CMS all along) and properly accounting for 1115 Waiver days as Medicaid Eligible days. *See* CMS Manual Instructions System, Change Request 12669, Transmittal No. 11912 (March 16, 2023) ("Transmittal 11912"), attached as Exhibit P-3.[14]

[13] Provider's Final Position Paper at 8.
[14] *Id.* at 9-10.

MAC's Contentions

The MAC argues that the Provider failed to submit a list of traditional Medicaid Eligible Days and has not fully addressed the issue in its Preliminary Position Paper, thereby essentially abandoning the issue. Additionally, the Provider is attempting to add the Section 1115 Waiver days issue improperly and untimely. The MAC maintains that Section 1115 Wavier days are a separate and distinct issue. There was no mention of Section 1115 waiver days as part of the original appeal request or preliminary position paper.

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

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 had until May 17, 2024, to file a timely response. The Provider did not file a Jurisdictional Response until May 22, 2024.

The Provider argues that it timely appealed all Medicaid eligible days including 1115 waiver days. The Provider's issue statement reads: "The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid 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."[16]

The Provider maintains that they have not abandoned their claim and has submitted a redacted listing with their Final Position Paper. The MAC's argument that the Provider has abandoned the "issue" of section 1115 waiver days is "not a jurisdictional argument and is inappropriate for a jurisdictional challenge."[17]

Analysis and Recommendation

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

1. Section 1115 Waiver Days

The Board finds that the 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

[15] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[16] Provider Jurisdictional Response at 1
[17] Id at 3.

appeal. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the section 1115 Waiver days.

The appeal was filed with the Board in October of 2018 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing…must 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…[18]

Board Rule 7[19] elaborated on this regulatory requirement instructing providers:

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

[18] 42 C.F.R. § 405.1835(b).
[19] v. 2 (Aug. 2018).

noted in Rules 7.3 and 7.4

Board Rule 8[20] explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: dual eligible Medicare Part A/Medicaid, dual eligible Medicare Part C/Medicaid, SSI data matching, state/program specific general assistance days, ***Section 1115 waiver days (program/waiver specific)***, and observation bed days.[21]

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.[22] 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 –
>
> . . .
>
> (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.[23] Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating

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[20] *Id*.
[21] (Emphasis added).
[22] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[23] 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 a beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act**.
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during **each** claimed patient hospital day.[24]

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.

[24] (Bold emphasis added).

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 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.[25]

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

The Provider's preliminary position paper, filed May 31 2019, indicated that it would be sending the eligibility listing under separate cover.[26]

Board Rule 7.3.2[27] 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

[25] Individual Appeal Request, Issue 5.
[26] Provider's Preliminary Position Paper at 8.
[27] v. 2 (Aug. 2018).

> 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.[28]

The Provider did not submit a listing of Medicaid Eligible Days until March 21, 2024. The listing included no explanations for the delay in the submission. The Board finds the Provider essentially abandoned the issue by failing to properly develop its arguments in its preliminary position paper and failing to provide supporting documents or to explain why it could not timely produce those documents, as required by the regulations and the Board Rules.[29]

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

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

Similarly, with regard to position papers,[31] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[32] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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:

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

> *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.[33]

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.

---

[33] (Emphasis added).

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"[34] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to timely provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what caused the delay with Board Rule 25.2.2. Indeed, based on these facts, plus the Provider's failure to timely respond to either the Medicare Contractor's request for the listing or the Medicare Contractor's Jurisdictional Challenge on this issue, the Board must assume 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.[35]

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

****

In summary, the Board hereby dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 19-0078 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

6/21/2024

X Kevin D. Smith, CPA

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

[34] (Emphasis added).
[35] 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.

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

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

RE: ***Board Decision* – Medicaid Eligible Days Issue**
University Medical Center (Provider Number 45-0686)
FYE: 12/31/2014
Case Number: 19-0315

Dear Mr. Ravindran and Mr. Redmond,

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

Background:

A. *Procedural History for Case No. 19-0315*

On **April 27, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2014.

On **October 29, 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)[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
6. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days[5]
7. DSH Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[6]

[1] This issue was withdrawn on March 6, 2024.
[2] On May 30, 2019, this issue was transferred to PRRB Case No. 19-1573G.
[3] On May 30, 2019, this issue was transferred to PRRB Case No. 18-1257G.
[4] On May 30, 2019, this issue was transferred to PRRB Case No. 18-1259G.
[5] On May 30, 2019, this issue was transferred to PRRB Case No. 18-1258G.
[6] On May 30, 2019, this issue was transferred to PRRB Case No. 18-1260G.

8. UCC Distribution Pool[7]
9. 2 Midnight Census IPPS Payment Reduction[8]
10. Standardized Payment Amount[9]

There is one remaining issue in the appeal: Issue 5 (DSH Payment – Medicaid Eligible Days).

On **November 16, 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 **May 30, 2019**, the Provider timely filed its preliminary position paper.

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.[11]

On **January 5, 2022**, the Provider changed its designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **November 14, 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***

[7] This issue was withdrawn on March 6, 2024.
[8] On May 30, 2019, this issue was transferred to PRRB Case No. 18-1256G.
[9] On May 30, 2019, this issue was transferred to PRRB Case No. 19-0721G. **Note**: This issue was not a part of the initial appeal but was added on December 20, 2018.
[10] (Emphasis added).
[11] *See* Medicare Contractor's Preliminary Position Paper at 13-14 (Sept. 26, 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 **March 21, 2024**, the Provider timely filed its final position paper.

On **April 17, 2024**, the Medicare Contractor timely filed its final position paper.

On **April 17, 2024**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 5.

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 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): 7,20,23,S-D
> Estimated Reimbursement Amount: $36,000[13]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that, pursuant to the Jewish Hospital case[14] and HCFA Ruling 97-2, "all patient days for

[12] (Emphasis added).
[13] Appeal Request at Issue 5.
[14] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).

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]

MAC's Contentions

The MAC contends that the Provider is attempting to untimely and improperly add the issue of Section 1115 waiver days as a sub-issue via its final position paper, filed on March 21, 2024.[16] 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.[17] 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.[18]

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.[19]

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

> The MAC contends that the Provider violated Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary 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 and final position papers, the Provider fails to include any evidence to establish the material facts in its case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats the language found in its appeal request.[20]

[15] Provider's Preliminary Position Paper at 7 (May 30, 2019).
[16] Jurisdictional Challenge at 7-10 (Apr. 17, 2024).
[17] *Id*. at 9.
[18] *Id*. at 8-9.
[19] *Id*. at 10-11.
[20] *Id*. at 6.

