DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Board Decision* – SSI Percentage (Provider Specific) Issue**
AllianceHealth Midwest (Provider Number 37-0094)
FYE: 06/30/2019
Case Number: 23-0328

Dear Mr. Ravindran and Mr. Lamprecht:

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

Background:

A. *Procedural History for Case No. 23-0328*

On **June 22, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2019.

On **November 29, 2022**, the Board received the Provider's individual appeal request. The Individual Appeal contained five (5) issues:

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

[1] On June 9, 2023, this issue was transferred to 22-1031GC.
[2] On February 23, 2024, this issue was withdrawn with an agreement to reopen/revise the cost report.
[3] On June 9, 2023, this issue was transferred to 23-0078GC.
[4] On February 7, 2024, this was bifurcated into two separate issues: Issue No. 5 – SSI Fraction Dual Eligible Days and Issue No.6 – Medicaid Fraction Dual Eligible Days. On February 13, 2024, Issue 5 was transferred to 22-1006GC, and Issue 6 was transferred to 23-0079GC.

As the Provider is owned by Community Health Systems, Inc. ("Community Health") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issue Nos. 2, 4, 5, and 6 to a Community Health CIRP group. After the withdrawal of Issue 3, the remaining issue in this appeal is Issue 1 (DSH Payment/SSI Percentage (Provider Specific)).

On **July 5, 2023**, the Provider timely filed its preliminary position paper.

On **August 29, 2023**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue Nos. 1, 3, and 5. Issue 3 was later withdrawn, and Issue 5 was transferred, leaving only Issue 1 remaining.

On **October 26, 2023**, the Medicare Contractor timely filed its preliminary position paper.

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

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

> The Provider contends that its' SSI percentage published by 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 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.

The group issue statement in Case No. 22-1031GC, CHS CY 2019 DSH SSI Percentage CIRP Group, to which the Provider transferred Issue 2 reads, in part:

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

include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

Statement of the Legal Basis

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

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

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

On **July 5, 2023**, the Provider filed its preliminary position paper. The following is the Provider's complete position on Issue 1 set forth therein:

Calculation of the SSI Percentage

The Provider contends that the MAC's determination of Medicare Reimbursement for DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww (d)(S)(F)(i). The Provider contends that the SSI percentage calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Report was incorrectly computed because of the following reasons:

Issue #1: Provider Specific

The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was

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

> incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission *in Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[6]

MAC's Contentions

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

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final [Medicare Contractor] determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. To date, the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the [Board] dismiss this issue consistent with recent jurisdictional decisions.[7]

[6] Provider's Preliminary Position Paper at 8-9 (July 5, 2023).
[7] Jurisdictional Challenge at 6-7 (Aug. 29, 2023).

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH/SSI issue that was transferred to PRRB Case No. 22-1031GC are considered the same issue by the Board.[8]

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.[9] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Similarly, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Board Decision

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

The jurisdictional analysis for Issue 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. As set forth below, the Board dismisses all aspects of Issue 1.

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 22-1031GC.

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

[8] *Id*. at 2.
[9] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

Income percentage in the Disproportionate Share Hospital calculation."[10] 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)."[11] 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."[12]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 22-1031GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage issue in Case No. 22-1031GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6,[13] the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 22-1031GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[14] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 22-1031GC.

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

> **25.2 – Position Paper Exhibits**
>
> **25.2.2 Unavailable and Omitted Documents:**

[10] Issue Statement at 1.
[11] *Id.*
[12] *Id.*
[13] PRRB Rules v. 3.1 (Nov. 2021).
[14] 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).

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

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

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

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

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[15]

This CMS webpage describes access to DSH data **from 1998 to 2022** and instructs providers to send a request via email to access their DSH data.[16]

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

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[15] Last accessed August 7, 2024.
[16] Emphasis added.

Accordingly, *based on the record before it*,[17] the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 22-1031GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

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

* * * * *

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 22-1031GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue.

Since no other issue remains, the case will be closed.

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 Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

8/7/2024

X Kevin D. Smith, CPA

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

[17] Again, the Board notes that the Provider failed to respond to the Jurisdictional Challenge and the Board must make its determination based on the record before it.

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision***
Abilene Regional Medical Center (Provider Number 45-0558)
FYE: 08/31/2017
Case Number: 20-0079

Dear Messrs. Ravindran and Lamprecht,

The Provider Reimbursement Review Board ("PRRB" or "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. 20-0079

On **April 1, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end August 31, 2017.

On **September 30, 2019**, the Provider's representative, Community Health Systems ("CHS"), filed the Provider's appeal request with the Board appealing the following five (5) issues:

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

On **October 9, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its*

> *position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[1]

On **May 22, 2020**, CHS filed the Provider's preliminary position paper. With respect to Issue 1, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover.[2] However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide the material fact of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2017 cost report does not reflect an accurate number of Medicaid eligible days."[3]

On **April 21, 2020**, the Provider transferred Issue 2 to PRRB Case No. 20-0997GC.

On **January 7, 2020**, the Medicare Contractor filed a Jurisdictional Challenge over Issues 1, 4, and 5 requesting the issues be dismissed. On **February 4, 2020**, CHS timely filed the Provider's response.

On **September 9, 2020**, the Medicare Contractor filed its preliminary position paper.

On **June 1, 2020**, the Medicare Contractor filed a request for DSH Medicaid Eligible Days Support. On **January 6, 2023**. the Medicare Contractor filed its Final Request for DSH Package for Issue 3. The Request asked the Provider to provide a listing of Medicaid eligible days within 30 days from the date of the letter. The Request further noted that the Medicare Contractor had previously requested the Provider furnish the listing on June 1, 2020, but received no response. The Provider did not file any response notwithstanding the instruction in 42 C.F.R. § 405.1853(e)(5) that "Each party is required to make a good faith effort to resolve or narrow any discovery dispute, regardless of whether the dispute is with another party or a nonparty."

As no response was received from the Provider, the Medicare Contractor filed its Motion to Dismiss Issue 3 on **July 17, 2023**. The Provider's response was due within 30 days pursuant to Board Rule 44.3 (i.e., no later than Thursday, August 17, 2023).

On July 20, 2023, the Provider requested a Change of Representative, and the Board acknowledged the change on July 21, 2023.

On **November 20, 2023**, 3 years after the preliminary paper was filed without a listing, QRS filed a Supplement To Position Paper/Redacted Medicaid Eligible Days Listing. QRS belatedly filed this Medicaid Eligible Days Listing without any explanation and as a result, the Board declines to consider it. The Provider ignored the June 1, 2020 Request and the Final Request for DSH Package filed on January 6, 2023. QRS did not explain why the listing was delayed or not previously available.

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[1] (Emphasis added.)
[2] Provider's Preliminary Position Paper at 8 (May 22, 2020).
[3] *Id.*

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

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

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

As mentioned above, on April 21, 2020, the Provider was directly added to PRRB Case No. 20-0997GC, appealing from the same NPR as the instant appeal. This common issue related party ("CIRP") group issue statement reads:

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

On May 22, 2020, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

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[4] Appeal Issues, Tab 3 (Sept. 30, 2019).
[5] See Group Issue Statement, PRRB Case No. 20-0997GC.

Calculation of the SSI Percentage

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 Fiscal Year End (August 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

Medicare Contractor's Contentions

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

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

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

> The MAC contends that the Board does not have jurisdiction over the realignment portion of issue 1 and respectfully request the Board to dismiss it from this appeal.[6]

In addition, the MAC argues the DSH Payment/SSI Percentage (Provider Specific) issue and the DSH Payment/SSI (Systemic Errors) issue are considered the same issue by the Board (and the Provider is appealing issue 2 in PRRB Case No. 20-0997GC). The MAC requests the Board to dismiss the SSI data accuracy sub-issue as duplicate filing in violation of Board Rule 4.6.1.[7]

Issue 4 – Uncompensated Care Pool

The MAC contends that Issue 4 should be dismissed because it is not an appealable issue, as affirmed most recently by the United States Court of Appeals for the District of Columbia Circuit. Additionally, the MAC argues that Issue 4 is a duplicate of the Provider's appeal of the same issue in PRRB Group cases #16-0769GC for service dates September 1, 2016 through September 30, 2016 and #17-1042GC for services dates October 1, 2016 through August 31, 2017. The Board previously found it lacked jurisdiction over the issue in both appeals and dismissed the appeals on July 30, 2018.[8]

Issue 5 – Two Midnight Census IPPS Payment Reduction

Similar to issue #4, the MAC also alleges that this issue is duplicative in nature. Issue #5 is a duplicate of the Provider's appeals in Group Case #16-0785GC for service dates September 1, 2016 through September 30 and Group Case #17-0661GC for service dates October 1, 2016 through August 31, 2017. Expedited Judicial Review was granted for Group Case #16-0785GC on December 27, 2016 and PRRB Group Case #17-0661GC was withdrawn by the Provider on December 31, 2020. Additionally, the MAC argues, through its rulemaking authority, CMS has already developed and implemented relief for this issue (see 81 FR 57058, August 22, 2016), and therefore the Provider would lack subject matter jurisdiction before the Board.[9]

Issue 3 – Medicaid Days

After numerous attempts to obtain a Medicaid days listing from the provider to no avail, the Medicare Contractor filed a Motion to Dismiss Issue 3 on July 17, 2023. The Medicare Contractor alleges they requested the DSH data on June 1, 2020 and received no response. The Provider then failed to included a listing in its preliminary position paper filed May 22, 2020. The Medicare Contractor submitted another request on January 6, 2023. When no listing was provider, FSS then filed the Motion to Dismiss on July 17, 2023, arguing that in fact the Provider has abandoned the issue.[10]

Provider's Response

Issue 1 – DSH SSI Percentage (Provider Specific)

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[6] Jurisdictional Challenge at 7 (Jan. 7, 2020).
[7] *Id.* at 6-7.
[8] *Id.*at 10-11.
[9] *Id*. at 12-13.
[10] Motion to Dismiss dated July 17, 2023.

The Provider argues that the issues are not duplicative because "issues #1 and 2 represent different components of the SSI issue, which was specifically adjusted during the audit."[11]Additionally, the Provider argues that the issue is not duplicative because the Provider is "not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category."[12]

Finally, the Provider contends the Provider Specific issue is appealable "because the MAC specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2017, as a result of its understated SSI percentage due to errors of omission and commission."[13]

Issue 4 – Uncompensated Care Pool

The Provider admits it has appealed "from the Federal Registers dated August 17, 2015, August 22, 2106 (*sic*) and from the NPR."[14] The Provider states its "appeals in PRRB CN #16-0769GC, 17-1042GC and #20-0079 are from two separate and distinct determinations, and appeal rights associated with Federal Register Publications vary from those of appeal rights based upon NPRs. Therefore, the Provider contends there is no conflict with PRRB Rule 4.6.2, and Provider wishes to preserve their appeal rights for both types of appeals."[15]

Issue 5 – Two Midnight Census IPPS Payment Reduction

The Provider admits it has appeals "from the Federal Register dated August 17, 2015, August 22, 2016, and from the NPR."[16] The Provider states its "appeals in PRRB CN 16- 0785GC, 17-0661GC, and 20-0079 are from two separate and distinct determinations, and appeal rights associated with Federal Register Publications vary from those of appeal rights based upon NPRs. Therefore, Provider contends there is no conflict with PRRB Rule 4.6.2, and Providers wish to preserve their appeal rights for both types of appeals."[17]

The Provider also states that the MAC is incorrect when it states that there was no final determination over the Two Midnight reduction, stating, "[t]his appeal involves the issue of whether the .06 positive adjustment in the FY 2017 Inpatient Prospective Payment System (IPPS) final rule (the FY 2017 Final Rule) is invalid for being arbitrary and capricious and promulgated in a procedurally deficient way."[18]

Issue 3 – Medicaid Days

The Board Rules require that Provider Responses to the MAC's Motion to Dismiss must be filed within thirty (30) days of the filing of the Motion to Dismiss.[19] The Provider has not filed a response to the Motion to Dismiss Issue 3 and the time for doing so has elapsed. Board Rule 44.3 specifies with respect

[11] Jurisdictional Response at 1 (Feb. 4, 2020)
[12] *Id.*at 2.
[13]*Id.*
[14] *Id.* at 3.
[15] *Id.*
[16] *Id.* at 7.
[17] *Id*.
[18] *Id.*
[19] Board Rule 44.3, v. 2 (Aug. 2018).

to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Board Analysis and Decision:

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

A. SSI Percentage (Provider Specific)

The 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 transferred into Group Case No. 20-0997GC "*CHS CY 2017 DSH SSI Percentage CIRP Group*."

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

The Provider's DSH Payment/SSI (Systemic Errors) issue in group Case No. 20-0997GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH Payment/SSI (Systemic Errors) issue in Case No. 20-0997GC. Because the issue is duplicative, and duplicative issues appealed from the same

[20] Issue Statement.
[21] *Id.*
[22] *Id.*

final determination are prohibited by PRRB Rule 4.6[23], 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 20-0997GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in Baystate, may impact the SSI percentage for each provider differently.[24] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-0997GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-0997GC, but instead refers to systemic Baystate data matching issues that are the subject of the issue in the group appeal. For example, the Provider asserts that "the SSI entitlement of individuals can be ascertained from State records"[25] but fails to explain what that means, what the basis for the alleged fact is,[26] or why that it even relevant to the issue. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be fully developed and include all available documentation necessary to provide a thorough understanding of their opponent's positions." Here, it is clear that the Provider failed to fully develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include all exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 (2018) to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 (2018) 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.

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,

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[23] PRRB Rules v. 2.0 (August, 2018).
[24] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. See *Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). See also *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[25] Provider's Preliminary Position Paper at 8.
[26] There are no exhibits or citations or examples of how SSI entitlement can be ascertained from state records, or any proof that such was done in this specific case.

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

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

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh .[27]

This CMS webpage describes access to DSH data from **1998 to 2022** and instructs providers to send a request via email to access their DSH data.[28]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 20-0997GC.

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 20-0997GC are the same issue. 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,

[27] Last accessed August 13, 2024.
[28] Emphasis added.

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- 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 payment. The Provider states Issue 3 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital (“DSH”) calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends 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.[29]

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

The Provider’s preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[30] However, no listing was submitted until almost 3.5 years later.

With regard to the filing of an individual appeal, Board Rule 7.3.2 (Aug. 2018) states:

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

[29] Provider’s Appeal Request (Sept. 30, 2019).
[30] Provider’s Preliminary Position Paper at 8.

> 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.[31]

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**[32]
>
> **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.

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

25.1.1 The Provider's Position Paper

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

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on October 9, 2019, included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

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

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[33]

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

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

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

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

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

[33] (Emphasis added.)

On May 22, 2020, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[34] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case. The Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2015 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[35]

In its Motion to Dismiss, the Medicare Contractor asserts that the Provider has failed to submit a list of additional Medicaid eligible days and neglected to include all supporting documentation, or

[34] Provider's Preliminary Position Paper at 8 (May 22, 2020).
[35] *Id.* at 7-8.

alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

On November 20, 2023, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission". The Listing, labeled as a "supplement" was 5 pages in length with several hundred Medicaid eligible days. QRS' filing did not explain why the listing of so many days was being submitted at this late date and was roughly 3½ years after the deadline for including it with its preliminary position paper, as the position paper deadline was May 27, 2020.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e*., the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled, consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 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 a couple of months after the Provider changed its designated representative to QRS does not excuse the Provider for its failure to include the information with its preliminary position paper or its failure to timely respond to the Motion to Dismiss. Board Rule 5.2 makes clear that "the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings." Moreover, the Board rejects the Provider's attempt to label the November 20, 2023 filing as a "Supplement to Position Paper" and does not accept that filing because:

1. The alleged "Supplement" was filed ***more than 3½ years*** *after the deadline* for that exhibit to be included with its preliminary position paper filing, consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)).

2. The alleged "Supplement" fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); and (b) *why* the listing days was not previously available, *in whole or in part*;

3. Neither the Board Rules nor the October 9, 2019 Case Acknowledgment and Critical Due Dates permit the Provider to file a "Supplement" to its preliminary position paper (nor did the Provider allege in the "Supplement" filing that they do).

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

> days listed in the alleged "Supplement" are, without explanation, *exponentially* larger than the original 50 estimated days included with the appeal request).[36]

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[37] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provider the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable.[38] [39]

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[36] *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."

[37] (Emphasis added.)

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

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

[39] Examples of QRS-represented individual provider cases which the Board dismissed the SSI Provider-Specific issue and/or the Medicaid eligible days issue include, but are not limited to: Case No. 14-2674 (Medicaid eligible days issue) dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 22, 2022); Case No. 16- 2521 (Medicaid eligible days only dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 25, 2022); Case No. 16-0054 (Medicaid eligible days only dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 25, 2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, 16-1712 (Medicaid eligible days dismissed by Board letter dated Sept. 30, 2022 initiated by MAC filing dated Dec. 10, 2020, Dec. 11, 2020, Mar. 12, 2021, Mar. 12, 2021, and Nov. 12, 2021 respectively); Case No. 21-1723 (both issues dismissed by Board letter dated Nov. 21, 2022 initiated by MAC filing dated Sept. 1, 2022); Case No. 16-1016 (both issues dismissed by Board letter dated Nov. 29, 2022 initiated by MAC filings dated May 17, 2018 and Mar. 2, 2022); Case No. 17-1747 (both issues dismissed by Board letter dated Nov. 29, 2022 initiated by MAC filings dated May 24, 2018 and Oct. 17, 2022); Case No. 15-2294 (Medicaid eligible days issue dismissed by Board letter dated Dec. 20, 2022 initiated by MAC filing dated May 23, 2022); Case No. 20-2155 (both issues dismissed by Board letter dated Dec. 30, 2022 initiated by MAC filing dated Oct. 17, 2022); Case No. 16-2131 (both issues dismissed by Board letter dated Feb. 10. 2023 initiated by MAC filing dated Dec. 22, 2022); Case No. 21-1765 (both issues dismissed by Board letter dated Feb. 22, 2023 initiated by MAC filing dated Dec. 6, 2022); Case No. 22-0719 (both issues dismissed by Board letter dated Mar. 8, 2023 initiated by MAC filing Mar. 8, 2023).

C. UCC Distribution Pool

The Board finds that Issue 4 is duplicative of the Provider's appeal of the same payment issue in PRRB Group cases #16-0769GC for service dates September 1, 2016 through September 30, 2016 and #17-1042GC for services dates October 1, 2016 through August 31, 2017. The Board has previously issued a decision over the issue in those appeals, as it found it lacked jurisdiction over both appeals and dismissed the appeals on July 30, 2018. Therefore, the Provider has appealed the same payment issue from two determinations, and as such those appeals are duplicates. Issue 4 is hereby dismissed.

Further, the Board finds that if they had not been duplicates, it would lack jurisdiction over the issue pursuant to 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) which precludes administrative and judicial review of certain aspects of the UCC payment calculation, as stated in its previous July 30, 2018 dismissal determinations.

D. 2 Midnight Census IPPS Payment Reduction

The Board finds that Issue 5 is duplicative of the Provider's appeals of the same issue in PRRB Group Case Nos. 16-0785GC CHS FFY 2016 Two Midnights 0.2% IPPS Payment Reduction CIRP Group and 17-0661GC QRS CHS FFY 2017 Two Midnight Census IPPS Payment Reduction CIRP Group. Both appeals were filed from the applicable Federal Register publications, for their applicable time periods. Both appeals were previously adjudicated by the Board (one of which EJR was granted, and the other was withdrawn by the Provider) and as such, the Board dismisses Issue 5, Two Midnight Rule, as duplicative.

Decision

Accordingly, based on the record before it, the Board hereby dismisses:

1. The DSH Payment/SSI Percentage (Provider Specific) issue from appeal because it is duplicative of the issue in PRRB Case No. 20-0997GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue and the Provider failed to properly develop the issue to establish it as a separate and distinct issue;

2. The DSH – Medicaid Eligible Days issue because the Provider failed to meet the Board requirements for preliminary position papers for this issue as described at 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rule 25; and

3. The UCC Distribution Pool issue because it is duplicative of issues filed in group appeals, therefore it is hereby dismissed.

4. The Two Midnight Census IPPS Payment Reduction because it is duplicative of issues filed in group appeals, therefore it is hereby dismissed.

As there are no other issues pending in the appeal, the case is closed and removed from the Board's docket.

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

Board Members:

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

For the Board:

8/13/2024

X Kevin D. Smith, CPA

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

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

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RE: ***Notice of Dismissal***
Laredo Medical Center (Provider Number 45-0029)
FYE: 09/30/2015
Case Number: 19-0730

Dear Mr. Ravindran and Mr. Berends:

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in Case No. 19-0730. Set forth below is the decision of the Board to dismiss the remaining issue in the appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days.

Background

A. *Procedural History for Case Nos. 19-0730*

Laredo Medical Center ("Laredo"), Provider No. 45-0029, fiscal year ending ("FYE") 09/30/2015, filed a timely Individual Appeal Request **on December 19, 2018**, from a Notice of Program Reimbursement ("NPR") dated **June 29, 2018**, appealing the following issues:

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

After all issues were transferred or withdrawn, Issue 3 (the DSH Medicaid eligible days issue)

[1] Provider withdrew this issue on May 7, 2024.
[2] Provider transferred this issue to Case No. 18-0552GC on July 12, 2019.
[3] Provider transferred this issue to Case No. 18-0555GC on July 12, 2019.
[4] Provider transferred this issue to Case No. 18-0554GC on July 12, 2019.

remains in the case.

On January 23, 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**.[5]

On April 11, 2019, the Medicare Contractor filed a Jurisdictional Challenge[6] over Issue 1 (the DSH SSI Percentage ("Provider Specific") issue), Issue 4 (the Uncompensated Care Distribution Pool issue) and Issue 5 (the Two Midnight Census IPPS Payment Reduction issue).[7]

On May 8, 2019, the Provider filed a timely response to the Medicare Contractor's Jurisdictional Challenge.

On August 7, 2019, Laredo filed its Preliminary Position Paper. With respect to Issue 3 (the DSH Medicaid eligible days issue), the Provider asserted that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made, and no explanation was included to explain why that listing was not included with the position paper filing. Indeed, the position paper failed to even provide the material fact of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2015 cost report does not reflect an accurate number of Medicaid eligible days . . . ."[8]

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[5] (Emphasis added).
[6] Jurisdictional Challenges are not limited to jurisdiction per se, as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.,* 568 U.S. 145 (2013) ("Auburn"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. See also Board Rule 4.1 ("The Board will dismiss appeals that fail to meet the timely filing requirements and/or jurisdictional requirements."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).
[7] Issue 1 was withdrawn on May 7, 2024, Issues 4 and 5 were transferred to group appeals on July 12, 2019.
[8] Provider's August 7, 2019 Preliminary Position Paper at 8, Ex. 1.

On December 9, 2019, the Medicare Contractor filed its Preliminary Position Paper. With regard to Issue 3 (the DSH Medicaid eligible days issue), the Medicare Contractor's position paper noted that the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under the regulations and Board Rules to file a fully developed position paper with all available documentation necessary to support its position; and the Provider had failed to respond to the Medicare Contractor's request for that Medicaid eligible days listing.[9]

On November 14, 2022, the Medicare Contractor filed a Jurisdictional Challenge over Issue 3 (the DSH Medicaid Eligible Days issue) requesting that the Board dismiss this issue as it was abandoned by the Provider in its preliminary position paper which had been filed in August, 2019.

On December 14, 2022, the Provider submitted a timely response to the Medicare Contractor's Jurisdictional Challenge.

On December 28, 2022, in response to the Provider's response to its Jurisdictional Challenge**,** the Medicare Contractor filed a Request for Dismissal of Issue 3 (the DSH Medicaid Eligible Days issue) asserting that the Provider had failed to submit a preliminary position paper with fully developed positions as required under both versions 2.0 and 3.1 of the Board Rules, that there is nothing in the record to suggest that the Provider was relying on Alert 19 or was otherwise prevented from following PRRB Rules due to COVID and that the Provider had effectively abandoned Issue 3.[10] Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismissal.

On January 20, 2023, the Provider filed an Administrative Resolution Package letter addressed to the Medicare Contractor dated January 19, 2023. The letter proposed to resolve the Medicaid eligible days issue and provided: "[f]ollowing is a description of each of the Exhibits enclosed: Exhibit 1- Medicaid DSH days per NPR - In this Exhibit you will find the listing of 25,552 Medicaid days and Medicaid HMO days which were audited and used on the NPR. . . . Exhibit 2- Medicaid Eligible Days-These are additional days that the provider is requesting to be added to the Medicare DSH calculation - **303 days**. Exhibit 3 – Electronic listings of Exhibits 1 through 2 plus the State Medicaid Eligibility responses."[11]

On March 8, 2024, Laredo filed its Final Position Paper. In its final position paper, the Provider included a new Exhibit P-1 which was a *redacted* listing of 5,874 "Additional Medicaid eligible days" identified as Additional ME & 1115 Waiver Days.[12]

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[9] Medicare Contractor's December 9, 2019 Preliminary Position Paper at 11-12.
[10] Medicare Contractor's December 28, 2022 Request for Dismissal at 3-4.
[11] (Emphasis added); the Providers' filing did not respond to the December 28, 2022 Motion to Dismiss. The filing also did **not** include a copy of the listing with 303 days that it allegedly sent to the Medicare Contractor (redacted or otherwise); Provider's January 20, 2023 Administrative Resolution Package letter at 1-2.
[12] Provider's March 8, 2024 Final Position Paper Ex. P-1.

On April 3, 2024, the Medicare Contractor filed its Final Position Paper. The Medicare Contractor states the following regarding the Provider's listing:

> The MAC has received and completed the review of the additional Medicaid eligible days claimed by the provider and is ready to resolve the issue through an administrative resolution. However, the provider is now attempting to add Section 1115 Waiver days under the Medicaid eligible days issue. The MAC contends that the Section 1115 Waiver Days issue is different from the generic Medicaid eligible days issue and must be appealed as a separate issue and the provider's attempt to add the Section 1115 Waiver days is untimely.[13]

On April 11, 2024, the Medicare Contractor filed a Jurisdictional Challenge over Issue 3 (the DSH Medicaid Eligible Days issue) asserting that "on May 19, 2023, when the Provider filed its final position paper it attempted to add the Section 1115 Waiver Days to issue number 3 by submitting a revised list of the Medicaid Eligible days which included Section 1115 Waiver Days**."**[14] Further, the Medicare Contractor notes that "[i]n the Provider's March 8, 2024 final position paper the Provider included a new Exhibit 1 which was a redacted listing of 5,874 "Additional Medicaid Days" identified as 1115 Waiver Days."[15]

On May 10, 2024, both the Provider and the Medicare Contractor timely filed their Witness Lists in this case. Further, on the same day, the Provider submitted an Unopposed Request for a Video Hearing in the above-referenced case.

Monday, **May 13, 2024,** was the deadline for the Provider to file its response to the April 11, 2024 Jurisdictional Challenge as the Provider is allotted only 30 days to respond per Board Rule 44.4.3.[16]

On May 14, 2024, the Provider submitted an ***untimely*** response to the Medicare Contractor's Jurisdictional Challenge as it was filed one day after the filing deadline.

On June 5, 2024, the Board issued a Request for Clarification on Jurisdictional Challenges letter to the parties requesting clarification from the Medicare Contractor on the Jurisdictional Challenges and the Motion to Dismiss filed prior to rendering a decision. The Board postponed the June 10, 2024 hearing to obtain the additional information.

On June 11, 2024, the Medicare Contractor filed a response to the Board's Request for Clarification on Jurisdictional Challenge letter.

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[13] Medicare Contractor's April 3, 2024 Final Position Paper at 13.
[14] Medicare Contractor's April 11, 2024 Jurisdictional Challenge at 2.
[15] *Id*. at 3.
[16] As the 30th day fell on Saturday, May 11, 2024, the filing deadline was automatically moved to the next business day, Monday, May 13, 2024.

B. Description of Issue 3-DSH Medicaid eligible days

In its December 19, 2018 Individual Appeal Request Laredo summarizes its DSH Medicaid eligible days issue as follows:

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. $ 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 5,25,29,S-D *See* Tab 4.
>
> Estimated Reimbursement Amount: $40,000. *See* Tab 5.[17]

On August 7, 2019, the Board received the Provider's Preliminary Position Paper. The following is the Provider's ***complete*** position on Issue 3 set forth therein:

> **PROVIDER'S POSITION**
>
> The Provider contends that the MAC's determination for Medicare reimbursement for Disproportionate Share Payments was not in accordance with the Medicare statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi). The amount at issue is $115,000. *See* Exhibit 2.

[17] Provider's December 19, 2018 Appeal Request, Issue Statement, Issue 3, at 2-3.

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 9l2 F. Supp. 478 (E.D.Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).

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

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

Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2015 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[18]

On March 8, 2024, the Provider submitted its Final Position Paper. The Provider's entire argument on the DSH Medicaid eligible days issue in its Final Position Paper is as follows:

[18] Provider's August 7, 2019 Preliminary Position Paper at 7-8.

Issue #3: 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).

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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 2015 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.
>
> With respect to section 1115 waiver days, the courts have firmly rejected CMS's interpretation of its regulations, holding instead that the plain language of the statute and the regulations require inclusion in the Medicaid Fraction of the days belonging to individuals who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool. *See Forrest General Hospital*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43(D.D.C. 2018); *Bethesda Health Inc., v. Azar*, 389 F. Supp. 3d 32, (D.D.C. 2019), *aff'd*, 980 F.3d 121 (D.C. Cir. 2020). CMS has acquiesced in *Bethesda* and is now following the statute and the plain meaning of its own regulations (which regulations represent the official policy of CMS all along) and properly accounting for 1115 Waiver days as Medicaid Eligible days. *See* CMS Manual Instructions System, Change Request 12669, Transmittal No. 11912 (March 16, 2023) ("Transmittal 11912"), attached as Exhibit P-4.[19]

Medicare Contractor's Contentions

A. Medicare Contractor's November 14, 2022 Jurisdictional Challenge

The Medicare Contractor maintains "[t]he Providers abandoned the issue when they failed to properly develop their arguments within their preliminary position paper in accordance with Board Rule 25.3."[20] The Provider "did not file complete preliminary position papers in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3."[21] The Medicare Contractor asserts "[p]ursuant 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. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn."[22] The Medicare Contractor asserts that, per the Board's Rules, "failure to file a complete preliminary position paper with the Board will result in dismissal of the appeal."[23] The Medicare Contractor contends "the Providers neglected to include all supporting documentation,

[19] (Emphasis added); Provider's March 8, 2024 Final Position Paper at 9-10.
[20] Provider's November 14, 2022 Jurisdictional Challenge at 1.
[21] *Id*. at 2.
[22] *Id.* at 3.
[23] *Id*. at 4.

or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable."[24] The Provider also "failed to respond to the [Medicare Contractor]'s two separate requests to submit the required documentation."[25]

The Medicare Contractor asserts additionally, "the Providers have failed to provide a list of additional Medicaid eligible days or any other supporting documents expanding why they cannot produce those documents."[26] The Medicare Contractor notes that "[t]he Providers have not include a list of additional Medicaid eligible days with their preliminary position papers, or under separate cover, which were requested twice."[27] The Medicare Contractor maintains that "[w]ithin their position papers and as an exhibit, the Providers indicate a list of additional Medicaid eligible days is being sent under separate cover. As of the filing of this jurisdictional challenge, the Providers have failed to submit a list of the additional Medicaid eligible days."[28]

B. Medicare Contractor's December 28, 2022 Request for Dismissal

The Medicare Contractor contends "[t]he Providers' argument that Rule 27.1 somehow permits the filing of incomplete preliminary position papers is simply incorrect."[29] The Medicare Contractor asserts this appeal was not filed prior to the effective date of the Board's Rules version 2.0. The Medicare Contractor maintains "[b]oth versions 2.0 and 3.1 of the Board's Rules require just the opposite. The commentary to Board Rule 23 version 2.0. . . . make[s] clear that providers are to file with the Board complete preliminary position papers, <u>including</u> exhibits, and final position papers are optional for appeals filed on or after the August 29, 2018, effective date of Version 2.0."[30] The Medicare Contractor asserts "[t]he Providers' understanding and expectation that the preliminary position papers could be filed without fully developed positions and exhibits is erroneous and without merit."[31]

The Medicare Contractor maintains "[t]he Providers' Representative's reference to 'patients suffering from COVID. . . is outright disingenuous. . . . There is nothing in the record to even suggest that the Providers were relying on Alert 19 or were otherwise prevented from following [Board] Rules due to COVID. To raise the recent raise in children respiratory illness cases as an extenuating circumstance for submitting preliminary position papers which fail to follow [Board] Rules is brazen, especially given that the preliminary position paper was submitted [over 3 years ago]."[32] The Medicare Contractor asserts "the Providers' Response offers no regulatory or [Board] Rule allowing for curing its defect of failing to follow [Board] Rules applying [to] the filing of preliminary position papers."[33]

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[24] *Id.*
[25] *Id*.
[26] *Id*. at 1.
[27] *Id*. at 6.
[28] *Id.* at 2.
[29] Medicare Contractor's December 28, 2022 Request for Dismissal at 2.
[30] *Id.*
[31] *Id.*
[32] *Id*. at 3.
[33] *Id*.