Provider's Jurisdictional Response

The Provider argues that, in their initial appeal request, they "appealed all Medicaid eligible days, including section 1115 waiver days".[21] The Provider points out that the appeal statement reads, in pertinent part:

> 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.[22]

The Provider goes on to argue that Board Rules requiring components be appealed as separate issues does not apply here:

> Because Rule 8 purports to comply with what is in the regulations; and because the regulations deal with appealing issues, not "components" of issues, and because the regulations consider an "issue" to be a specific cost report adjustment, Rule 8's extension to "components" is not consistent with the regulations and is invalid because it is based on a false premise.
>
> Neither "section 1115 waiver days" nor even "Medicaid eligible days" are mentioned in Rule 8. Thus, even if Rule 8's extension to "components of issues" were valid (and the Provider contends it is not), the Provider had no notice that it was required to specify section 1115 waiver days in its appeal request, and it would be denial of due process for the PRRB to dismiss the section 1115 waiver days component of its appeal of Medicaid eligible days.
>
> The fact that the PRRB subsequently modified Rule 8 to mention specifically section 1115 waiver days indicates that the 2015 version of the PRRB's Rules did not contemplate that Plaintiff was required to include the magic language of "section 1115 waiver days" in its appeal request.[23]

The Provider also argues that it has not abandoned the section 1115 waiver days as "the Provider discusses section 1115 waiver days in its Final Position Paper."[24] The Provider also posits that the MAC's argument that the Provider did not brief the section 1115 waiver days in its

[21] Jurisdictional Response at 1 (May 22, 2024).
[22] *Id*. (Emphasis included).
[23] *Id*. at 3.
[24] *Id*.

Preliminary Position Paper is "not a jurisdictional argument and is inappropriate for a jurisdictional challenge."[25]

Board Decision

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

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 October of 2018 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing…must 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…[26]

Board Rule 7[27] elaborated on this regulatory requirement, instructing providers as follows:

> **7.2.1 General Information**

[25] *Id*.
[26] 42 C.F.R. § 405.1835(b).
[27] v. 2 (Aug. 2018).

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

Board Rule 8[28] explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: dual eligible Medicare Part A/Medicaid, dual eligible Medicare Part C/Medicaid, SSI data matching, state/program specific general assistance days, ***Section 1115 waiver days (program/waiver specific)***, and observation bed days.[29]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[30] 42 C.F.R. § 405.1835(e) (2016) 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

[28] *Id*.
[29] (Emphasis added).
[30] *See* 73 Fed. Reg. 30190 (May 23, 2008).

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

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

In this regard, the Board notes that section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[31] Rather, 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 a beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

[31] 65 FR 47054, 47087 (Aug. 1, 2000).

> **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 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.[32]

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.

[32] Individual Appeal Request, Issue 5.

The Provider's preliminary position paper, filed on May 30, 2019, indicated that it would be sending the eligibility listing under separate cover.[33]

Board Rule 7.3.2[34] states:

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

In this case, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.[35]

In actuality, the Provider did not submit a listing of Medicaid Eligible Days until February 27, 2024. The listing included no explanations for the delay in the submission. The Board finds the Provider 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.[36]

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*.[37]

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[33] Provider's Preliminary Position Paper at 8.
[34] v. 2 (Aug. 2018).
[35] *Id*.
[36] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.
[37] (Emphasis added).

Similarly, with regard to position papers,[38] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[39] 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.[40]

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:

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

> • 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"[41] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to timely provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what caused the delay with Board Rule 25.2.2. Indeed, based on these facts plus the Provider's failure to timely respond to either the Medicare Contractor's request for the listing and the Medicare Contractor's Jurisdictional Challenge on this issue, the Board must assume that the Provider 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.[42]

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

****

In summary, the Board hereby dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue, in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 19-0315 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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[41] (Emphasis added).
[42] 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.

Board Members Participating:

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

For the Board:

6/21/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Southern Virginia Regional Medical Center (Provider Number 49-0097)
FYE: 02/29/2016
Case Number: 19-0523

Dear Mr. Summar:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-0523. Set forth below is the decision of the Board to dismiss the 3 remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") SSI Percentage (Provider Specific), Medicaid Eligible Days, and Uncompensated Care ("UCC") payments.

Background

A. *Procedural History for Case No. 19-0523*

On **May 29, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end February 29, 2016. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **November 20, 2018**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

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

[1] On June 17, 2019, this issue was transferred to Case No. 19-1409GC.
[2] On June 17, 2019, this issue was transferred to Case No. 19-1410GC.

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

On **December 18, 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.[3]

On **January 15, 2019**, the Medicare Contractor requested the additional evidentiary documentation needed to support Provider's additional Medicaid days requested for Issue 3, to include a Medicaid eligibility listing to be submitted within 45 days from the date of the letter. The Provider failed to respond to this request.[4]

On **March 15, 2019**, the Medicare Contractor timely filed a Jurisdictional Challenge[5] with the Board over Issues 1, 4 and 5 requesting that the Board dismiss these issues. Issue 5 was later transferred to CIRP group appeal Case No. 19-1410GC on June 17, 2019.

On **April 10, 2019**, the Provider timely filed a response to the Medicare Contractor's Jurisdictional Challenge.

On **July 16, 2019**, the Provider timely filed its preliminary position paper. With respect to Issue 3, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, Provider made no such filing

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[3] (Emphasis added.)
[4] Medicare Contractor's Final Position Paper at 3, *See also,* Exhibit C-2 (Apr. 15, 2024).
[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).

and offered no explanation to explain why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days were at issue and instead asserted that "[b]ased on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 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."[6] As a result, the Provider included, as an Exhibit, the original "estimated impact" for this issue of $30,904, based on an *estimated* 50 days.

On **November 1, 2019**, 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 the Medicare Contractor's request for that Medicaid eligible days listing dated January 15, 2019.[7]

On **March 28, 2024**, the Provider filed its Final Position Paper. In support of its claim for additional Medicaid eligible days, the Provider included Exhibit P-1, an "Eligibility Listing" and added the *caveat* that the "[L]isting of additional Medicaid Eligible days being claimed is being submitted directly to the MAC. A redacted version of the same list is being included with this position paper."[8] The Provider's listing also stated it was "pending finalization upon receipt of State eligibility data."[9] The Listing was three pages long with roughly 321 Medicaid eligible days. Provider's filing did not explain why the listing of days was being submitted at this late date or why it was not final (*i.e.*, why it was "pending finalization") at this late date, ***more than 8 years after the fiscal year at issue had closed***. NOTE—the roughly 321 days included in this belated listing is *much* greater than the original *estimated* impact of 50 days included with the appeal request.