The Medicare Contractor states that [t]he concept of practical impediment applies in the context of whether there existed a circumstance or barrier, 'through no fault of its own, prevented it from identifying and/or verifying with the relevant State the Medicaid eligible days at issue prior to filing of the cost reports at issue.'"[34] The Medicare Contractor asserts it "is not requesting the Board deny jurisdiction due to Providers' failing to claim the Medicaid days at issue on its cost report. Rather, [it] is requesting the Board dismiss the issue due to each Provider's failure to file preliminary position papers in accordance with Board] Rules, and effectively abandoning said issue. The Providers' claiming or not claiming the Medicaid eligible days on the applicable cost reports is not at issue in the [Medicare Contractor's] request for dismissal."[35]

C. Medicare Contractor's Aprill 11, 2024 Jurisdictional Challenge

The Medicare Contractor maintains that "when the Provider filed its final position paper, it attempted to add the Section 1115 Waiver Days to issue number 3 by submitting a revised list of the Medicaid eligible days which included Section 1115 Waiver Days."[36] The Medicare Contractor asserts "[t]he Provider failed to include a list of additional Medicaid eligible days it expected to be included in its Medicaid percentage and DSH computations with its initial hearing request. When the Provider filed its preliminary position paper. . . Exhibit 1 stated that the eligibility listing was '[b]eing sent under separate cover'."[37] The Medicare Contractor contends it "received a non-redacted copy of these days and completed the review of those documented days."[38] The Medicare Contractor states that in the Provider's final position paper, "the provider included a new Exhibit 1 which was a redacted listing of 5,874 "Additional Medicaid Days" identified as 1115 Waiver Days. The reviewable listing of Section 1115 Waiver Days was submitted to the MAC on May 19, 2023. The MAC contends the Provider's submission was untimely and improperly added a new issue of Low Income Pool Section 1115 Waiver Days, to the appeal."[39]

The Medicare Contractor contends "the Provider is attempting to improperly and untimely add the issue of Section 1115 Waiver Days by including it in the narrative of its [ ] position paper."[40] The Medicare Contractor maintains "[t]he issue the provider is now trying to address was not timely added.[41] The Provider filed its individual appeal request pursuant to 42 C.F.R. § 405.1835(a)(3) which requires the date of receipt by the Board of the provider's hearing request to be no later than 180 days after the date of receipt by the provider of the intermediary or

[34] *Id.*
[35] *Id*.
[36] Provider's April 11, 2024 Jurisdictional Challenge at 2.
[37] *Id.* at 3.
[38] *Id.*
[39] *Id*.
[40] *Id.* at 12.
[41] *Id.*

secretary determination.[42] The Medicare Contractor contends that the regulation at 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 provides that a provider may add issues to an appeal if "[t]he Board receives the Provider's request to add issues no later than 60 days after the expiration of the applicable 180-day period."[43] The Medicare Contractor maintains that, [p]ursuant to 42 C.F.R. § 405.1835(e), the Provider's deadline for adding issues to this appeal was February 24, 2019. The issue was informally added through the Board portal on February 29, 2024, when the Provider filed its final position paper."[44]

The Medicare Contractor asserts "[t]he Provider did not formally add Section 1115 Waiver Days to the appeal request as required by 42 C.F.R. § 405.1835(a) (b), and (e). Rather, the Provider first raised the Section 1115 Waiver Days issue in its redacted Medicaid eligible days listing submitted to the MAC on May 19, 2023. . . after the regulatory deadline for adding new issues."[45] The Medicare Contractor maintains Section 1115 Waver Days issue is one component of the DSH issue, and the Provider's attempt to add this new issue was improper and untimely and should be dismissed.[46]

Provider's Responses

A. Provider's December 14, 2022 Response to November 14, 2022 Jurisdictional Challenge

The Provider maintains "[i]t is unclear [ ] whether the [Medicare Contractor] relies on the current Board rules version 3.1 or the Board Rules version 2.0 (8/29/2018), which was in effect in 2019 when the Preliminary Position Paper was filed. Under Board Rules Version 2.0, a Final Position Paper is required for appeals filed prior to the effective date of version 2.0. Rule 27.1. It was the reasonable understanding and expectation of the Providers, therefore, that the outside date for submission of the listing of additional Medicaid eligible days was the Final Position Paper deadline."[47]

The Provider asserts that "[j]ust as the operations of the Board and the [Medicare Contractor] were disrupted by the COVID pandemic, as witness by the issuance of Alert 19, the operations of Providers likewise were disrupted. Indeed, the Providers faced, and continue to face, the challenge of providing life-saving health services to patients suffering from COVID (and, more recently, children suffering from life-threatening respiratory disease)."[48]

The Provider contends "practical impediments are preventing it from obtaining the necessary support. These impediments are related to the State eligibility matching being unavailable due to a change in the State's matching vendor changes. Concurrent with this letter to the Board the

[42] *Id*. at 12.
[43] 42 C.F.R. § 405.1835(e)(3).
[44] Provider's Jurisdictional Challenge (April 11, 2024) at 13.
[45] *Id.* at 14.
[46] *Id.* at 14-15.
[47] Provider's December 14, 2022 Response to Medicare Contractor's Jurisdictional Challenge at 1.
[48] *Id.*

Providers are sending to the MAC the listing of additional Medicaid eligible days for providers not impacted by practical impediment."[49] The Provider maintains it has "cured the sole defect on which the [Medicare Contractor] relies. . . ha[s] not abandoned the issue and contend[s it] ha[s] complied with the preliminary position paper rules. Therefore, the Board should not dismiss the issue."[50]

B. Provider's May 14, 2024 Response to April 11, 2024 Jurisdictional Challenge

The Board notes the provider's response to this Jurisdictional Challenge was ***not*** timely filed as required by Board Rule 44.4.3.[51] As a consequence, the Board declines to consider the arguments raised therein below.

The Provider contends that it "filed a timely appeal dated December 17, 2018, and its appeal statement read as follows:

> 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.[52]

The Provider argues "[t]he italicized language above makes clear that the Provider appealed all Medicaid eligible days, including Section 1115 waiver days. By definition, Section 1115 waiver days are Medicaid eligible days. See 42 C.F.R. § 412.106(b)(4)(i) and (ii)."[53] The Provider maintains it is not attempting to untimely add the "issue" of Section 1115 waiver days because

> [s]ection 1115 waiver days are part and parcel of Medicaid eligible days. . . . the regulations at 42 C.F.R. § 405.1835 contain requirements for appealing an "issue" and a time limit on adding an "issue" - not on clarifying a "sub-issue" or (to use the MAC's terminology) "components" of an issue. Both a June 25, 2004 proposed rule (69 *Fed. Reg.* 35716) and a May 23, 2008 final rule (73 *Fed. Reg.* 30190) indicate that an "issue" is encapsulated by a specific cost report adjustment. They do not slice and dice an "issue" into component parts, including the specific reason why Medicaid eligible days were not counted in the numerator of the Medicaid Fraction of the Disproportionate Payment Percentage.[54]

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[49] *Id.* at 2.
[50] *Id*. at 2-3.
[51] Board Rule 44.4.3 (Nov. 1, 2021) specifies that: "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."
[52] Provider's May 14, 2024 Jurisdictional Response at 3.
[53] *Id.*
[54] *Id*. at 3-4.

The Provider maintains "the same adjustment to so-called generic Medicaid eligible days also governs Medicaid eligible days associated with beneficiaries covered under a Section 1115 waiver."[55] The Provider contends that "[b]ecause 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."[56]

The Provider asserts that:

> [n]either '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 a 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 'section 1115 waiver days' in its appeal request. Rule 8 is also internally inconsistent with Rule 7. Whereas Rule 8 refers to 'components' of an issue, Rule 7.1 provides that, for purposes of identifying the 'issue' under appeal, the provider need only '[g]ive a concise issue statement' that describes the cost report adjustment, including the cost report adjustment number and why the cost report adjustment is incorrect. Thus, Rule 8 is both inconsistent with the regulations and Rule 7. Further, whereas Rule 7 directs providers to Rule 8, Rule 8 directs the providers to Rule 7, this direction is flatly inconsistent with Rule 7, as explained above, or at the very least is confusing and misleading.[57]

The Provider maintains "[t]he [Medicare Contractor] is required by specific command of CMS to accept and audit the Provider's section 1115 waiver days. CMS has issued instructions that require the inclusion of Section 1115 waiver days in providers' Medicaid Fractions."[58] The Provider asserts it "submitted a redacted listing with their Final Position Paper Submission on March 8, 2024, and an unredacted listing to the MAC."[59]

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[55] *Id*. at 4.
[56] *Id.* at 5.
[57] *Id.*
[58] *Id*.
[59] *Id*. at 6.

Board Analysis and Decision:

The Board grants the Medicare Contractor's request that the Board dismiss Issue 3, both the newly-but-untimely-added Section 1115 waiver days issue as well as the original Medicaid eligible days issue.

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. To pursue those appeal rights, the appeal request must meet certain content requirements set forth at 42 C.F.R. § 405.1835(b).

A. Newly Added Issue – Section 1115 Waiver Days

The Board finds that the Section 1115 Waiver days issue is not properly part of this appeal because it was not properly included in the original appeal request, and it was not properly or timely added. The Board finds 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. The Board finds while the Provider appealed Medicaid eligible days, this issue is separate and distinct from the § 1115 waiver days issue as recognized by multiple Board, Administrator and Court decisions[60] (many of which were issued prior to the Provider's March 1, 2019 deadline for adding issues to this appeal).[61]

42 C.F.R. § 405.1835(b) (Sept. 2016) gives the following "contents" requirements for an initial appeal request for a Board hearing:

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

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

[61] The NPR at issue was issued on June 29, 2018, and the Provider had until December 31, 2018, to file this appeal. The deadline to add issues is 60 days beyond that date, i.e., by March 1, 2019.

> and the request must include the elements described in paragraphs (b)(1) through (b)(4) of this section.
>
> **If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (b)(2), or (b)(3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action**.
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the 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.[62]

Regarding the filing of an Individual Appeal request, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Aug. 2018), states:

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See*

[62] (Bold and underline emphasis added).

subsections below and Rule 8 for special instructions regarding multi-component disputes.

* * *

7.2 Issue-Related Information

7.2.1 General Information

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

• An issue title and a concise issue statement describing:

o the adjustment, including the adjustment number,

o the controlling authority,

o why the adjustment is incorrect,

o how the payment should be determined differently,

o the reimbursement effect, and

o the basis for jurisdiction before the PRRB.

• A copy of the applicable audit adjustment report page(s) or a statement addressing why an adjustment report is not applicable or available.

• A calculation or other support for the reimbursement effect noted in the issue statement.

• Support for protested items or claim of dissatisfaction as noted in Rules 7.3 and 7.4.

* * *

7.3 Self-Disallowed Items (Applies to Cost Reporting Periods Ending on or Before 12/31/15)

7.3.1 Authority Requires Disallowance

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

> • a concise statement describing the self-disallowed item,
>
> • the reimbursement or payment sought for the item, and
>
> • the authority that predetermined that the claim would be disallowed.
>
> **7.3.2 No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.
>
> **7.3.3 Protest**
>
> Effective for cost reporting periods ending on or after December 31, 2008, items claimed under protest on the cost report must follow the applicable procedures as contained in CMS Pub. 15-2, Section 115. See 42 C.F.R. § 405.1835(a)(1)(ii).
>
> For the appeal, you must:
>
> • identify the amount that was protested for the specific item being appealed,
>
> • attach a copy of the protested items worksheet submitted with your as-filed cost report, and
>
> • the as-filed Worksheet E or audit adjustment report to demonstrate the total protested claim.
>
> Note: CMS Ruling 1727-R governs for cost reporting periods ending on or after 12/31/08 and beginning before 1/1/16.

The Board finds that Board Rule 7 and Board Rule 8 (August 2018) provide "special instructions" for issue statements involving multi-component disputes. In particular, Rule 8.1 explains that, when framing issues for adjustments involving multiple components, each contested component "must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7." Board Rule 8.1 (August 2018) gives common examples of different components of the Disproportionate Share Hospital payment calculation that may be in dispute. Specifically, Board Rule 8 states:

Rule 8 Framing Issues for Adjustments Involving Multiple Components

Rule 8.1 General

Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7. Several examples are identified below, but these are not exhaustive lists of categories or issues.

A. **Disproportionate Share Hospital Payments**

Common examples include: dual eligible Medicare Part A/Medicaid, dual eligible Medicare Part C/Medicaid, SSI data matching, state/program specific general assistance days, Section 1115 waiver days (program/waiver specific), and observation bed days.

B. **Bad Debts**

Common examples include: crossover bad debts, collection effort, use of collection agency, 120-day presumption, and indigence determination.

C. **Graduate Medical Education/Indirect Medical Education**

Common examples include: managed care days, new programs, current year resident count, prior year count, penultimate year count, intern to bed ratio, and rotations to non-hospital settings.

C. **Wage Index**

Common examples include: wage data corrections, occupational mix, wage vs. wage-related costs, pension, rural floor, and data corrections.

Pursuant to the May 23, 2008 final rule, new Board regulations went into effect on August 21, 2008 that limited the addition of issues to appeals.[63] As a result of this final rule, 42 C.F.R. § 405.1835(e) (Sept. 2015) provides in relevant part:

[63] *See* 73 Fed. Reg. 30190 (May 23, 2008)

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

The Board finds that this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination.[64] However, there is no evidence in the record to indicate the Provider added the Section 1115 waiver days issue to the case properly or timely. In this regard, the first discussion of Section 1115 waiver days in this case occurred in the Provider's March 8, 2024 final position paper, well after the deadline for adding issues had passed (5 years).

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid eligible days. Indeed, it was only effective January 20, 2000 that the Secretary incorporated, at her discretion by regulation, only certain types of Section 1115 waiver days into the DSH calculation (i.e., the Secretary maintains that no statute requires that days associated with § 1115

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[64] As noted in the preamble to the May 23, 2008 final rule, prior to the 240-day limitation going into effect, provider could add issues any time before the Board hearing began. The Secretary gave the following explanation for adopting this limitation:

> We believed the availability of such an extended period for adding issues had become a major obstacle to the Board's efforts to reduce its backlog. The ability of providers to add issues at any time to a hearing request not only has led to larger and more complex cases, but has also meant that the Board's ability to schedule and hold hearings efficiently has been significantly impaired through the practice of some providers of adding issues shortly before the scheduled hearing date. Some providers apparently wish to keep a hearing request open as long as possible in the hope or anticipation of a favorable court case on some reimbursement issue that they can then add to their hearing requests. Therefore, we proposed that, rather than having an open-ended period for adding issues, it would be appropriate and prudent to allow providers a 60- day period for adding issues, commencing with the expiration of the applicable 180-day period for filing the original hearing request. In essence, this additional 60-day period would afford providers an adequate opportunity to appeal all the issues that may have been overlooked in the original hearing request.
>
> ****
>
> After careful consideration of the comments received in this final rule, we are adopting our proposal to include a 60-day period for a provider to add issues beyond the 180-day period permitted for filing a hearing request. . . . We believe it is quite reasonable to expect that from the time it takes to file a cost report to a 240-day period after a final determination has been issued, covering a span of approximately two years or more, a provider should have sufficient opportunity to identify the issues it wishes to appeal for that cost year. The Board will then be able to set a hearing date with full knowledge that the hearing will not be further delayed by the inclusion of last-minute issues. 73 Fed. Reg. at 30203.

waiver/expansion programs be included be included in the DSH calculation and that she exercised her discretion to include only certain such days).[65] Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to § 1115 waiver days. Specifically, § 412.106(b)(4) states in pertinent part:

> (2) Second computation. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> (ii) **Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act**.
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.[66]

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

[66] (Emphasis added).

Significantly, Section 1115 waiver programs can pertain to not just Medicaid (Title XIX), but also to other programs under Titles I, X, XIV, XIV or part A or D of Title IV of the Social Security Act.[67] Hence, an important limitation is that the § 1115 waiver program receive Title XIX matching payments. Moreover, not every state Medicaid program has a qualifying Section 1115 expansion program receiving Title XIX matching payments[68] and not every inpatient day associated with beneficiary enrolled in such a Section 1115 waiver program qualifies to be included in the numerator of the DSH Medicaid fraction.[69] In contrast, every state has a

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

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

[69] Unlike traditional Medicaid eligible days under a State Plan, the following discussion from the FY 2004 IPPS Final Rule, 68 Fed. Reg.at 45420-21 highlights that not all § 1115 waiver days can be included in the numerator of the Medicaid fraction and that factual determinations must be made regarding any § 1115 waiver day program to determine if 42 C.F.R. § 412.106(b)(4) is applicable to that program: Since that revision, we have become aware that there are certain section 1115 demonstration projects that serve expansion populations with benefit packages so limited that the benefits are not similar to the medical assistance available under a Medicaid State plan. These section 1115 demonstration projects extend coverage only for specific services and do not include inpatient care in the hospital. Because of the limited nature of the coverage offered, the population involved may have a significantly higher income than traditional Medicaid beneficiaries. In allowing hospitals to include patient days related to section 1115 expansion waiver populations, our intention was to include patient days of section 1115 expansion waiver populations who receive benefits under the demonstration project that are similar to those available to traditional Medicaid beneficiaries, including inpatient benefits. Because of the differences between expansion populations in these limited benefit demonstrations and traditional Medicaid beneficiaries, in the May 19, 2003 proposed rule, we proposed that the Medicare DSH calculation should exclude from treatment as Medicaid patient days those patient days attributable to limited benefit section 1115 expansion waiver populations (proposed § 412.106(b)(4)(i)). For example, a State may extend a family planning benefit to an individual for 2 years after she has received the 60- day postpartum benefit under Medicaid, or a State may choose to provide a family planning benefit to all individuals below a certain income level, regardless of having previously received the Medicaid postpartum benefit. This is a limited, temporary benefit that is generally administered in a clinic setting (see section 1905(a)(4)(C) of the Act). Also, a number of States are developing demonstrations that are limited to providing beneficiaries an outpatient prescription drug benefit. Generally, these limited benefits under a demonstration project do not include inpatient benefits. If a hospital were to include the days attributable to patients receiving benefits under such a limited benefit, the hospital would be able to receive higher DSH payments, perhaps substantially, for patients who may otherwise be insured for inpatient care. For example, these limited demonstrations provide benefits that may be needed to supplement private insurance coverage for individuals who do not have incomes low enough to qualify for Medicaid under the State plan. We do not believe such patients should be counted in the DSH patient percentage as eligible for title XIX. **** Therefore, we proposed to revise § 412.106(b)(4)(i) to clarify that patients must be eligible for medical assistance inpatient hospital benefits under an approved State Medicaid plan (or similar benefits, including inpatient hospital benefits, under a section 1115 demonstration project) in order for their hospital inpatient days to be counted as Medicaid days in the calculation of a hospital's DSH patient percentage. Under the proposed clarification, hospital inpatient days attributed to patients who do not receive coverage for inpatient hospital benefits either under the approved State plan or through a section 1115 demonstration would not be counted in the calculation of Medicaid days for purposes of determining a hospital's DSH patient percentage. Under this reading, in the examples given above, the days associated with a hospital inpatient who receives coverage of prescription drugs or family planning services on an outpatient basis, but no inpatient hospital coverage, through either a Medicaid State plan or a section 1115 demonstration, would not be counted as Medicaid days for purposes of determining the DSH patient percentage.

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

Because the Provider did not raise the Section 1115 waiver days prior to the deadline to add issues, and it is a distinct issue consistent with the appeal request content requirements at 42 C.F.R. § 405.1835(b) and Board Rules 7 and 8, the Board finds that the issue was not properly or timely appealed. Notwithstanding the fact that Section 1115 waiver days are handled differently from regular Medicaid eligibility under a State plan, the appeal request only generically references Medicaid eligible days. In this regard, documentation needed to verify eligibility for a § 1115 waiver day is materially different than that for a traditional Medicaid eligible day and, similarly, it is not a given that all Section 1115 waiver days (even those under a program receiving Title XIX matching payments) necessarily would qualify under § 412.106(b)(4) as demonstrated by Board decisions and case law. Here, 42 C.F.R. § 405.1835(b) and Board Rules 7 and 8 required each separate issue to be identified. Here, the Provider failed to do so. Accordingly, as the DSH Medicaid Eligible Days issue as stated in the original appeal request did not include the Section 1115 waiver days and the issue was not timely added to the appeal, the Board dismisses it from this appeal.

B. DSH Medicaid Eligible Days

The Board agrees with the Medicare Contractor's request to dismiss the original Medicaid eligible days issue due to the failure of the Provider to properly develop the merits of the issue and material facts during the position paper process in accordance with 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iv), Board Rules 25 and 27, and the instructions included in the Board Notices.

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

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

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

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

> **appeal (as described in § 405.1840 of this subpart), and the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[70]

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

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

> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the following sub-sections.
>
> **25.1.1 The Provider's Position Paper**
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
> B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
> C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
> D. Provide a conclusion applying the material facts to the controlling authorities.
>
> *** * ***
>
> **25.2 Position Paper Exhibits**
>
> **25.2.1 General**

[70] (Bold emphasis added.)

> With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. The Medicare contractor must also give the provider all evidence the Medicare contractor considered in making the determination (see 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Medicare contractor believes is necessary for resolution but has not been submitted by the provider. When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.
>
> **25.2.2 Unavailable and Omitted Documents**
>
> If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.
>
> **25.2.3 List of Exhibits**
>
> Parties must attach a list of the exhibits exchanged with the position paper.
>
> **25.3 Filing Requirements to the Board**
>
> Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

Moreover, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish each Medicaid eligible day being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(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 reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On August 7, 2019, the Provider filed its preliminary position papers in which it indicated that it would be sending the eligibility listing under separate cover.[71] The position paper did not identify how many Medicaid eligible days remained in dispute in this case.

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

The Board finds the Medicare Contractor sent (2) two requests for the Provider's list of Medicaid eligible days. The first notice was sent on February 6, 2019,[72] the second request was made on September 8, 2022,[73] (over three years later as the Provider had not responded to the Medicare Contractor's first request). The Board finds the Provider finally responded to the Medicare Contractor's request on January 20, 2023 (almost four years after the initial request was made), requesting 303 additional days be added to the Medicare DSH calculation.[74] The Board finds that, on March 8, 2024, with its final position paper submission, the Provider filed a redacted listing of Medicaid eligible days requesting 5,874 additional Medicaid eligible days including Section 1115 Waiver Days. The Board finds the listing the Provider submitted was not accompanied by any substantiating evidence. The Board finds the Provider has not produced adequate evidentiary documentation to support the additional days.

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[71] Provider's August 7, 2019 Preliminary Position Paper at 8.
[72] Medicare Contractor's December 9, 2019 Preliminary Position Paper Ex. C-2.
[73] Medicare Contractor's November 14, 2022 Jurisdictional Challenge Ex. C-1.
[74] Provider's January 20, 2023 Administrative Resolution Package letter at 1.

The Board finds the Provider failed to *timely* include a list of additional Medicaid eligible days with its appeal request, preliminary position paper, or submit such list under separate cover as instructed, or when requested from the Medicare Contractor. The Medicare Contractor thus asserts, 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.[75]

The Board concurs with the Medicare Contractor that the Provider is required to identify the material facts (i.e., the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid eligible days at issue, to which it believes it entitled, consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to *timely* identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).The fact that the listing was filed over three years after the initial request was made and a supplemental listing was filed over a year later does not excuse the Provider for its failure to include the information with its preliminary position paper, nor does it excuse its failure to *timely* respond to the Motion to Dismiss and April 11, 2024 Jurisdictional Challenge.

Finally, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for each Medicaid patient day claimed" 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 regarding filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)- (3) and 412.106(b)(4)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable. Thus, the Board dismisses the Medicaid eligible days issue from the appeal.

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[75] *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.

Based on the foregoing, the Board has dismissed the remaining issue in this case – Issue 3 the Medicaid eligible days issue as well as the newly, improperly and untimely, added issue, Section 1115 Waiver Days issue. As no issues remain, the Board hereby closes Case No. 19-0730 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

8/14/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
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RE: ***Notice of Dismissal***
Moberly Regional Medical Center, Prov. No. 26-0074, FYE 10/31/2017
Case No. 21-0172

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 21-0172. 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. 21-0172*

On **February 25, 2020**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end October 31, 2017. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **August 7, 2020**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained four (4) issues:

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

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **March 23, 2021**, the Provider transferred Issue 2 to a CHS CIRP group.

[1] On March 23, 2021, this issue was transferred to Case No. 20-0997GC.
[2] On January 13, 2023, the Provider withdrew this issue from the appeal.
[3] On March 17, 2021, the Provider withdrew this issue from the appeal.

On **March 17, 2021**, the Provider withdrew Issue 4, 2 Midnight Census IPPS Payment Reduction, from the appeal, and on **January 13, 2023**, the Provider withdrew Issue 3, Medicaid Eligible Days, from the appeal.

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

On **November 5, 2020**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

On **March 29, 2021**, the Provider timely filed its preliminary position paper.

On **July 7, 2021**, the Medicare Contractor timely filed a Jurisdictional Challenge[5] with the Board over Issue 1 requesting that the Board dismiss this issue. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **July 14, 2021**, the Medicare Contractor filed its preliminary position paper.

On **August 24, 2021**, the Medicare Contractor filed a Substantive Claim Challenge[6] relative to Issues 1 and 3, requesting that the Board find that there is not an appropriate cost report claim for

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[4] (Emphasis added.)

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

[6] As explained at Board Rule 44.5, "The Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

these issues per 42 C.F.R. § 413.24(j) and that these items are not reimbursable, regardless of whether the Board were to issue a favorable final hearing decision under 42 C.F.R. § 405.1871(a). Significantly, under Board Rule 44.5.1, the Provider had 30 days to respond to the Substantive Claim Challenge. However, the Provider ***failed*** to file any response.[7]

On **November 14, 2022**, the Medicare Contractor filed a second Jurisdictional Challenge[8] with the Board over the Medicaid Eligible Days issue. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. The Provider timely filed a response on December 14, 2022, but withdrew the issue from the appeal on January 13, 2023.

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

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20-0997GC - CHS CY 2017 DSH SSI Percentage CIRP Group

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

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

The Group issue Statement in Case No. 20-0997GC, to which the Provider transferred Issue No. 2, reads, in part:

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

[7] As the Board is dismissing the remaining issue in the appeal for claims processing violations, it need not rule on the substantive claim challenge.
[8] The Medicare Contractor filed a second jurisdictional challenge for this appeal on November 14, 2022, which included 45 other CHS appeals over the Medicaid Eligible Days issue. The Provider has withdrawn that issue from the instant appeal.
[9] Issue Statement at 1 (Aug. 7, 2020).

> Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[10]

On March 29, 2021, the Board received the Provider's preliminary position paper in Case No. 21-0172. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation based on the Provider's Fiscal Year End (October 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.

[10] Group Appeal Issue Statement in Case No. 20-0997GC.

> Similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services,* No. CV-94-0055 (C.D. Cal June 2, 1995), the SSI entitlement of individuals can be ascertained from [s]tate records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the completed MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008).[11]

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

> According to the Provider's appeal request, Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the portions of Issue 1 related to SSI data accuracy and individuals who are eligible for SSI but did not receive SSI payment are duplicates of Issue 2, which was transferred to Group Case No. 20-0997GC, "CHS CY 2017 DSH SSI Percentage CIRP Group" and should be dismissed.
>
> With respect to the portion of Issue 1 related to SSI data accuracy, the Provider states:
>
> > The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the

[11] Provider's Preliminary Position Paper at 8-9 (Mar. 29, 2021).

> Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage is flawed.

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

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

This component of Issue 1 is repeated by the Provider, word-for-word, within Issue 2.

The MAC contends that the Provider raises the same disputes in Issue 2. The Provider describes Issue 2 as follows:

> The Provider contends that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed.

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

…

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

As previously noted, Issue 2 has been transferred to Group Case No. 20-0997GC. This means that the Provider is appealing an issue from a single final determination in more than one appeal. The Board's Rules are clear on this matter. No duplicate filings. Board Rule 4.6.1. states:

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

Consistent with the Board's previous jurisdictional decisions the MAC respectfully requests the Board dismiss the portions of Issue 1 concerning SSI data accuracy and individuals who are eligible for SSI but did not receive SSI payment. [12]

[12] Jurisdictional Challenge at 5-7 (Jul. 7, 2021).

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

> Issue 1 includes the Provider's appeal over SSI realignment. The Provider states:
>
> > The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).
>
> SSI realignment is still active in this appeal. Within its preliminary position paper, the Provider states:
>
> > The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (October 31). (Emphasis added).
>
> The decision to realign a hospital's SSI percentage with its fiscal year end is a provider election. It is not a final MAC determination. The provider must make a formal request to the MAC and CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of the reimbursement impact.
>
> ****
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue. The MAC requests that the PRRB dismiss this issue consistent with recent jurisdictional decisions.[13]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[14] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board

[13] *Id.* at 7-8.
[14] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."[15]

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 one (1) remaining issue.

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Case No. 20-0997GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[16] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[17] The Provider argues in its issue statement, which was included in the appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[18]

[15] The Provider did file a response to the MAC's second jurisdictional challenge over the Medicaid eligible days issue, however that issue has since been withdrawn.
[16] Issue Statement at 1.
[17] *Id.*
[18] *Id.*

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-0997GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 21-0172 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-0997GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[19], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[20] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors are specific to this provider.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-0997GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records" but fails to explain how it can, explain how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2.[21] Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Aug. 29, 2018), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

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

25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)

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

> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[22]

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

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

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

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[23]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** And instructs providers to send a request via email to access their DSH data.[24]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 20-0997GC.

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[22] (Italics and underline emphasis added.)
[23] Last accessed August 12, 2024.
[24] Emphasis added.

Accordingly, *based on the record before it*,[25] the Board finds that the SSI Provider Specific issue in Case No. 21-0172 and the group issue from the CHS CIRP group under Case No. 20-0997GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

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

* * * * *

Based on the foregoing, the Board has dismissed the only remaining issue in this case – (Issue 1). As no issues remain, the Board hereby closes Case No. 21-0172 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

8/14/2024

X Ratina Kelly

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

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

[25] Again, the Board notes that the Provider failed to respond to the Jurisdictional Challenge over the SSI Provider Specific issue and the Board must make its determination based on the record before it.

Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Dismissal of DSH Payment -Provider Specific Issue***
Christian Hospital Northeast - Northwest (Provider No. 26-0180)
FYE: 12/31/2019
Case Number: 24-0307

Dear Mr. Kramer 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. 24-0307*

On **June 13, 2023**, Christian Hospital Northeast - Northwest ("Christian Hospital" or "Provider") was issued a Notice of Program Reimbursement ("NPR") for its fiscal year ended December 31, 2019.