On **April 11, 2024**, the Medicare Contractor filed a second Jurisdictional Challenge with the Board over Issues 1, 3 and 4 requesting that the Board dismiss these issues.

On **April 15, 2024**, the Medicare Contractor filed its Final Position Paper. The Medicare Contractor, again, requested dismissal of Issue 1 and Issue 4. The Medicare Contractor also requested dismissal of the DSH Medicaid Eligible Days because: (1) the Provider failed to furnish documentation in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); (2) the Provider failed to furnish the Medicaid eligible days listing with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2; and (3) the Provider has effectively abandoned Issue 3.

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[6] Provider's Preliminary Position Paper at 8.
[7] Medicare Contractor's Preliminary Position Paper at 12.
[8] Provider's Final Position Paper, Exhibit P-1 (Apr. 15, 2024). (Emphasis added).
[9] *Id.*

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

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

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).[10]

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

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

[10] Issue Statement at 1 (Nov. 20, 2018).

Statement of the Legal Basis

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

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

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

On July 16, 2019, the Board received the Provider's preliminary position paper in 19-0523. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation based on the Provider's Fiscal Year End (February 29).

The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.

Similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services,* No. CV-94-0055 (C.D. Cal June 2, 1995), the SSI entitlement of individuals can be ascertained from [s]tate records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the

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

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

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

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 and states the following:

> In Issue 1 the Provider asserts 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." In Issue 2 the Provider asserts that "… 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." In both Issue 1 and Issue 2 the Provider is disputing whether the correct SSI percentage was used in computing its DSH payments. The accuracy of the SSI data is the underlying issue in both the DSH – SSI Percentage Provider Specific issue and the DSH – SSI Percentage issue.
>
> In Issue 1 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

[12] Provider's Preliminary Position Paper at 8-9 (Jul. 16, 2019).

> 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 statement is repeated by the Provider in Issue 2.
>
> The MAC respectfully requests the Board to consolidate the portions of Issue 1 concerning data accuracy and individuals who are eligible for SSI but did not receive SSI payment into Issue 2.[13]

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

> Issue 1 also 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 decision to realign a hospital's SSI percentage with its fiscal year end is a provider 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 the 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.[14]

In its second jurisdictional challenge, the MAC also argues that Provider has abandoned the issue of SSI realignment. The MAC contends:

---

[13] Jurisdictional Challenge at 5-6 (Mar. 15, 2019).
[14] *Id.* at 6.

> 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, the rule states:
>
> > Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.[15]

Issue 3 – DSH – Medicaid Eligible Days

The MAC argues that the Board should dismiss the DSH – Medicaid Eligible Days issue because the Provider has effectively abandoned the issue:

> According to the Provider's issue statement of the appeal request[,] all Medicaid eligible days were not included in the calculations of the DSH calculations. The Provider states Issue 3 as:
>
> > Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation…
>
> Specifically, the Provider contends that the MAC:
>
> > … 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.
>
> The MAC issued the NPR on 05/29/2018, and the Provider filed their appeal on 11/19/2018. 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.
>
> On 07/17/2019, the Provider filed its preliminary position paper. Within its position paper and Exhibit 1, the Provider indicates a listing of the additional Medicaid eligible days will be submitted directly to the MAC under separate cover. Within its final position paper submitted on 03/28/2024, the Provider submitted an incomplete and redacted listing, but did not explain why a full

[15] Jurisdictional challenge at 7 (Apr. 11, 2024).

> unredacted version was not available. This version does not meet the requirements to initiate a review. As of the filing of this jurisdictional challenge, the Provider has failed to submit a complete unredacted list of additional Medicaid eligible days to the MAC.[16]
>
> …
>
> 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 claim in its preliminary and final position papers. Pursuant to Board Rule 25.3, parties should file 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. The Board also added commentary to its rules stating that failure to file a complete preliminary position paper with the Board will result in dismissal of the appeal or other actions.
>
> …
>
> 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] 2016 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 its appeal request. Moreover, the list of additional Medicaid eligible days was redacted, incomplete and insufficient to meet the requirements to initiate review.
>
> …
>
> Notably, the Provider has not included a complete unredacted list of Medicaid eligible days with its preliminary or final position papers or submitted such list under separate cover. The Provider has not submitted accurate and sufficient data to demonstrate that patients were eligible for Medicaid on the contested claimed patient hospital days or identified why the data is not yet available or when it will become available. Therefore, the Provider is in

[16] Jurisdictional Challenge at 10-11 (Apr. 11, 2024).

> violation of the regulations at 42 C.F.R. §§ 413.24(c) and 412.106(b)(4)(iii) and the Board Rules and the MAC respectfully requests that the Board dismiss Issue 3.[17]

Regarding Issue 3, the MAC also argues that the Provider attempts to add a new issue, Section 1115 Waiver Days, improperly and untimely.

> The MAC contends that the Provider is attempting to untimely add the issue of Section 1115 waiver days by including it in the narrative of its preliminary position paper.
>
> Added issues must be added within 60 days of the expiration of the appeal filing deadline. The inclusion of any added issues in the Provider's position paper would have occurred after the deadline to add issues (i.e. 240 days after the NPR date).
>
> A provider's inclusion of this sub-issue in its preliminary position paper does not qualify as adding an issue.
>
> The Provider filed its individual appeal request pursuant to 42 C.F.R. § 405.1835(a)(3) which requires:
>
> > (3) Unless the provider qualifies for a good cause extension under §405.1836 of this subpart, the date of receipt by the Board of the provider's hearing request is –
> >
> > (i) No later than 180 days after the date of receipt by the provider [or] the intermediary or Secretary determination.
>
> 42 C.F.R. § 405.1835(b)(2) requires the appeal request to include:
>
> (2) [a]n explanation (for each specific item at issue…) of the provider's dissatisfaction with the contractor's… determination under appeal, including an account of all of the following:
>
> > (i) Why the Provider believes Medicare payment is incorrect <u>for each disputed item</u> (or where applicable, why the provider is unable to determine whether Medicare payment is correct

[17] *Id.* at 12-14.

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.

(Emphasis added).

…

42 C.F.R. § 405.1835(e) sets forth the requirements to add issues to an appeal after a hearing request has been filed, and states as follows:

(e) Adding issues to the hearing request. After filing a hearing request in accordance with paragraphs (a) and (b) or paragraphs (c) and (d), of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board only if –

(1) The request to add issues complies with the requirements of paragraphs (a)(1) and (b), or paragraphs (c) and (d), of this section as to each new issue.

(2) The specific matters at issue raised in the initial hearing request and the matters identified in subsequent requests to add issues, when combined, satisfy the requirements of paragraph (a)(2) or paragraph (c)(3) of this section.

(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.

According to Board Rule 6.2.1, an issue may be added 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." The original NPR was issued on 05/29/2018, thereby setting the period to add issues to close on 01/24/2019. The Provider did not raise the issue of Section 1115 Waiver Days in its appeal request on its preliminary position paper. Rather, the Provider first introduced the issue of Section 1115 Waiver Days in its final

> position paper which was filed on 03/28/2024, over five years after the deadline to add new issues.
>
> Specifically, the Provider modified Issue 3 in its final position paper as follows:
>
> > 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).
>
> Again, the issue the Provider is now trying to address was not timely added, and even if it had been timely as part of the position paper, this does not constitute adding an issue. Moreover, the Provider did not formally add the disputed issue to the appeal request via a Model Form C. The Section 1115 Waiver Days issue is a separate and distinct issue from the Medicaid eligible days that was originally appealed and should be considered a part of this appeal. Therefore, the Section 1115 Waiver Days issue should be dismissed.[18]

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). 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. 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…
>
> …
>
> The D.C. Circuit Court has repeatedly maintained this position in subsequent cases, and the Board has consistently ruled that it lacks

[18] *Id.* at 14-15.

> jurisdiction over the UCC DSH issue. Therefore, the MAC respectfully requests that the Board dismiss Issue 4.[19]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[20] The Provider has not filed a response to the second Jurisdictional Challenge filed by the MAC on April 11, 2024, 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."

On April 10, 2019, the Provider timely filed a response to the Medicare Contractor's first Jurisdictional Challenge, and presented the following arguments:

> **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 determination by the [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.

[19] *Id.* at 18.
[20] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

SSI Provider Specific Issue:

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

Accordingly, this is an appealable item because the MAC specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2016, as a result of its understated SSI percentage due to errors of omission and commission.[21]

Uncompensated Care ("UCC") Distribution Pool

(a) The Statute does not authorize the Secretary to Estimate the Uninsured Patient Population Percentage

The MAC argues that the Secretary's *"estimates"* are shielded from review. However, this ignores the central point that the Secretary is not authorized to "*estimate"* the uninsured patient percentage.

The DSH statute does not use the word *"estimate"* in connection with the computation of the second prong of Factor 2, i.e. the FY 2014-2017 nationwide uninsured patient percentage. 42 U.S.C. § 1395ww(r)(2)(B)(i)(II). The omission of the term *"estimate"* from

[21] Provider's Jurisdictional Response at 2 (Apr. 10, 2019).

> the second prong of Factor 2 was evidently deliberate, given that the word was employed elsewhere in numerous instances in the same section of the statute. *See Georgetown University Hosp. v. Bowen,* 862 F.2d 323, 327 (D.C. Cir. 1988). *"Indeed, the Secretary acknowledged that elsewhere in the same section of the statute Congress expressly indicated when the Secretary's estimates would constitute key components of the PPS rates … In these passages and others, Congress showed that it knew how to enshrine estimates into the rate calculations when it so desired."*
>
> Notwithstanding CMS position to the contrary, the Secretary should be required to reconcile her initial estimate of the uninsured patient percentage with actual data when it becomes available after the close of the year. Only *"estimates"* are subject to the ban on administrative or judicial review. 42 U.S.C. § 1395ww(r)(3). Therefore, the PRRB has jurisdiction over provider challenges to the uninsured patient percentage computed by the Secretary on the basis that such computation is not supposed to be an *"estimate."*
>
> We also wish 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. Assuming such subsidies are held to be illegal, this could result in a significant increase in the uninsured patient population for 2015 and beyond. 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.
>
> **(b) The 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 similarly. Thus, administrative review should be available if judicial review is also available.[22]

The Provider's jurisdictional response only addressed Issues 1 and 4. There is nothing in the record to show that the Provider responded to the MAC's second jurisdictional challenge, which

[22] *Id.* at 3-4.

also challenged Issue 3, DSH Medicaid eligible days and the improper addition of the Section 1115 Waiver Days issue.

Decision of the Board

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

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

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. *First Aspect of Issue 1*

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

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."[23] 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)."[24] 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."[25]

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

[23] Issue Statement at 1.
[24] *Id.*
[25] *Id.*

the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 19-0523 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[26], 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.[27] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors are specific to this provider.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 19-1409GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records" but fails to explain how it can be done, to explain how that information is relevant, and whether or not such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2.[28] Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Aug. 29, 2018), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the

[26] PRRB Rules v. 2.0 (Aug. 2018).
[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).
[28] 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.

> 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.[29]

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. [30]

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."[31]

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

[29] (Italics and underline emphasis added.)
[30] Last accessed June 21, 2024.
[31] Emphasis added.

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. 19-0523 and the group issue from the CHS CIRP group under Case No. 19-1409GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

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

B. DSH Payment – Medicaid Eligible Days

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 preliminary position paper.

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

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

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

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the

> appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[32]

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

> **Rule 25 Preliminary Position Papers**[33]
>
> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the following sub-sections.
>
> **25.1.1 The Provider's Position Paper**
>
> A. Identify any issues that were raised in the appeal but are

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

already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.

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

* * *

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on December 18, 2018 included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

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

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

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

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

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

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

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board

[34] (Emphasis added.)

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

On July 16, 2019, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[35] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $31,000 based on an estimated 50 days). The Provider's complete briefing of this issue in its position paper is as follows:

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

[35] Provider's Preliminary Position Paper at 8 (Jul. 16, 2019).

> state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[36]

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

Notably, the Medicare Contractor sent a request for the Provider's list of Medicaid Eligible days (and also discussed the lack of the listing in the Medicare Contractor's own position paper filing). The notice was sent to the Provider on January 15, 2019. The Provider failed to file any response to this request.