On **November 30, 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. 24-0307, included (2) issues:

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

As Christian Hospital is commonly owned/controlled by BJC Healthcare, it is thereby, subject to the mandatory Common Issue Related Party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(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. 24-0307*

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

In its 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 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 there is a BJC Healthcare CIRP group for the SSI Percentage issue under Case No. 22-0434GC, *BJC Healthcare CY 2019 DSH SSI Percentage CIRP Group*. **Christian Hospital is not yet a participant in the 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.

[2] Provider Request for Hearing, Issue Statement (Nov. 30, 2023).

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.[3]

Board Analysis and Decision:

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 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. 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 ". . .

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

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."[6]

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 Christian Hospital'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. 24-0307 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, for which there are other providers under the same common ownership as the Provider in this case, and the group in Case No. 22-0434GC is not yet fully formed,[8] the Board hereby directs QRS to transfer the DSH Payment - SSI Percentage (Provider Specific) issue from Case No. 24-0307 to the Group Case No. 22-0434GC. The transfer must be effectuated using the transfer button in OH CDMS within 15 days of the signature of this

---

[6] *Id.*

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

[8] *See* 42 C.F.R. § 405.1837(e), which provides that when the Board has determined that a group appeal brought under paragraph (b)(1) of this section (quoted above) is fully formed, no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.

determination. Relatedly, the Board points QRS' attention to Board Rule 4.6, which prohibits duplicative issues appealed from the same final determination being pursued in multiple cases.[9]

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.

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 finds that it lacks jurisdiction in this aspect of the appeal.

* * * * *

In summary, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue from Case No. 24-0307 is duplicative of the issue in Case No. 22-0434GC 1031GC and requires the Provider to transfer that issue to the CIRP group, in order to comply with 42 C.F.R. § 405.1837(b)(1), ***within 15 days*** of the date of this letter. Failure to do so will result in the Board deeming the SSI Percentage issue abandoned for this Provider and closing Case No. 24-0307. The Board also finds that there is no final determination from which the Provider can appeal the SSI realignment portion of the issue and dismisses that aspect of the issue. Upon the expiration of the 15-day period to allow the transfer, or upon effectuation of said transfer, there will be no issues pending, and the Board will close Case No. 24-0307 and remove 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 upon final disposition of the case.

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

For the Board:

8/16/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., FSS

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Steward Melbourne Hospital (Provider Number 10-0291)
FYE: 09/30/2015
Case Number: 19-0670

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-0670. Set forth below is the decision of the Board to dismiss the remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific), Medicaid Eligible Days, including § 1115 Waiver Days, and the Medicaid Fraction/Medicare Managed Care Part C Days.

Background

A. *Procedural History for Case No. 19-0670*

On **June 6, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2015. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **December 6, 2018**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

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

[1] On July 19, 2019, this issue was transferred to Case No. 18-0552GC.
[2] On July 19, 2019, this issue was transferred to Case No. 18-0553GC.

7. DSH Medicaid Fraction / Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[3]
8. Uncompensated Care ("UCC") Distribution Pool[4]
9. 2 Midnight Census IPPS Payment Reduction[5]

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **July 19, 2019**, the Provider transferred Issues 2, 4, 7, 8 and 9 to CHS CIRP groups. As a result of the case transfers, there are four (4) remaining issues in this appeal: Issue 1 (DSH – SSI Percentage Provider Specific), Issue 3 (DSH – SSI Fraction / Medicare Managed Care Part C Days), Issue 5, (DSH Medicaid Eligible Days), including Provider's claims for § 1115 Waiver Days, and Issue 6 (DSH Medicaid Fraction / Medicare Managed Care Part C Days).

On **January 15, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

On **July 19, 2019**, transfer requests were filed for numerous issues in the appeal, including issues 3 and 6. However, on February 21, 2020, the Board denied the transfer requests of the Part C days issues to group appeal 17-1571GC, as the letter of representation did not specifically list this provider and the group representative for 17-1571GC was not Quality Reimbursement Services ("QRS") (who was the representative of the individual appeal at the time of the transfer) and QRS was requesting the transfer, not the actual provider. Subsequent to the denial of the transfers to 17-1571GC, the Provider failed to submit corrected requests to transfer the issues out of the individual appeal. However, upon review of the documentation in Case No. 17-1571GC, the Provider was directly added to the group on December 3, 2019, ***prior to*** this individual appeal being filed.

---

[3] On July 19, 2019, this issue was transferred to Case No. 18-0551GC.
[4] On July 19, 2019, this issue was transferred to Case No. 18-0555GC.
[5] On July 19, 2019, this issue was transferred to Case No. 18-0554GC.
[6] (Emphasis added.)

On **July 31, 2019**, the Provider timely filed its preliminary position paper. With respect to Issue 5, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover.[7] However, no such filing was made until June 14, 2024, and no explanation was included explaining why that listing was not included with either the preliminary or the final position paper filing. Indeed, the preliminary position paper failed to even address *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' 2015 cost report does not reflect an accurate number of Medicaid eligible days."[8] As a result, the Provider included, as an Exhibit, the original "estimated impact" for this issue of $51,843 based on an *estimated* 100 days. The Board also notes that it had not yet denied the transfers of the Part C issues to group appeal 17-1751GC when the paper was filed, and yet the Provider did not brief these issues in its preliminary position paper.

On **October 18, 2019**, the Medicare Contractor timely filed a Jurisdictional Challenge[9] with the Board over Issue 1, requesting that the Board dismiss this issue. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **November 14, 2019**, the Medicare Contractor filed its preliminary position paper. Regarding Issue 5, the Medicare Contractor's position paper noted that the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position.[10]

On **April 22, 2024**, the Provider filed its final position paper. For the first time since the filing of the appeal 5 years earlier, the Provider includes the term Section 1115 waiver days in the appeal and includes a multi-page listing for 818 "1115 waiver and additional ME days Consolidated" at Exhibit P-1. The reimbursement impact at Exhibit P-2 still identifies an additional 100 estimated days for a increase of $51,843. The Board also notes that the final position paper was filed ***over four years*** after the Part C transfers were denied, and the Provider failed to file proper transfer requests or brief the issues in its final position paper. However, as noted above, this Provider was directly added to 17-1571GC, on December 3, 2018.

---

[7] Provider's Preliminary Position Paper ("Provider's PPP") at 8 (July 31, 2019).
[8] *Id.*
[9] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement, as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).
[10] Medicare Contractor's Preliminary Position Paper ("Contractor's PPP") at 10-11 (Nov. 14, 2019).

On **June 10, 2024**, the Provider changed its designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **June 14, 2024**, almost five years after the provider submitted its preliminary position paper, QRS filed a "Redacted Medicaid Eligible Days Listing Submission." The Listing was now seven pages with roughly 952 Section 1115 waiver days, and no Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again, close to 1,000) was being submitted at this late date, ***nearly 9 years after the fiscal year at issue had closed*** and did not address the still missing Medicaid eligible days listing.

On **May 17, 2024**, the Medicare Contractor filed a second Jurisdictional Challenge with the Board over Issues 3, 5, and 6, requesting that the Board dismiss these issues from the appeal. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

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

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).[11]

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

> **Statement of the Issue:**
>
> Whether the Medicare/SSI fraction used in the Medicare Disproportionate Share Hospital and LIP payment calculations

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

> accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSI fraction calculation per the Medicare Statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi). The Provider(s) contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Reports were incorrectly computed.
>
> …
>
> The Provider(s) further contend(s) that the SSI percentage calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.
>
> Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the [*Baystate*] case:
>
> 1. Availability of MEDPAR and SSA records
> 2. Failure to adhere to required notice and comment rulemaking procedures
> 3. Fundamental problems in the SSI percentage calculation
> 4. Not in agreement with provider's records
> 5. Paid days vs. Eligible days
> 6. Covered days vs. Total days[12]

On July 31, 2019, the Board received the Provider's preliminary position paper in 19-0670. 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

[12] Group Appeal Issue Statement in Case No. 18-0552GC.

> all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Florida and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Florida and has learned that similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from [s]tate records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50, 548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[13]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $22,000.

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:

> In Issue 1, the Provider contends that '…its' (sic) SSI percentage published by the Centers for Medicare and Medicaid Services ('CMS') was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.' In Issue 2, the Provider asserts '…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

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

> in computing its DSH payments. The accuracy of the SSI data is a common issue in both the DSH – SSI (Provider Specific) issue and the DSH – SSI 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 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.
>
> Issue 2 has been transferred to group case 18-0552GC. Thus, the Provider has ventured an attempt to appeal the same issue in more than one appeal at the same time.
>
> The PRRB's rules are clear on this matter: No duplicate filings. Rule 4.6 states:
>
> > A provider may not appeal an issue from a single final determination in more than one appeal.
>
> The fact pattern in this case is not new to the Board. The Board has dealt with it in other cases – and there are many such cases. Moreover, the Board has consistently ruled that these issues are considered the same issue. The MAC maintains that a similar decision should be reached in this case. [14]

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

> Issue 1 includes the Provider's subsidiary appeal over SSI realignment. The Provider states:

[14] Jurisdictional Challenge at 3-4 (Oct. 18, 2019).

> The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).

The Provider fails to note that its cost reporting year end is identical to the Federal fiscal year end. This oversight leaves the MAC questioning the right the Provider is attempting to preserve. The MAC contends that the Provider has abandoned the issue of SSI realignment and, therefore, it should be considered withdrawn. The Provider did not brief this issue within its preliminary position paper (*see* Exhibit C-3). 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.

Even if the Board finds that the issue of SSI realignment 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 decision to realign a hospital's SSI percentage with its fiscal year end is a Provider election. It is not a final MAC determination. A Provider must make a formal request to the MAC and CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.

The 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 right to a PRRB hearing derives from an intermediary or Secretary determination, which is defined at 42 C.F.R. § 405.1801(a):

> [A] determination of the amount of total reimbursement due the provider, pursuant to § 405.1803 following the close of the provider's cost reporting period.

> To date, the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue.[15]

Issue 3 – DSH – Part C Days in SSI Fraction and Issue 6: DSH – Part C Days in Medicaid Fraction

The Medicare Contractor also contends that the Part C days issues have been abandoned and argues the following:

> On July 19, 2019, the Provider requested to transfer Issues 3 and 6 to Group Case No. 17-1571GC. Pursuant to a letter dated February 21, 2020, the Board denied the Request to Transfer and Issue 3 and 6 remain in the individual appeal.
>
> The MAC contends that Issues 3 and 6 were abandoned when the Provider failed to brief these issues in its final position paper. PRRB Rule 25.3 addresses issues that are not briefed in a provider's position paper. In relevant part, this rule states:
>
> > If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn.
>
> Since Issues 3 and 6 reside in this individual appeal and were not briefed in the Provider's final position paper, they should be considered abandoned and effectively withdrawn in accordance with Board Rule 25.3. [16]

Issue 5 – Medicaid Eligible Days

The Medicare Contractor argues that the Board should dismiss the DSH – Medicaid Eligible Days issue because the Provider has not complied with Board Rules regarding the content of position papers and attempts to untimely and improperly add the issue of Section 1115 Waiver Days as a sub-issue via its final position paper. Specifically, the MAC argues:

> 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. Moreover, the Provider neglected to include all supporting documentation, or

[15] *Id.* at 4-6.
[16] Jurisdictional Challenge at 2-3 (May 17, 2024).

> 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.[17]
>
> …
>
> Notably, the Provider has not included a complete unredacted list of additional Medicaid eligible days with its preliminary or final position papers or submitted such list under separate cover contrary to its statements in its position papers. 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 violation of the regulations at 42 C.F.R. §§ 413.24(c) and 412.106(b)(4)(iii) and the Board Rules.
>
> The MAC contends 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 cannot produce those documents, as required by the regulations and the Board Rules. Therefore, the MAC respectfully requests that the Board dismiss the DSH – Medicaid Eligible Days issue.[18]

Issue 5 – Section 1115 Waiver Days

The Medicare Contractor asserts that the Provider attempts to improperly and untimely add the issue of Section 1115 Waiver Days to the instant appeal. The MAC contends:

> Added issues must be added within 60 days of the expiration of the appeal filing deadline. In this case, that would be 240 days from the date of the original Notice of Program Reimbursement (NPR). 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 final 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:

[17] *Id*. at 7.
[18] *Id.* at 8-9.

> (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 of 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 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.

*** (Emphasis added)

Moreover, pursuant to Board Rule 8.1, 'each contested component must be appealed as a separate issue and described as narrowly as possible…'

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 June 6, 2018, thereby setting the period to add issues to close on February 1, 2019. The Provider did not raise the issue of Section 1115 Waiver Days in its appeal request or in 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 April 22, 2024, over five years after the deadline to add new issues.

Specifically, the Provider modified Issue 5 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 (<u>including section 1115 waiver days</u>).

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. Therefore, the Section 1115 Waiver Days issue should be dismissed.[19]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the Medicare Contractor's Jurisdictional Challenge must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[20] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Decision of the Board

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

As set forth below, the Board hereby ***dismisses*** the Provider's 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. 18-0552GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[21] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C.

[19] *Id.* at 8-9.
[20] Board Rule 44.4.3, v. 2.0 (Aug. 2018).
[21] Issue Statement at 1.

§ 1395ww(d)(5)(F)(i)."[22] The Provider argues in its issue statement, which was included in the appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[23]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 18-0552GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 19-0670 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 18-0552GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[24], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[25] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors are specific to this provider.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 18-0552GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records"[26] but fails to explain how it can, explain how that information is relevant, and whether such a review was done for purposes of the year in question, consistent with its obligations under Board Rule 25.2.[27] 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'

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[22] *Id.*
[23] *Id.*
[24] PRRB Rules v. 2.0 (Aug. 2018).
[25] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[26] Provider's PPP at 9.
[27] It is also not clear whether this is a systemic issue for CHS providers in the same state subject to the CIRP rules or something that is provider specific because, if it was a common systemic issue, it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

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

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

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[28]

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

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

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

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh. [29]

[28] (Italics and underline emphasis added.)
[29] Last accessed August 14, 2024.

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data.[30]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 18-0552GC.

Accordingly, *based on the record before it*,[31] the Board finds that the SSI Provider Specific issue in Case No. 19-0670 and the group issue from the CHS CIRP group under Case No. 18-0552GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Further, the Provider's cost reporting period is congruent with the Federal Fiscal Year, both ending on 9/30. Thus, realignment of the SSI from one to the other would have no effect on reimbursement. Therefore, the Board dismisses this aspect of the appeal.

B. The Part C Days Issues

On July 19, 2019, Quality Reimbursement Services, Inc. filed a *Model Form D – Request to Transfer Issue to a Group Appeal* for Issue 3 (DSH Payment – SSI Fraction/Medicare Managed Care Part C Days issue), requesting that this issue be transferred to Group Case No. 17-1571GC. On the same date, Quality Reimbursement Services, Inc. also filed a *Model Form D – Request to Transfer Issue to a Group Appeal* for Issue 6 (DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days), requesting that this issue also be transferred to Group Case No. 17-1571GC.

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[30] Emphasis added.

[31] Again, the Board notes that the Provider failed to respond to the Jurisdictional Challenge and the Board must make its determination based on the record before it.

On February 21, 2020, the Board denied the Provider's request to transfer the Medicare and Medicaid Part C Days Issues (Issue 3 and Issue 6) to CHS 2015 DSH Part C Days CIRP Group (Case No. 17-1571GC) as QRS was not the Case Representative for either this individual appeal or the Group Case. The Board instructed QRS to file proper transfer requests for these issues.

However, as the Provider was properly directly added to Case No. 17-1571GC on December 3, 2018, it is properly in that group appeal, despite the Board denying the secondary transfer request. Therefore, as an issue cannot be pursued in both an individual and group appeal as duplicative issues from the same final determination are prohibited by Board Rule 4.6, as discussed above, the Board hereby dismisses the Part C days issues from Case No. 19-0670.

C. Medicaid Eligible Days

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

Regarding the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Aug. 2018) states in Rule 7.3.2:

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

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

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

> **timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[32]

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

As cited above, Board Rule 25 requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation.

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

[32] (Bold emphasis added.)

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

Further, the Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on January 15, 2019, included instructions on the content of the Provider's preliminary position paper, consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

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

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[33]

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

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

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

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

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),
- 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 31, 2019, the Provider filed its preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[34] The position paper did not identify how many Medicaid eligible days remained in dispute in this case.