The Medicare Contractor filed a second Jurisdictional Challenge on April 11, 2024 requesting dismissal of the DSH Medicaid Eligible Days because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish the list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2 (or when requested by the Medicare Contractor). 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.[37]

However, on March 28, 2024, Provider filed its final position paper and Exhibit P-1, an "Eligibility Listing" and added the *caveat* that the "[L]isting of additional Medicaid Eligible days being claimed is being submitted directly to the MAC. A redacted version of the same list is being included with this position paper." The Provider added the caveat that the "Listing [is] pending finalization upon receipt of State eligibility data." The Listing was three pages with roughly 321 Medicaid eligible days. Provider's filing did not explain why the listing of days (again around 321 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 8 years after the fiscal year at issue had***

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

[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.

closed. NOTE—the roughly 321 days included in this belated listing is much larger than the original estimate of 50 days included with the appeal request and referred to in the preliminary position paper..

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 with Provider's final position paper 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 MAC's request in January, 2019. The Board rejects the Provider's attempt to include the redacted eligibility listing with March 28, 2024 final position paper for the following reasons:

1. The listing was filed ***more than five years*** *after the deadline* for that exhibit to be included with its preliminary position paper filing, consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)). Indeed, the Provider also failed to timely reply to the Medicare Contractor's request for the information in January, 2019.

2. The listing fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the roughly 321 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 almost 6 years after this appeal was filed in 2018, and more than 8 years after the fiscal year at issue had closed); and (c) why the listing still was ***not*** a "*final*" listing at this late date.

3. Neither the Board Rules nor the December 18, 2018 Case Acknowledgment and Critical Due Dates permit the Provider to file a "Supplement" to its preliminary position paper (nor did the Provider allege in the "Supplement" filing that they do).

4. Given the fact that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the position paper filing, if the Board were to accept the late filing, 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,

> the preliminary position paper did not identify any "unavailable" exhibits, consistent with Board Rule 25.2.2. Further, the listing cannot be considered a refinement of the position paper since no specific days or listing were included with the preliminary position paper (indeed the *tentative* 321 days listed is, without explanation, much larger than the original estimated 50 days included with the appeal request).[38]

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

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable.[40]

C. 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.

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[38] *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."

[39] (Emphasis added.)

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

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

The appeal was filed with the Board in November of 2018 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing…must 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…[41]

Board Rule 7[42] elaborated on this regulatory requirement instructing providers:

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

[41] 42 C.F.R. § 405.1835(b).
[42] v. 2 (Aug. 2018).

Board Rule 8[43] explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: dual eligible Medicare Part A/Medicaid, dual eligible Medicare Part C/Medicaid, SSI data matching, state/program specific general assistance days, ***Section 1115 waiver days (program/waiver specific)***, and observation bed days.[44]

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.[45] 42 C.F.R. § 405.1835(e) provides in relevant part:

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

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

In this regard, the Board notes that section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[46] 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

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[43] *Id*.
[44] (Emphasis added).
[45] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[46] 65 FR 47054, 47087 (Aug. 1, 2000).

expansion program ***and*** not every inpatient day associated with a beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

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

D. UCC Distribution Pool

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

1. Bar on Administrative Review

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

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[47]
>
> (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*"),[48] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[49] 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

[47] 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.
[48] 830 F.3d 515 (D.C. Cir. 2016).
[49] 89 F. Supp. 3d 121 (D.D.C. 2015).

data as well."[50] 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.[51]

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.[52]

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*").[53] 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."[54] 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.[55]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[56] 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.[57] 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

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[50] 830 F.3d 515, 517.
[51] *Id.* at 519.
[52] *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*").
[53] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[54] *Id.* at 506.
[55] *Id.* at 507.
[56] 514 F. Supp.3d 249 (D.D.C. 2021).
[57] *Id.* at 255-56.

DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[58] 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.[59] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[60]

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.[61]

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."[62] 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.[63] 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.[64]

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[58] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[59] *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.
[60] *Id.*
[61] *Id.* at 262-64.
[62] *Id.* at 265.
[63] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[64] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).

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.[65] 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*").[66] 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.[67] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the provider's claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."[68] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[69] 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***."[70]

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

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[65] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[66] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[67] *Id*. at *127.
[68] *Id.* at *134.
[69] 139 S. Ct. 1804 (2019).
[70] *Ascension* at *132 (bold italics emphasis added).

* * * * *

Based on the foregoing, the Board has dismissed the three (3) remaining issues in this case – (Issues 1, 3 and 4). As no issues remain, the Board hereby closes Case No. 19-0523 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

6/22/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

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

RE: ***Board Decision* – SSI Percentage (Provider Specific) & Uncompensated Care Distribution Pool Issues**
Southside Regional Medical Center (Provider Number 49-0067)
FYE: 02/29/2016
Case Number: 19-1063

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. 19-1063*

On **July 27, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end February 29, 2016.

On **January 15, 2019**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

As 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 **August 23, 2019**, the Provider transferred Issues 2 and 5 to Community Health groups. As a result, there are two (2) remaining issues in this

[1] On August 23, 2019, this issue was transferred to PRRB Case No. 19-1409GC.
[2] This issue was withdrawn on June 10, 2024.
[3] On August 23, 2019, this issue was transferred to PRRB Case No. 19-1410GC.

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

On **February 11, 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 **May 6, 2019**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1, 4 and 5.[5]

On **September 6, 2019**, the Provider timely submitted its preliminary position paper.

On **December 10, 2019**, the Medicare Contractor timely filed its preliminary position paper.

On **December 16, 2022**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

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 requirements. If the Provider misses its due date, the Board will dismiss the cases.[6]

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[4] (Emphasis added).
[5] As previously noted, Issue No. 5 was subsequently transferred to PRRB Case No. 19-1410GC on Jan. 22, 2020.
[6] (Emphasis added).

On **April 8, 2024**, the Provider timely submitted its final position paper.

On **April 15, 2024**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1, 3 and 4.[7] This supplemented the prior jurisdictional challenge of Issue Nos. 1 and 4 from May 6, 2019.

On **May 6, 2024**, the Medicare Contractor timely submitted its final position paper.

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.[8]

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

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

[7] As previously noted, Issue No. 3 was subsequently withdrawn. It had previously been challenged in a Jurisdictional Challenge filed on Nov. 14, 2022, and a Motion to Dismiss filed on Dec. 28, 2022.
[8] Issue Statement at 1 (Jan. 15, 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 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.[9]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $79,000.

On September 6, 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 (February 29).

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

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

> 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).[10]

On April 8, 2024, the Provider filed its final position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its record with CMS data and identify records that CMS failed to included 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 (Appeallants' reply brief included as Exhibit P-3).[11]

[10] Provider's Preliminary Position Paper at 8-9 (Sept. 6, 2019).
[11] Provider's Final Position Paper at 8-9 (Apr. 8, 2024).

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue for two reasons. First, the MAC argues that the SSI realignment portion of the issue is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The 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.[12]

The MAC also argued that the Provider failed to brief the SSI realignment issue in their final position paper and therefore, it should be considered withdrawn, as per Board Rules 25.3 and 27.2.[13]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are duplicates.[14]

Finally, "the MAC contends that the Provider was in violation of Board Rules 25.3 and 27.2 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary and final position papers."[15]

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)."[16]

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[12] Jurisdictional Challenge #1 at 6 (May 6, 2019).
[13] Jurisdictional Challenge #2 at 7 (Apr. 15, 2024).
[14] Jurisdictional Challenge #1 at 5-6.
[15] Jurisdictional Challenge #2 at 10.
[16] *Id*. at 19.

The MAC further contends that this issue is a duplicate of PRRB Case Nos. 15-1134GC and 16-0769GC and should therefore, be dismissed.[17]

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.[18] The Provider has not filed a response to the 2019 or 2024 Jurisdictional Challenges 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 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 two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

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

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[19] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare

[17] *Id*. at 20.
[18] Board Rule 44.4.3, v. 2 (Aug. 2018). This rule was also in place for the second Jurisdictional Challenge via Board Rule v. 3.2 (Dec. 2023).
[19] 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)."[20] 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."[21]

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

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case 19-1409GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[23] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-1409GC.

To this end, the Board also reviewed the Provider's Preliminary and Final Position Papers to see if 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 Preliminary and Final Position Papers failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its

[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).

position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary and Final Position Papers and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[24]

The 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. [25]

[24] (Emphasis added).
[25] Last accessed June 25, 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."[26]

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 19-1409GC are the same issue.[27] 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 statement of the issue, 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)."[28] 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 or how these arguments are specific to the present case.

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*.[29]

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

2. Second Aspect of Issue 1

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

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal

[26] Emphasis added.
[27] 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).
[28] Provider's Final Position Paper at 9.
[29] (Emphasis added).

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).[30]

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).[31]
>
> (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*"),[32] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[33] 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

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[30] The Provider was also a participant in PRRB Case Nos. 16-0769GC (appealing from the Fed. Reg. dated Aug. 17, 2015 and covers service dates July 1, 2016 through Sept. 30, 2016) and 17-1150GC (appealing from the Fed. Reg. dated Aug. 22, 2016 and covers service dates Oct. 1, 2016 through June 30, 2017). Both CIRP Group appeals have been dismissed for a lack of jurisdiction.

[31] 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.

[32] 830 F.3d 515 (D.C. Cir. 2016).

[33] 89 F. Supp. 3d 121 (D.D.C. 2015).

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."[34] 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.[35]

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.[36]

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*").[37] 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."[38] 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.[39]

[34] 830 F.3d 515, 517.
[35] *Id.* at 519.
[36] *Id.* at 521-22.
[37] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[38] *Id.* at 506.
[39] *Id.* at 507.

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[40] 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.[41] 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.[42] 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.[43] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[44]

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.[45]

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

[40] 514 F. Supp. 249 (D.D.C. 2021).
[41] *Id.* at 255-56.
[42] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[43] *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.
[44] *Id.*
[45] *Id.* at 262-64.
[46] *Id.* at 265.

review is precluded by statute, the criteria in *Scranton* were not met.[47] For review to be available in these circumstances, the following criteria must be satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[48]

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.[49] 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*").[50] 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.[51] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the provider's claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."[52] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[53] 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***."[54]

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

[47] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[48] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[49] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[50] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[51] *Id*. at *127.
[52] *Id.* at *134.
[53] 139 S. Ct. 1804 (2019).
[54] *Ascension* at *132 (bold italics emphasis added).

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. The Board also dismisses the UCC Distribution Pool issue as the Board does not have jurisdiction because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation. As no issues remain pending, the Board hereby closes Case No. 19-1063 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

6/25/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Shelly Geis
Kate Dishman Rehabilitation Hospital
2830 Calder St. 6th Floor South
Beaumont, TX 77702

Re: ***Dismissal for Untimely Filed Appeal That Does not Meet Minimum Filing Requirements***
Case No. 24-1976 – Kate Dishman Rehabilitation Hospital, Prov. No. 67-3030, FYE 06/30/2024

Dear Ms. Geis:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced appeal to which it has assigned Case No. 24-1976. After review of the facts outlined below, the Board has determined that the appeal must be dismissed pursuant to 42 C.F.R. § 405.1835 and Board Rules. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

On **June 21, 2024**, Kate Dishman Rehabilitation Hospital (the "Provider") filed an appeal with the Board to establish Case No. 24-1976. The appeal was filed from a determination entitled "Notice of Quality Reporting Program Noncompliance Decision Upheld" ("Quality Reporting Determination") dated **October 13, 2023**. The appeal was filed 252 days after issuance of the Quality Reporting Determination.

In addition, although the appeal included various support documents specifically labeled "Representative Letter", "Issue Statement Document" and "Other Issue Document," each upload is a copy of a one paragraph letter which states:

> This letter is in response to the 2% reduction to our FY 2024 annual increase factor for CNN 673030. Please see attached documentation that shows all of our CY 2022 quality reporting has been submitted for the whole year of 2022. We would greatly appreciate your reconsideration.

This document does not, however, constitute a proper issue statement as required in Board Rule 7.2 nor does it meet the requirements of a Representative letter as indicated in Board Rule 5.4.[1]

Rules/Regulations:

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

[1] Board Rules Version 3.2 (Dec 15, 2023)

more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

In addition, 42 C.F.R. § 405.1835(b) establishes the required contents for an appeal request.

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

Board Rules 6, 7 and 8 further address individual appeal requirements and support for the appealed final determination, availability of issue-related information, and the basis for dissatisfaction. Specifically, Board Rule 6.1.1, advises that the Board will dismiss appeal requests that do not meet the *minimum* filing requirements as identified in 42 C.F.R. § 405.1835(b).

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

Board Determination:

After its review, the Board has determined that the Provider's appeal request is fatally flawed as it was not filed in accordance with the regulations at 42 C.FR. §§ 405.1835(a)(3) and 405.1835(b).