The Provider's complete briefing of this issue in its final position paper, filed on April 22, 2024, is as follows:

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[33] (Emphasis added.)
[34] Provider's PPP at 8.

Calculation of Medicaid Eligible Days

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

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

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

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

…

Based on the Listing of Medicaid Eligible days being sent under separate cover 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' 2015 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[35]

[35] Provider's Final Position Paper at 9-10 (Apr. 22, 2024).

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.[36]

On June 14, 2024, QRS filed a "Redacted Medicaid Eligible Days Listing Submission." The Listing *only* includes a list of 952 Section 1115 waiver days. It does not include a list of any Medicaid eligible days.

The Provider failed to timely include a list of additional Medicaid eligible days with its preliminary position paper, or submit such list under separate cover as instructed, or when requested from the Medicare Contractor. The Medicare Contractor thus asserts that "the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules."[37]

The Board thereby finds the issue abandoned after failing for over four years to file a listing. The Board agrees with the Medicare Contractor's contention that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled, consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25.

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).

Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[38] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filings, 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 dismisses this issue from the appeal.

Section 1115 Waiver Days

The Board finds that the § 1115 Waiver Days issue is *not* properly part of this appeal because it

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[36] Medicare Contractor's Jurisdictional Challenge at 3-8 (May 17, 2024).
[37] *Id.* at 7-8. *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.
[38] (Emphasis added.)

was not properly included in the original appeal request, and it was not properly or timely added to the appeal. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the § 1115 Waiver Days as recognized by multiple Board, Administrator and Court decisions[39] (many of which were issued prior to the Provider's February 6, 2019 deadline for adding issues to this appeal).[40]

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

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing to the Board, and the request **must include** the elements described in paragraphs (b)(1) through (b)(4) of this section. **If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (b)(2), or (b)(3) of this section, the Board 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).

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

[40] Here, the NPR at issue was issued on June 6, 2018 and the Provider had until Monday, December 10, 2018 to file the appeal (where receipt is presumed to be 5 days later and the Provider had 180 from that date to file an appeal request). Accordingly, the deadline to add issues is 60 days beyond that date, *i.e.*, Wednesday, February 6, 2019.

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

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

(3) A copy of the final contractor or Secretary determination under appeal and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section.[41]

Board Rule 7 (Aug. 29, 2018) elaborated on these regulatory "contents" requirements instructing providers:

> **7 - Support for Final Determination, Issue-Related Information and Claim of Dissatisfaction**
>
> The Provider must support the determination being appealed and the basis for its dissatisfaction for <u>each</u> issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Board Rules 7.2 and 7.3 provider further information regarding issue pleading and specificity:

> **7.2 - Issue Related Information**
>
> **7.2.1 General Information**
>
> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
> - An issue title and a concise issue statement describing:
> - 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

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

- the basis for jurisdiction before the PRRB.

• A copy of the applicable audit adjustment report page(s) or a statement addressing why an adjustment report is not applicable or available.
• A calculation or other support for the reimbursement effect noted in the issue statement.
• Support for protested items or claim of dissatisfaction as noted in Rules 7.3 and 7.4.

7.2.2. Additional Information

Providers must submit additional information not specifically addressed above in order to support jurisdiction or appropriate claim for the appealed issue(s). Example: Revised NPR workpapers and applicable cost report worksheets to document that the issue under appeal was specifically adjusted. NPR or Revised NPR Adjustments

7.3 Self Disallowed Items (Applies to Cost Reporting Periods Ending On or Before 12/31/15)

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

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

7.3.2 No Access to Data

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

7.3.3 Protest

Effective for cost reporting periods ending on or after December 31, 2008, items claimed under protest on the cost report must follow the applicable procedures as contained in CMS Pub. 15-2, Section 115. See 42 C.F.R.§ 405.1835(a)(1)(ii). [*March 2013*][42]

For the appeal, you must:

• identify the amount that was protested for the specific item being appealed,
• attach a copy of the protested items worksheet submitted with your as-filed cost report, and
• the as-filed Worksheet E or audit adjustment report to demonstrate the total protested claim.
Note: CMS Ruling 1727-R governs for cost reporting periods ending on or after 12/31/08 and beginning before 1/1/16.

Board Rule 8 (Aug. 29, 2018) provides "*special instructions*" for issue statements *involving* ***multi-component disputes***. In particular, 8.1 explains that, when framing issues for adjustments *involving multiple components*, that providers must "***specifically*** identify" each cost item in dispute, and "…each contested component must be appealed as a *separate* issue and described as ***narrowly as possible***…".[43] Board Rule 8.1 (Aug. 29, 2018) gives common *examples* of different components of the Disproportionate Share Hospital payment calculation that may be in dispute. Specifically, Board Rule 8 states:

Rule 8 – Framing Issues for Adjustments Involving Multiple Components

8.1 – General

Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7. Several examples are identified below, ***but these are not exhaustive lists of categories or issues.***[44]

A. Disproportionate Share Hospital Payments

Common examples include: dual eligible Medicare Part A/Medicaid, dual eligible Medicare Part C/Medicaid, SSI data matching, state/program specific general assistance days, Section

[42] (Italics emphasis in initial paragraph for Rule 7 added.)
[43] (Emphasis added.)
[44] (Emphasis added.)

> 1115 waiver days (program/waiver specific), and observation bed days.
>
> **B. Bad Debts**
> Common examples include: crossover bad debts, collection effort, use of collection agency, 120-day presumption, and indigence determination.
>
> **C. Graduate Medical Education/Indirect Medical Education**
> Common examples include: managed care days, new programs, current year resident count, prior year count, penultimate year count, intern to bed ratio, and rotations to non-hospital settings.
>
> **D. Wage Index**
> Common examples include: wage data corrections, occupational mix, wage vs. wage-related costs, pension, rural floor, and data corrections.[45]

Pursuant to the May 23, 2008 final rule, new Board regulations went into effect on August 21, 2008 *that limited the **addition** of issues to appeals*.[46] As a result of this final rule, 42 C.F.R. § 405.1835(e) (Sept. 2015) provides in relevant part:

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

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to establish that the Provider timely and properly added the § 1115 Waiver Days to the case. In this regard, the first discussion of § 1115 waiver days in this case occurred in the Provider's April 22, 2024 final position paper, well after the deadline for adding issues had passed.

In this regard, the Board notes that § 1115 Waiver days are *not* traditional Medicaid eligible days. Indeed, it was only effective January 20, 2000 that the Secretary incorporated, ***at her discretion*** *by regulation*, only ***certain*** types of § 1115 waiver days into the DSH calculation (*i.e.,* the Secretary maintains that no statute requires that days associated with § 1115

[45]Board Rules are available https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-rules-and-board-orders (last visited Aug. 19, 2024).
[46] *See* 73 Fed. Reg. 30190 (May 23, 2008).

waiver/expansion programs be included in the DSH calculation and that she exercised her discretion to include only certain such days).[47] Rather, § 1115 waiver days relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R.§ 412.106(b)(4) relating to § 1115 waiver days. Specifically, § 412.106(b)(4) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> (ii) **Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act**.
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.[48]

*Significantly, **§ 1115 waiver programs can pertain** to not just Medicaid (Title XIX), but also **to***

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[47] 65 Fed. Reg. 47054, 47087 (Aug. 1, 2000). *See also* 68 Fed. Reg. 45346, 45420 (Aug. 1, 2003) (stating: "On January 20, 2000, we issued an interim final rule with comment period (65 FR 3136), followed by a final rule issued on August 1, 2000 (65 FR 47086 through 47087), to allow hospitals to include the patient days of all populations that receive benefits under a section 1115 demonstration project in calculating the Medicare DSH adjustment. Previously, hospitals were to include only those days for populations under the section 1115 demonstration project who were, or could have been made, eligible under a State plan. Patient days of those expansion waiver groups who could not be made eligible for medical assistance under the State plan were not to be included for determining Medicaid patient days in calculating the Medicare DSH patient percentage. Under the January 20, 2000 interim final rule with comment period (65 FR 3137), hospitals could include in the numerator of the Medicaid fraction those patient days for individuals who receive benefits under a section 1115 expansion waiver demonstration project (effective with discharges occurring on or after January 20, 2000).").

[48] (Bold emphasis added.)

other programs under Titles I, X, XIV, XIV or part A or D of Title IV of the Social Security Act.[49] Hence, an important limitation is that the § 1115 waiver program receive Title XIX matching payments. Moreover, not every state Medicaid program has a qualifying § 1115 expansion program receiving Title XIX matching payments[50] and not every inpatient day associated with a beneficiary enrolled in such a § 1115 waiver program qualifies to be included in the numerator of the DSH Medicaid fraction.[51] In contrast, every state has a Medicaid state

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

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

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

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

plan; every state Medicaid plan includes inpatient hospital benefits; and by statute at 42 U.S.C.§ 1395ww(d)(5)(F)(vi)(II), the numerator of the DSH Medicaid fraction must include inpatient days of patients "who . . . were eligible for medical assistance ***under a State plan*** approved under subchapter XIX" but who were not entitled to Medicare Part A.[52]

In this regard, documentation needed to verify eligibility for a § 1115 waiver day is materially different than that for a traditional Medicaid eligible day[53] and, similarly, it is not a given that *all* § 1115 waiver days (even those under a program receiving Title XIX matching payments) necessarily would qualify under § 412.106(b)(4) as demonstrated by Board decisions and case law.[54] Here, 42 C.F.R. § 405.1835(b) and Board Rules 7 and 8 required each separate issue to be identified in the appeal request. Here, the Provider failed to do so, notwithstanding including a ***detailed*** description of "The Process That The Provider Used To Identify And Accumulate The Actual Medicaid Paid And Unpaid Days That Were Reported And Filed On The Medicare Cost Report At Issue" to support its assertion that the Medicaid eligible days at issue in the appeal were ones that could not have been identified through that process.[55] **Significantly, at the time of the appeal the Provider sought only 100 additional Medicaid eligible days. The listing of days submitted after the filing of the final position paper were for 952 days and it is unclear why that amount increased more than nine times over.**

Regardless of whether the Provider *properly* included the § 1115 waiver days issue in its appeal request (which it did not), the Provider failed to properly develop the merits of § 1115 waiver day issue in any of the Provider's position papers. Specifically, the Provider's preliminary position paper nor the final position paper mention, much less identify, the **specific state** § 1115

> benefits, including inpatient hospital benefits, under a section 1115 demonstration project) in order for their hospital inpatient days to be counted as Medicaid days in the calculation of a hospital's DSH patient percentage. Under the proposed clarification, hospital inpatient days attributed to patients who do not receive coverage for inpatient hospital benefits either under the approved State plan or through a section 1115 demonstration would not be counted in the calculation of Medicaid days for purposes of determining a hospital's DSH patient percentage.
>
> Under this reading, in the examples given above, the days associated with a hospital inpatient who receives coverage of prescription drugs or family planning services on an outpatient basis, but no inpatient hospital coverage, through either a Medicaid State plan or a section 1115 demonstration, would not be counted as Medicaid days for purposes of determining the DSH patient percentage.

[52] (Emphasis added.)

[53] In addition to providing proof that the patient at issue was eligible for the § 1115 waiver program for each day claimed, the Provider must also establish that the particular § 1115 waiver program at issue relates to Title XIX and qualified under 42 C.F.R. § 412.106(b)(4) as demonstrated by the preamble discussion in *supra* note 51 and litigation in *supra* note 39.

[54] *See* litigation in *supra* note 39.

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

waiver program(s) at issue[56] or how any days under such program(s) would qualify under 42 C.F.R.§ 412.106(b) to be included in the numerator of the DSH Medicaid fraction, notwithstanding its obligation to do so, consistent with the position paper content requirements at 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules 25 and 27.[57] This is an independent basis for dismissal of the § 1115 waiver day issue. Specifically, the material facts and legal arguments needed to establish the merits of the Provider's claims regarding the § 1115 waiver days issue along with the relevant supporting documentation were not properly briefed and included in the position paper filings.

Finally, even if the Board were to find that Issue 5 encompassed § 1115 waiver days, **there is no indication that any of the § 1115 waiver days included in the listing submitted on June 14, 2024, were included with the as-filed cost report and, if true that they were not included,** this would make them an *unclaimed* cost and provide an independent basis for dismissal (*see* Board Alert 10). In raising this issue, the Board notes that it has found that when a class of days (*e.g.*, § 1115 waiver days) is excluded due to choice, error, and/or inadvertence from the as-filed cost report,[58] then that class of days is an unclaimed cost for which the Board would lack jurisdiction under 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835(a)(1)(i)-(ii) (2012) as clarified by CMS Ruling 1727-R.[59] The Provider's briefings generally address this jurisdictional issue by generically asserting that its process did not identify certain Medicaid eligible days. However, this discussion did not identify or discuss the class of days known specifically as § 1115 waiver days and whether that class of days was included on the cost report. In this regard, if the Provider purposefully excluded § 1115 waiver days from the as-filed cost report, then CMS Ruling 1727-R confirms that the Provider only had a right to appeal those days if it "***had a good faith belief*** *that claiming reimbursement for [the § 1115 waiver days at issue] in the cost report would be futile because [the § 1115 waiver days at issue] was subject to a regulation or other payment policy* ***that bound the Medicare contractor and left the contractor with no authority or***

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

[57] 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25 (Aug. 2018) required a fully-developed preliminary position paper that includes the legal merits and material facts of the Provider's position as well as all available supporting documents as required by Board Rule 25.2 (Aug. 2018).

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

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

[59] *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 06-1852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days because no days were claimed with the as-filed cost report due to choice, error and/or inadvertence and, as such, the practical impediment standard or futility concept in the *Norwalk* and *Danbury* decisions under PRRB Dec. Nos. 2012-D14 and 2014-D03 is not applicable (available at: https://www.cms.gov/regulations-and- guidance/review-boards/prrbreview/downloads/jd-2017-11.pdf (last accessed July 3, 2024)).

discretion to make payment in the manner sought by the provider."[60] Here the Provider has failed to specifically address or discuss the Board's jurisdiction over this unique class of days. This is an independent basis for the Board to dismiss the § 1115 waiver days issue (*i.e.*, in addition to and independent from dismissal for failure to properly include the issue in its appeal request or to properly brief and develop the issue).

In summary, as the DSH Medicaid Eligible Days issue as stated in the original appeal request did not include the § 1115 waiver days and the issue was not timely added to the appeal, the Board dismisses it from this appeal. Because the Provider did not raise the § 1115 Waiver Days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The DSH Medicaid Eligible Days issue as stated in the original appeal request cannot be construed to include Section 1115 Waiver Days. Indeed, even if the Provider had properly included the issue as part of its appeal request, there are multiple independent bases upon which the Board would dismiss the issue, namely the failure to establish the Board's jurisdiction over the issue and the failure to properly develop the merits of the issue in its position paper filings.

* * * * *

Based on the foregoing, the Board dismisses the final four (4) remaining issues in this case – (Issues 1, 3, 5 and 6). As no issues remain, the Board hereby closes Case No. 19-0670 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:

8/19/2024

X Kevin D. Smith, CPA

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

cc: Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)
Wilson Leong, FSS

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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Geoff Pike
First Coast Service Options, Inc. c/o GuideWell Source
Provider Audit and Reimbursement Dept.
532 Riverside Avenue
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RE: ***Jurisdictional Decision***
Bayfront Health – St. Petersburg (Provider Number 10-0032)
FYE: 9/30/2015
Case Number: 19-2364

Dear Messrs. Ravindran and Pike,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above referenced appeal pursuant to a jurisdictional challenge filed by the Medicare Contractor. The jurisdictional decision of the Board is set forth below.

Background

A. *Procedural History for Case No. 19-2364*

On **February 13, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2015. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **August 6, 2019**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

[1] On June 23, 2020, the Medicare Contractor filed a jurisdictional challenge over Issue 1. On August 5, 2024, the issue was withdrawn.
[2] On March 19, 2020, this issue was transferred to Case No. 18-0552GC.
[3] On May 22, 2024, the Medicare Contractor filed a jurisdictional challenge over Issue 3.
[4] On March 19, 2020, this issue was transferred to Case No. 18-0555GC.
[5] On March 19, 2020, this issue was transferred to Case No. 18-0554GC.