As noted in the facts above, the Medicare Contractor issued the Quality Reporting determination for Kate Dishman Rehabilitation Hospital on October 13, 2023. The 185th day fell on Monday, April 15, 2024. The individual appeal was not filed until Friday, June 21, 2024, which was well beyond 185 days after the issuance of the final determination.[2] Secondly, the Board finds that the document labeled by the Provider as an "Issue Statement" does not constitute an issue statement consistent with the appeal content requirements in Board Rule 7.2 and 42 C.F.R. § 405.1835(b). Board Rule 7.2 requires, among other things, the controlling authority (e.g. specific regulation . . . manual provision, or Ruling), why the adjustment(s) is incorrect, how it should be determined differently, etc.[3]

Accordingly, the Board hereby dismisses Case No. 24-1976 because it was not timely filed in accordance with 42 C.F.R.§ 405.1835(a)(3) and pursuant to 42 C.F.R. § 405.1835(b), the appeal does not meet the minimum filing requirements. Therefore, the Board closes this case and removes it from its docket.

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

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

For the Board:

6/27/2024

X Ratina Kelly

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

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

[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 must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination." There was no allegation of good cause filed with the request for appeal in any of the Provider's support documents.

[3] The Board notes that the Provider uploaded a copy of the same document as the Representative letter. Although this letter is not technically a designation of Representative as required, the Board finds that the letter does include the majority of required information (i.e. the provider name, provider number, fiscal year under appeal, and contact information for the case representative) although it omitted the Provider contact's email address.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21207
410-786-2671

Via Electronic Delivery

Byron Lamprecht
WPS Government Health Administrators
1000 N. 90th St., Ste. 302
Omaha, NE 68114-2708

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

RE: ***Denial of Request for Remand and Notice of Dismissal***
QRS HMA 06-07 DSH SSI Denominator Days Group
PRRB Case No. 09-1597GC

Dear Mr. Lamprecht and Mr. Ravindran:

The Board received the Providers' Request for Remand pursuant to CMS Ruling 1498-R filed on June 4, 2024. The decision of the Board to deny the request and dismiss the case is set forth below.

BACKGROUND

On **April 28, 2009**, the Board received a common issue related party ("CIRP") group appeal request which covered Fiscal Years ending September 30, 1997 to September 30, 2008. The Group Issue submitted with this appeal request was as follows:

> **Group Issue: Disproportionate Share – Problems in the Denominator of the SSI Percentage, including the exclusion of Part C Days**
>
> **Description of the Issue**
>
> Whether the Intermediary correctly determined denominator [*sic*] of the SSI percentage of the Disproportionate Share Payment calculation
>
> **Statement of Legal Basis**
>
> According to Medicare Statute and Regulations the SSI percentage is to be determined based upon the number of patients entitled to both SSI and Medicare Part A. Among other problems with the SSI denominator, CMS included Medicare Part C/Medicare + Choice patents in the calculation of the Provider's SSI percentage. As clarified in the Federal Register of May 19, 2003, an individual is eligible to elect a Medicare + Choice plan if he or she is entitled to

> Medicare Part A and enrolled in Part B however once the beneficiary has elected to join a Medicare + Choice plan their benefits are no longer administered under Part A. CMS therefore clarified in the proposed rule that once a beneficiary elected Medicare Part C, those patent days attributable to the beneficiary should be included in the Medicaid fraction and not be included in the Medicare fraction of the DSH patient percentages. The Provider contends that the Intermediary's calculation of the DSH Payment adjustment is not in accordance with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) because of errors in determining the denominator of the Medicare Percentage.

On **May 7, 2009**, the Board sent a Group Acknowledgement noting that the FYEs 2005-2008 in the appeal request were assigned to Case No. 09-1597GC entitled "*QRS HMA 05-08 DSH SSI Denominator Days*." The Board also created Case No. 09-1596GC entitled "*QRS HMA 97-04 DSH SSI Denominator Days*."

On **February 13, 2012**, the Board issued a letter closing for Case No. 09-1596GC because no providers were ever added to the case. It also revised the case name for Case No. 09-1597GC to "*QRS HMA 06-07 DSH SSI Denominator Days Group*" to reflect the actual fiscal years in dispute; all of the providers in the group has fiscal years ending in 2006 and 2007 (and none for 2005 or 2008). On **November 13, 2014**, the Providers' Representative notified the Board that the group was complete and fully formed.

On **July 6, 2015**, the Providers filed a letter with the Board stating:

> QRS contends that the Disproportionate Share Hospital/Supplemental Security Income Denominator Day issue is subject to the Centers for Medicare and Medicaid Services Ruling 1498-R and respectfully requests PRRB Case Number 09-1597GC be remanded.

On **December 29, 2015**, the Board issued a decision related to the Providers' July 6, 2015 request for remand. The Board explained that it had already remanded Case Nos.13-0310GC[1] and 13-0309GC[2] on April 7, 2014 and April 24, 2014, respectively, pursuant to CMS Ruling 1498-R. Those two cases included all of the FYE 2006 and 2007 providers present in Case No. 09-1597GC. It also noted that the issue under appeal in Case No. 09-1597GC was a challenge to the inclusion of Medicare + Choice ("Part C") days in the calculation of the SSI percentage. It specifically found that "the issue in the subject group appeal is limited to that which was expressed in the original appeal request – the inclusion of Medicare + Choice days in the SSI denominator." The Board also explained that CMS Ruling 1498-R did not apply to pending appeals on Medicare Part C days for patients who were receiving Medicare benefits under Part C of the Medicare statute through enrollment in a Medicare + Choice or Medicare Advantage plan.

[1] *QRS HMA 2007 DSH SSI Percentage CIRP Group*.
[2] *QRS HMA 2006 DSH SSI Percentage CIRP Group.*

On **April 13, 2018,** the Board granted Expedited Judicial Review ("EJR") in Case Nos. 13-0312GC[3] and 13-0313GC.[4] Similarly, on April 4, 2019, the Board granted EJR in Case Nos. 13-2995GC[5] 13-3075GC.[6] These group cases concerned the same providers as Case No. 09-1597GC for FYs 2006 and 2007 and were challenging the treatment of Part C days in the DSH calculation.

BOARD DECISION

On June 4, 2024, the Providers' Representative filed a Request for Remand stating:

> The instant group appeal includes a challenge to the data matching process used in calculating the Supplemental Security Income (SSI) fraction. Under the terms of the Centers for Medicare & Medicaid Services (CMS) Ruling CMS-1498-R (1-3), this issue is to be remanded to the Intermediary. Accordingly, the Providers respectfully request that the PRRB remand this group appeal under the terms of 1498-R.

The Board finds that the Provider has *improperly* attempted to expand the appealed issue in both of its Final Position Papers and, in doing so, improperly ignored the prior Board ruling in this case dated December 29, 2015 specifically finding that this group did not encompass the data matching issue. In its Final Position Paper filed on July 30, 2015, the Providers stated they disagreed with how the disproportionate share hospital ("DSH") percentage was calculated and that the SSI Fractions used were not in accordance with their underlying records.[7] They made several arguments related to the availability of underlying records used to calculate SSI Fractions, the data matching process used for SSI Fractions as outlined in *Baystate*, the inclusion of "non-covered" or exhausted benefit days in the DSH calculation, and the treatment of Part C days in the DSH calculation.

Similarly, the Providers filed a new Final Position Paper filed on March 19, 2024 pursuant to the Notice of Hearing issued on December 1, 2023. They make many of the same arguments from their original Final Position Paper and frame the issue in this appeal as "Inconsistent Interpretation of 'Entitled.'" The Providers claim that ***both*** the SSI and Medicaid Fractions in their DSH calculations were inconsistent with the Medicare statute.

The Board reaffirms its holding in its December 29, 2015 decision that the issue under appeal in Case No. 09-1597GC is ***only*** a challenge to the inclusion of Part C days in the calculation of the SSI percentage. Accordingly, the Board ***denies*** the Request for Remand pursuant to CMS

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[3] *QRS HMA 2006 DSH Medicare Managed Care Part C Days CIRP Group.*
[4] *QRS HMA 2007 DSH Medicare Managed Care Part C Days CIRP Group.*
[5] *QRS HMA 2006 DSH Medicare Managed Care Part C Days CIRP Group (2).*
[6] *QRS HMA 2007 DSH Medicare Managed Care Part C Days CIRP Group 2.*
[7] Provider's Final Position Paper at 3 (July 30, 2015).

Ruling 1498-R because that Ruling does ***not*** apply to the issue in this case and, in fact, was already adjudicated in Case Nos. 13-0310GC and 13-0309GC.

In addition, the Board finds that the Providers in the instant case have *already* pursued the Part C Days issue for the same fiscal years in Case Nos. 13-0312GC, 13-0313GC, 13-2995GC, and 13-3075GC. The Board's Rules prohibit providers from appealing an issue from a final determination in more than one appeal and commonly owned providers must pursue a common issue for a year in only one CIRP group pursuant to 42 C.F.R. § 405.1837(b)(1), (e)(1).[8] Accordingly, because the Part C days issue is duplicative, and duplicative issues appealed from the same final determination for the same year are prohibited by the Board's Rules as well as the CIRP group rules governing commonly owned providers at 42 C.F.R. § 405.1837(b)(1) and (e)(1), the Board hereby dismisses the instant group appeal and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

6/27/2024

X Clayton J. Nix

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

cc: Wilson Leong, FSS

[8] Board Rule 4.5 (2008); Board Rule 4.5 (2009); Board Rule 4.5 (2013).

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

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

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

RE: ***Board Dismissal of DSH Payment -Provider Specific Issue***
Progress West Hospital (Provider Number: 26-0219)
FYE: 12/31/2019
Case Number: 24-0288

Dear Messrs. Kramer 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. 24-0288*

On **May 30, 2023**, Progress West Hospital ("Progress West" or "Provider") was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2019.

On **November 28, 2023**, the Board received the Provider's individual appeal request filed by Quality Reimbursement Services, Inc. ("QRS"). The Individual Appeal Request, which was assigned Case No. 24-0288, included two (2) issues:

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

After the withdrawal of the Medicaid Eligible Days issue, the only remaining issue in this appeal is Issue 1, DSH Payment/ SSI Percentage (Provider Specific.)

B. Description of Issue 1 in Case No. 24-0288

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

[1] The Provider withdrew this issue on 6/4/2024.

> 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 pursuant to 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).[2]

The Board notes that this Provider was directly added to a BJC Healthcare Common Issue Related Party ("CIRP") group for the SSI Percentage issue under Case No. 22-0434GC, *BJC Healthcare CY 2019 DSH SSI Percentage CIRP Group*. The Group Issue Statement in Case No. 22-0434GC describes the issue in dispute as:

> The Providers contend that the Lead MAC's determination of Medicare Reimbursement for their DSH payments are not in accordance with the Medicare statute 42 U.S.C. §1395ww(d)(5)(F)(i). The Providers further contend that the SSI percentages calculated by [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

[2] Provider Request for Hearing, Issue Statement (Nov. 28, 2023).

3. Not in agreement with provider's records
4. Fundamental problems in the SSI percentage calculation
5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.[3]

Board Analysis and Decision:

The Board is reviewing the last remaining issue in this appeal on its own motion.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2013), 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 SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 22-0434GC.

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."[4] The Provider's legal basis for its DSH Payment–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)."[5] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Lead 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."[6]

[3] See Group Issue Statement, PRRB Case No. 22-0434GC.
[4] Issue Statement at 1.
[5] *Id.*
[6] *Id.*

The DSH – SSI Percentage (Systemic Errors) issue pending in the BJC Healthcare group, Case No. 22-0434GC also alleges that the Lead 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). Pursuant to 42 C.F.R. § 405.1837(b)(1):

> 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 of fact or interpretation of law, regulations, or CMS Rulings 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.

Thus, the Board finds the first aspect of Issue 1 in Progress West's individual appeal to be duplicative of the SSI Systemic issue in Case No. 22-0434GC, for CY 2019. 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, to that end, BJC Healthcare is pursuing that issue as part of the group under Case 22-0434GC. 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.[7] In this respect, the Provider in this case has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the issue appealed in Case No. 22-0434GC, even if the Provider considers that group issue to be "systemic" rather than provider-specific.

Accordingly, the Board finds that Issue 1 in Case No. 24-0288 and the group issue in Group Case No. 22-0434GC, are the same issue. Because the issue is duplicative of the specific matter appealed in the group appeal, this aspect of the issue is hereby dismissed from the individual appeal, Case No. 24-0288.

Relatedly, the Board points BJC Healthcare to Board Rule 4.6, which prohibits duplicative issues appealed from the same final determination or from multiple distinct determinations being pursued in multiple cases.[8]

B. 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.

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[7] 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).
[8] PRRB Rules v. 3.1 (Nov. 2021).

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 the Provider's DSH SSI Percentage realignment. Therefore, the Board dismisses this aspect of the appeal.

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In summary, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue from Case No. 24-0288 is duplicative of the issue in Case No. 22-0434GC and that there is no final determination from which the Provider can appeal the SSI realignment portion of the issue and dismisses those aspects of the issue. As no issues remain pending, the Board hereby closes Case No. 24-0288 and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

6/27/2024

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