On **August 8, 2019**, CHS added the following issue to the appeal:

6. Nursing and Allied Health Education Costs – Legal Operator[6]

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **March 19, 2020**, the Provider transferred Issues 2, 4, and 5 to CHS CIRP groups. On **August 5, 2024**, the Provider withdrew Issues 1 and 6. As a result, one issue remains in the appeal: Issue 3 (DSH Payment – Medicaid Eligible Days).

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

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

On **March 27, 2020**, the Provider timely filed its preliminary position paper ("PPP"). The Provider briefed the DSH Payment/SSI Percentage (Provider Specific) and DSH Payment – Medicaid Eligible Days issues. In briefing the DSH Payment - Medicaid Eligible Days issue the Provider did not address Section 1115 waiver days.

With respect to the DSH Payment – Medicaid Eligible Days issue, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made, and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2015 cost report does not reflect an accurate number of Medicaid eligible days." As a result the Provider included, as Exhibit 2, the original "estimated impact" for this issue of $15,959 based on an *estimated* 50 days.

On **June 26, 2020**, the Medicare Contractor timely filed its PPP. With regard to the DSH Payment – Medicaid Eligible Days issue, the Medicare Contractor's position paper noted that the Provider had failed to include a Medicaid eligible days listing with its position paper

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[6] On June 23, 2020, the Medicare Contractor filed a jurisdictional challenge over Issue 6. On August 5, 2024, the issue was withdrawn.
[7] (Emphasis added.)

notwithstanding its obligation under 42 C.F.R. § 413.24 to "submit adequate documentation to support its claims."[8]

On **May 1, 2024,** the Provider timely filed its final position paper ("FPP"). Attached as Exhibit P-1 to the Provider's FPP was a redacted 35-page listing entitled "1115 Waiver and Additional ME Days Consolidated. The listing totaled 5,298 days, over 100 times greater than the Provider's original estimate in its appeal request. A note on the listing indicated that it was "pending finalization upon receipt of State eligibility data."[9]

Regarding the DSH Payment – Medicaid Eligible Days issue, the Provider argues in its Final Position Paper that pursuant to the Jewish Hospital case[10] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" when the DSH adjustment is calculated.[11] The Provider then, for the first time in this appeal, states it is seeking reimbursement for section 1115 waiver days as a part of the Medicaid eligible days 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).[12]

On **May 22, 2024**, the Medicare Contractor timely filed its FPP. With respect to the Medicaid eligible days issue, the Medicare Contractor stated the following:

> At this time, the MAC has not received an unredacted listing of the additional Medicaid eligible days in question. The Provider submitted a list of days to the MAC in separate correspondence, but the list appears to consist of 1115 Waiver Days and not the Medicaid eligible days that are under appeal. According to 42 CFR § 413.24, a provider must submit adequate documentation to support its claims on the cost report. The MAC will work with the Provider towards a resolution of this issue pending receipt and review of documentation to support the Medicaid days in question and pending jurisdiction.

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[8] Medicare Contractor's Preliminary Position Paper ("Contractor's PPP") at 10 (June 26, 2020).
[9] Provider's Final Position Paper ("Provider's FPP"), Exhibit P-1 (May 1, 2024).
[10] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[11] Provider's FPP at 9.
[12] Provider's FPP at 9-10.

> The MAC contends that the Medicaid days, as determined in the original NPR, included all documented and audited Medicaid days at the time the review was originally completed. The Board should uphold the original determination of the DSH calculation until such time that the MAC has been able to fully verify the validity of the additional Medicaid eligible days being claimed in this appeal.
>
> In addition, the Provider includes wording regarding Section 1115 waiver days in its final position paper. The MAC contends that the Provider is attempting to untimely add this issue to the appeal. The Section 1115 waiver days is a separate and distinct issue from the Medicaid eligible days that were appealed.[13]

On **May 22, 2024,** the Medicare Contractor filed a jurisdictional challenge over Issue 3 in the appeal, requesting that the Board dismiss the issue in its entirety. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge.

On **June 10, 2024**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **July 10, 2024**, the Provider filed an **untimely** response to the Medicare Contractor's jurisdictional challenge over Issue 3.

Description of Issue 3 in the Appeal Request

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

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

[13] Medicare Contractor's Final Position Paper ("Contractor's FPP") at 11.

> 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.

Estimated Reimbursement Amount: $16,000[14]

Medicare Contractor's May 22, 2024 Jurisdictional Challenge

The Medicare Contractor states that the Provider "failed to include a list of additional Medicaid eligible days it expects to be included in its Medicaid percentage and DSH computation with its appeal request [submitted on August 6, 2019]."[15] The Medicare Contractor then notes that within the Provider's preliminary position paper and Exhibit 1 submitted on March 27, 2020, the Provider indicated that "a list of additional Medicaid eligible days is being sent under separate cover."[16] Finally, the Medicare Contractor explains that within the Provider's final position paper and Exhibit P-1 submitted on May 1, 2024, "the Provider submitted an incomplete and redacted version of the Eligibility Listing and advised that an unredacted version would be submitted directly to the [Medicare Contractor].[17] The Medicare Contractor contends that "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. The only unredacted list submitted by the Provider was a list of Section 1115 waiver days."[18]

The Medicare Contractor contends "that the Provider was in violation of Board Rules 25.3 and 27 when in 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."[19]

Notably, the Medicare Contractor contends,

> the Provider has not included a complete unredacted list of additional Medicaid eligible days with its preliminary or final position papers or submitted such list under separate cover contrary to its statements in its position papers. 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 violation of the regulations at 42 C.F.R. §§ 413.24(c) and

[14] Issue Statement at 2-3 (Aug. 6, 2019).
[15] Medicare Contractor's Jurisdictional Challenge at 2 (May 22, 2024).
[16] *Id.*
[17] *Id.*
[18] *Id.*.
[19] *Id.* at 5.

> 412.106(b)(4)(iii) and the Board Rules. The [Medicare Contractor] contends 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 cannot produce those documents, as required by the regulations and the Board Rules.[20]

With respect to the Section 1115 waiver days portion of Issue 3, the Medicare Contractor contends that "the Provider is attempting to untimely add the issue of Section 1115 waiver days by including it in the narrative of its final position paper."[21] Further, it notes that:

> [a]ccording 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 February 13, 2019, thereby setting the period to add issues to close on October 11, 2019. The Provider did not raise the issue of Section 1115 waiver days in its appeal request or 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 May 1, 2024, over four years after the deadline to add new issues.[22]

Provider's Untimely July 10, 2024 Jurisdictional Response

The Provider points to the phrase utilized in describing Issue 1 in its appeal request: "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."[23] It argues, "[t]he italicized language above makes clear that the Provider appealed all Medicaid eligible days, including section 1115 waiver days. By definition, section 1115 waiver days are Medicaid eligible days."[24]

The Provider contends that "[b]oth a June 25, 2004 proposed rule (69 *Fed. Reg.* 35716) and a May 23, 2008 final rule (73 *Fed. Reg.* 30190) indicate that an 'issue' is encapsulated by a specific cost report adjustment. They do not slice and dice an 'issue' into component parts, including the specific reason why Medicaid eligible days were not counted in the numerator of the Medicaid Fraction of the Disproportionate Patient Percentage. . . . A MAC's cost report determination is synonymous with an "adjustment." In this case, the same adjustment to so-called generic Medicaid eligible days also governs Medicaid eligible days associated with beneficiaries covered under a section 1115 waiver."[25]

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[20] *Id.* at 6-7.
[21] *Id.* at 7.
[22] *Id.* at 8.
[23] Provider's Jurisdictional Response at 3 (July 10, 2024).
[24] *Id*.
[25] *Id.* at 3-4.

The Provider then points to the July 1, 2015 PRRB instructions at Rule 7.1 and Rule 8 that were in effect at the time the Provider filed its appeal. The Provider contends that for purposes of identifying the "issue" under appeal per Rule 7.1,

> the provider need only
>
> > Give a concise issue statement describing:
> > * the adjustment, including the adjustment number,
> > * why the adjustment is incorrect, and
> > * how the payment should be determined differently.
>
> There is no dispute that the same cost report adjustment that affects other types of Medicaid eligible days also effects section 1115 waiver days.[26]

The Provider then went on to address Rule 8, stating,

> [b]ecause 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 a 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 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 'section 1115 waiver days' in its appeal request.[27]

The Provider continues, arguing that "Rule 8 is also internally inconsistent with Rule 7. Whereas Rule 8 refers to 'components' of an issue, Rule 7.1 provides that, for purposes of identifying the 'issue' under appeal, the Provider need only '[g]ive a concise issue statement' that describes the cost report adjustment, including the cost report adjustment number and why the cost report adjustment is incorrect. Thus, Rule 8 is both inconsistent with the regulations and Rule 7."[28]

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[26] *Id.* at 4.
[27] *Id.* at 4.
[28] *Id.* at 5.

The Provider also refutes the MAC's argument that the Provider has abandoned the issue of section 1115 waiver days because it did not brief it in the Provider's Preliminary Position Paper. The Provider states that "this is not a jurisdictional argument and is inappropriate for a jurisdictional challenge."[29]

The Provider argues that

> [t]he MAC is required by specific command of CMS to accept and audit the Provider's section 1115 waiver days. CMS has issue instructions that require the inclusion of section 1115 waiver days in providers' Medicaid Fractions. . . . The directions in such manual instructions are binding on all of the Secretary's MACs. . . . Thus, the MAC has the duty to accept the Provider's listing of section 1115 days and audit them.[30]

Board Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2014), 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.

Traditional Medicaid Eligible Days

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

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:

> **7.3.2 No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

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**

[29] *Id.* at 5.
[30] *Id.* at 5-6.

> **must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[31]

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

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

> **Rule 25 Preliminary Position Papers**[32]
>
> **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

[31] (Bold emphasis added.)
[32] (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 August 8, 2019 included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

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

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[33]

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

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

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

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

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

[33] (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 March 27, 2020, the Provider filed its preliminary position paper in which it indicated that an eligibility listing was imminent by promising that the listing was being sent under separate cover.[34] 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 $15,959 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 state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.

[34] Provider's PPP at 8.

> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2015 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[35]

On May 1, 2024, the Provider filed its final position paper. Attached as Exhibit P-1 to the paper was a redacted 35-page listing entitled "1115 Waiver and Additional ME Days Consolidated. The listing totaled 5,298 days. A note on the listing indicated that it was "pending finalization upon receipt of State eligibility data." The Provider's filing did not explain why the listing of so many 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 5,298 days included in this belated listing is *exponentially* larger than the original estimate of 50 days included with the appeal request. Regardless, this filing ***was roughly 4 years past the deadline for including it with the preliminary position paper,*** since the preliminary position paper deadline was April 2, 2020.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e*., the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional traditional 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 traditional Medicaid eligible days issue because the provider has failed to identify any specific traditional Medicaid eligible days[36] at issue (much less provide any supporting documentation for those days).

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[37] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provider the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board finds that there are no such days in dispute and that the actual amount in controversy is $0.

Accordingly, the Board dismisses the traditional Medicaid eligible days issue from the appeal.

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[35] Provider's PPP at 7-8.
[36] In its Final Position Paper dated May 22, 2024, the Medicare Contractor states that the listing that the Provider submitted with its Final Position Paper appears to consist of 1115 waiver days and not the traditional Medicaid days under appeal.
[37] (Emphasis added.)

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 an issue in its appeal request and failed to timely and properly add this additional issue to the appeal. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the section 1115 Waiver days.

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

> (d) *Contents of request for a Board hearing based on untimely contractor determination.* The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include. . .
>
> . . .
>
> (2) An explanation (for each specific item at issue) of the following:
>
> (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…[38]

Board Rule 8.1 explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each cost item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". Board Rule 8.2 gives a common example of the Disproportionate Share Hospital payment calculation and the different types of days which must be separately identified such as dual eligible, general assistance, charity care, HMO days, etc.[39]

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.[40]
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 –

[38] 42 C.F.R. § 405.1835(d) (2015).
[39] Board Rules are available at https://www.cms.gov/regulations-guidance/provider-reimbursement-review-board/prrb-rules-and-board-orders (last visited Aug. 21, 2024)
[40] *See* 73 Fed. Reg. 30190 (May 23, 2008).

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

In practice, this means that new issues had to be added to Bayfront's appeal no later than 240 days after receipt of the Medicare Contractor's determination. The deadline to add issues in the appeal was October 11, 2019. Bayfront's first mention of Section 1115 Waiver Days was in its Final Position Paper submitted on May 1, 2024, well after the deadline to add issues to the appeal.

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

Specifically, § 412.106(b)(4) 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**

[41] 65 FR 47054, 47087 (Aug. 1, 2000).

> **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 issue 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 and dismisses it from the appeal. 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.

Conclusion:

The Board dismisses Issue 3 DSH Payment – Medicaid Eligible Days in its entirety from the appeal. As no issues remain in the appeal, the Board closes Case No. 19-2364 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:

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For the Board:

8/21/2024

X Kevin D. Smith, CPA

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Expedited Judicial Review Determination***
24-0640GC Care New England FFY 2024 Area Wage Index Standard. Amt. Reduct. CIRP Grp.
24-0641GC Emory Healthcare FFY 2024 Area Wage Index Standard. Amt. Reduct. CIRP Grp.
24-0844GC HCA FFY 2024 Area Wage Index Standardized Amount Reduction CIRP
24-1457G Hooper Lundy & Bookman FFY 2024 Area Wage Index Standard. Amt. Reduct. Grp.
24-0642GC UNC Health FFY 2024 Area Wage Index Standard. Amount Reduct. CIRP Grp.
24-1094GC Univ. of Chicago MC FFY 2024 Area Wage Index Standard. Amt. Reduct. CIRP Grp.
24-0651GC Yale-New Haven FFY 2024 Area Wage Index Standard. Amt. Reduct. CIRP Grp.

Dear Ms. Carroll:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' consolidated request for expedited judicial review ("EJR") filed on July 23, 2024, in the seven (7) above-referenced group appeals. The Board's decision on jurisdiction and EJR for the seven (7) above-referenced group appeals is set forth below.

Issue:

The issue for which EJR has been requested is:

> [W]hether the Providers' FFY 2024 standardized amount and hospital-specific operating IPPS [inpatient prospective payment system] payment rate[s] were improperly reduced by approximately 0.2598% for FFY 2024.[1]

Statutory and Regulatory Background:

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[2] known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs").

[1] Consolidated request for Expedited Judicial Review at 3 (July 23, 2024).
[2] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).

The base payment rate is comprised of a standardized amount[3] for all subsection (d) hospitals located in an "urban" or "rural" area.[4]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[5] adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).[6]

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts.[7]

A. Changes to the Wage Index Calculation

In the FFY 2019 IPPS proposed rule,[8] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information ("RFI") as part of the FFY 2020 IPPS proposed rule.[9] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates

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[3] The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994). Section 1395ww(d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).
[4] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[5] of the Department of Health and Human Services.
[6] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index (last visited Aug. 6, 2024).
[7] *Id.*
[8] 83 Fed. Reg. 20164 (May 7, 2018).
[9] 84 Fed Reg 19158, 19393-94 (May 3, 2019).

and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[10] Based on these concerns, the Secretary proposed "[t]o help mitigate the wage index disparities" by "reduc[ing] the disparity between high and low wage index hospitals by increasing wage index values for certain low wage index hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values to maintain budget neutrality, and changing the calculation of the rural floor . . . ."[11]

In the FY 2020 IPPS final rule, the Secretary summarized his proposal as follows:

> [N]otwithstanding the challenges associated with comprehensive wage index reform, we agree with respondents to the request for information who indicated that some current wage index policies create barriers to hospitals with low wage index values from being able to increase employee compensation due to the lag between when hospitals increase the compensation and when those increases are reflected in the calculation of the wage index. (We noted that this lag results from the fact that the wage index calculations rely on historical data.) We also agreed that addressing this systemic issue did not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure." Therefore, in response to these concerns, in the FFY 2020 LTCH PPS proposed rule . . . , we proposed a policy that would provide certain low wage index hospitals with an opportunity to increase employee compensation without the usual lag in those increases being reflected in the calculation of the wage index.[12]

In the FFY 2020 IPPS Final Rule, the Secretary finalized the "proposal to increase the wage index for hospitals with a wage index value below the 25th percentile wage index by half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value across all hospitals is 0.8457."[13] In doing so, the Secretary determined that "quartiles are a reasonable method of dividing the distribution of hospitals' wage index values" and that "identifying hospitals in the lowest quartile as low wage index hospitals, hospitals in the second and third 'middle' quartiles as hospitals with wages index values that are neither low nor high, and hospitals in the highest quartile as hospitals with high wage index values, is a reasonable method of determining low wage index and high wage index hospitals for purposes of our proposals . . . addressing wage index disparities."[14]

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[10] *Id.*
[11] *Id.*
[12] 84 Fed. Reg. at 42326 (citations omitted).
[13] *Id.* at 42328.
[14] *Id.* at 42326

The Secretary acknowledged that "there is no set standard for identifying hospitals as having low or high wage index values"; however, he believes his "proposed quartile approach is reasonable for this purpose, given that . . . quartiles are a common way to divide distributions, and that our approach is consistent with approaches used in other areas of the Medicare program." The Secretary stated in the proposed rule that, based on the data for the proposed rule, for FY 2020, the 25th percentile wage index value across all hospitals was 0.8482 and that this number would be updated in the final rule based on the final wage index values.[15] When the FFY 2020 IPPS final rule was published the 25th percentile wage index value across all hospitals for FFY 2020 was 0.8457.[16]

Under the Secretary's methodology, he decided to increase the wage index for hospitals with a wage index value below the 25th percentile wage index. The increase in the wage indices for these hospitals would be equal to half of the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year for all hospitals.[17] The Secretary also confirmed that he was "finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in this rule, is implemented in a budget neutral manner" and asserted that his authority to do so "falls within the scope of the authority of section 1886(d)(3)(E) of the Act" and "even if [budget neutrality] were not required [under section 1886(d)(3)(E)], we believe it would be inappropriate to use the wage index to increase or decrease overall IPPS spending."[18]

The Secretary announced that the low wage index policy would be *in effect* ***for at least*** *four years beginning in FFY 2020*, in order to allow employee compensation increases implemented by low wage index value hospitals sufficient time to be reflected in the wage index calculation. The Secretary explained that, for the FFY 2020 wage index, data from 2016 cost reports was used to calculate the wage indices and four years is the minimum time before increases in employee compensation included in Medicare cost reports could be reflected in the wage index. The Secretary acknowledged that additional time may be necessary to determine the duration of the policy.[19]

In the FFY 2021 IPPS Final Rule, the Secretary stated he was continuing the low wage index hospital policy for FY 2021, and also applying this policy in a budget neutral manner by applying an adjustment to the standardized amounts.[20] Based on the data for this final rule, for FFY 2021, the 25th percentile wage index value across all hospitals was 0.8465, which was later corrected to 0.8469.[21]

Thereafter, in the FY 2022 IPPS Final Rule, the Secretary again stated he was continuing the low wage index hospital policy for FY 2022, and also applying this policy in a budget neutral manner

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[15] *Id.*
[16] *Id.*
[17] *Id.*
[18] *Id.* at 42331.
[19] *Id.* at 42326-7
[20] 85 Fed. Reg. 58432, 58436, 58767-68 (Sept. 18, 2020).
[21] *Id.* at 58768; 85 Fed. Reg. 78748, 78754 (Dec. 7, 2020) (Correction).

by applying an adjustment to the standardized amounts.[22] Based on the data for this final rule, for FY 2022, the 25th percentile wage index value across all hospitals was 0.8437.[23]

Again in the FY 2023 IPPS Final Rule, the Secretary indicated he was continuing the low wage index hospital policy for FY 2023, and also applying this policy in a budget neutral manner by applying an adjustment to the standardized amounts.[24] Based on the data for this final rule, for FY 2023, the 25th percentile wage index value across all hospitals was 0.8427.[25]

Finally, in the FY 2024 IPPS Final Rule, the Secretary indicated he was continuing the low wage index hospital policy for FY 2024, and also applying this policy in a budget neutral manner by applying an adjustment to the standardized amounts.[26] Based on the data for this final rule, for FY 2023, the 25th percentile wage index value across all hospitals was 0.8667.[27]

B. Budget Neutrality and the Wage Index

In the 2020 Proposed IPPS Rule, the Secretary explained that he believed that while it would not be appropriate to create a wage index floor or a wage index ceiling, it would be appropriate to provide a mechanism to increase the wage index of low wage index hospitals while maintaining budget neutrality for that increase through an adjustment to the wage index of high wage index hospitals. The Secretary maintained that this action had two key merits: (1) "by compressing the wage index for hospitals on the high and low ends, that is, those hospitals with a low wage index and those hospitals with a high wage index, such a methodology increases the impact on existing wage index disparities more than by simply addressing one end;" and (2) "such a methodology ensures those hospitals in the middle, that is, those hospitals whose wage indices are not considered high or low, do not have their wage index values affected by this proposed policy."[28] Thus, the Secretary concluded that, "given the growing disparities between low wage index hospitals and high wage index hospitals, . . . it would be appropriate to maintain budget neutrality for the low wage index policy proposed . . . by adjusting the wage index for high wage index hospitals."[29]

Following significant criticism from commenters to the proposed rule, the Secretary acknowledged that "some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between the proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States."[30] Based on this feedback, the Secretary decided to "finalize a budget neutrality adjustment for our low wage hospital policy but . . . not [to] finaliz[e] our proposal to target that budget neutrality adjustment on high wage hospitals" given that: (1) budget neutrality is required under [§ 1395ww(d)(3)(E)]; (2) even if it were not required,

[22] 86 Fed. Reg. 44774, 44778 (Aug. 13, 2021).
[23] *Id.* at 45178.
[24] 87 Fed. Reg. 48780, 49006 (Aug. 10, 2022).
[25] *Id.*
[26] 88 Fed. Reg 58640, 58978-58979 (Aug. 28, 2023).
[27] *Id.* at 58978.
[28] 84 Fed. Reg. at 42329.
[29] *Id.* at 42328-42329.
[30] *Id.* at 42331.

he believes that it would be inappropriate to use the wage index to increase or decrease overall IPPS spending; and (3) he wished to consider further the policy arguments raised by commenters regarding the budget neutrality proposal.[31] Specifically, "consistent with the Secretary's current methodology for implementing wage index budget neutrality under [§1395ww(d)(3)(E)] and the alternative approach we considered in the proposed rule (84 FR 19672), we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in the rule, was implemented in a budget neutral manner."[32]

The Secretary has continued the low wage index hospital policy the following four years, for FFYs 2021 to 2024, and continued to apply this policy in a budget neutral manner by applying an adjustment to the labor portion of the standardized amounts.[33]

Providers' Position:

The Providers are challenging their IPPS payments for FFY 2024 on the grounds that those payments were and continue to be improperly understated as a result of the reduction to the standardized amount, which the Secretary allegedly unlawfully imposed as part of the new policy increasing the Area Wage Index ("AWI") values of hospitals with an AWI value in the lowest quartile.

The Providers explain that the Secretary continues to implement, without any changes, his policy that increases the AWI values of hospitals with an AWI in the lowest quartile, nationally (the "Low Wage Index Redistribution") that he first adopted for FFY 2020. The Low Wage Index Redistribution was implemented in 2020 to address what the Secretary called "wage index disparities" by impacting the AWI values and the IPPS Medicare reimbursement that hospitals receive. Specifically, the Providers contend that the Low Wage Index Redistribution increases the AWI values of hospitals with AWI values in the lowest quartile, nationally, by half of the difference between their accurately calculated AWI and the 25th percentile of AWI values.

The Providers note that in the FFY 2024 IPPS Final Rule, the Secretary reiterated his assertion that he had the authority to implement this new policy under 42 U.S.C. § 1395ww(d)(3)(E) despite acknowledging that the district court in *Bridgeport Hospital, et al. v. Becerra,* No. 1:20-cv-01574 (D.D.C.)[34] held that the Secretary did not have the legal authority under 42 U.S.C. §§ 1395ww(d)(3)(E) or 1395ww(d)(5)(I)(i) to adopt the FFY 2020 Low Wage Index Redistribution. This section of the statute authorizes the Secretary to adjust the labor-related portion of IPPS payments to account "for area differences in hospital wage levels" by a "factor" (the wage index) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level, citing 42 U.S.C. § 1395ww(d)(3)(E). The

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[31] *Id*.
[32] *Id*.
[33] 85 Fed. Reg. at 58436 (Sept. 18, 2020); 86 Fed. Reg. at 44778 (Aug. 13, 2021); 87 Fed. Reg. at 49006 (Aug. 10, 2022); 88 Fed. Reg 58640, 58978-58979 (Aug. 28, 2023).
[34] 589 F. Supp. 3d 1 (2022), *aff'd in part and rev'd in part*, *and remanded, Bridgeport Hosp. v. Becerra*, 108 F.4th 882 (D.C. Cir. 2024). The Providers note the same conclusions were made in the 9th Circuit in *Kaweah Delta Health Care District v. Becerra*, 2022 WL 18278175 (C.D. Cal. 2022).

Secretary must "update" the wage index annually "on the basis of a survey . . . of the wages and wage-related costs of [IPPS-participating] hospitals in the United States."

The Providers contend that the Secretary again elected to implement his Low Wage Index Redistribution in a budget neutral manner for FFY 2023. As a result, the Providers allege, the Secretary decreased the standardized payment amounts of all IPPS hospitals by 0.1854 percent to offset the AWI increases to those hospitals in the lowest AWI quartile.

The Providers point out that the Secretary continues to assert that he had the authority to implement this budget neutrality adjustment under 42 U.S.C. § 1395ww(d)(3)(E); however, he noted that even if he did not have such authority under § 1395ww(d)(3)(E), he would invoke is statutory "exceptions and adjustments" authority in support of such a budget neutrality adjustment. This "exceptions and adjustments" authority provision, codified at 42 U.S.C. § 1395ww(d)(5)(I)(i), addresses IPPS payments and states: "The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate." The Providers contend that there is no statute that precludes administrative or judicial review of the Secretary's adjustments for different area wage levels under 42 U.S.C. § 1395ww(d)(3)(E) or adjustments under 42 U.S.C. § 1395ww(d)(5)(I).

The Providers argue that the Secretary lacks the authority to (a) continue the Low Wage Index Redistribution in the manner set forth in the FFY 2022 Final IPPS Rule; and (b) continue to implement such policy in a budget neutral manner under the AWI statutory provision, the exceptions or adjustments authority, or otherwise. Therefore, the Providers are challenging the adjustment to the standardized amount on several grounds, including, but not limited to, that it exceeds statutory authority, contradicts the AWI congressional mandate, was developed in an arbitrary and capricious manner, lacks support from substantial evidence, and is otherwise defective both procedurally and substantively.

The immediate detrimental effect will be a 0.2598 percent negative adjustment of the standardized amount and the hospital-specific operating payment rate for FFY 2023 for every IPPS hospital, resulting in a reduction in overall IPPS payments for all IPPS hospitals, including the Providers. Further, as this is the fourth year of the implementation of the Low Wage Index Redistribution and the related budget neutrality adjustment, the Providers already suffered an unlawful negative adjustment in FFYs 2020 to 2023.

Based on the foregoing, the Providers are challenging the Low Wage Index Redistribution in this group appeal for several reasons, including but not limited to, whether the Secretary: (1) improperly exercised the authority granted through 42 U.S.C. § 1395ww(d)(3)(E) and 42 U.S.C. § 1395ww(d)(5)(I); and (2) improperly reduced FFY 2024 IPPS payments to IPPS hospitals, including the Providers, as a result of the budget neutral implementation of the Low Wage Index Redistribution, which has been in effect since October 1, 2019, and continues through FFY 2024. The Providers seek their proper IPPS payments plus interest calculated under 42 U.S.C. § 1395oo(f)(2) and/or 42 U.S.C. § 1395g(d).

The Providers believe EJR is appropriate because the Board has jurisdiction over the appeals, the Providers are dissatisfied with the final determination of the Secretary, but lacks the authority to

decide the question at issue and cannot grant the relief sought. Pursuant to 42 C.F.R. § 405.1867, the Board must comply with all the provisions of Title XVIII of the Social Security Act and is therefore, bound to apply the 0.2598 percent reduction issued by the Secretary in the FFY 2024 IPPS Final Rule.

Medicare Contractor's Position:

On July 25, 2024, in three (3) of these seven (7) group cases,[35] the Medicare Contractor filed a Jurisdictional Review document, pursuant to Board Rule 22, noting that there were no jurisdictional impediments. On July 30, 2024, the Medicare Contractor's representative filed a response to the EJR Request, noting the same but reserving the right to file substantive claim challenges once the providers file their cost reports.

Decision of the Board:

A. Jurisdiction and Request for EJR

Each of the participants in these seven (7) group cases appealed from the FFY 2024 IPPS Final Rule.[36] The Board has determined that: (1) the participants' documentation in each of the group appeals shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal;[37] (2) the appeals were timely filed; and (3) Board review of the matter in these appeals is not precluded by statute or regulation. In finding that the groups meet the $50,000 amount in controversy, the Board recognizes that the Group Representative has explained that the amount in controversy ("AiC") calculation is simply based on the estimated IPPS payments for the period at issue multiplied by 0.2598 percent (*i.e.,* the adjustment to the wage index that they are challenging in this appeal) and this AiC unmistakably demonstrates each of the groups more than clears the minimum $50,000 AiC hurdle. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractors for the actual final amounts in each case.

B. Application of 42 C.F.R. §§ 405.1873 and 413.24(j)

1. Regulatory Background

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

> (1) *General Requirement*. In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost

[35] 24-0640GC, 24-0642GC, and 24-0651GC.
[36] The CMS Administrator confirmed that, consistent with the D.C. Circuit's decision in *Washington Hosp. Ctr. v. Bowen*, 795 F.3d 139 (D.C. Cir. 1986, a wage index notice published in the Federal Register is a final determination from which a provider may appeal to the Board within the meaning of 42 U.S.C. § 1395oo(a)(1)(A)(ii). *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993*), rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015); 42 C.F.R. § 405.1837.
[37] *See* 42 C.F.R. § 405.1837.

> reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), **must include an appropriate claim for the specific item**, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **and describing** how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[38]

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

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

[38] (Bold and underline emphasis added.)

> (b) *Summary of Procedures*.
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> ****
>
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ****
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ****
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section*—(1) Board jurisdictional dismissal decision. **If the Board issues a jurisdictional dismissal decision** regarding the specific item under appeal (pursuant to § 405.1840(c)), **the Board's specific findings of fact and conclusions of law** (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must not be included in such jurisdictional dismissal decision**.[39]

These regulations are applicable to the cost reporting periods in these group cases.

2. Appropriate Cost Report Claims: Findings of Fact and Conclusions of Law

As explained above, at issue in this appeal are cost reports beginning after January 1, 2016, which are subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[40] The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal

[39] (Bold and underline emphasis added.)
[40] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").

years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[41] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included *if review under subsection (b)(1) has been triggered by a party raising a question under subsection (a) of whether a provider made an appropriate claim for the specific item under appeal on the relevant as-filed cost report*.

Accordingly, the Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[42] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made on the relevant as-filed cost report.[43] The Board further notes that, when the participants in a group have not filed their cost report, then § 405.1873(b) would not be triggered because the issue of whether the relevant participants' cost reports included an appropriate claim for the specific item under appeal would not yet be ripe.[44] Section 405.1873(b) sets forth the procedures for Board review of Substantive Claim Challenges:

> The Board must give the parties an adequate opportunity to submit factual evidence and legal argument regarding the question of whether the provider's cost report included an appropriate claim for the specific item under appeal. Upon receipt of timely submitted factual evidence or legal argument (if any), the Board must review such evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with, for the specific item under appeal, the cost report claim requirements prescribed in § 413.24(j) of this chapter.

Significantly, the regulation simply directs the Board to give an adequate opportunity to take in evidence and argument and does not discuss staying appeals based on Federal Register to allow future review and consideration of Substantive Claim Challenges. In this regard, the fact that a cost report has not been filed would not stop or delay the Board proceedings as set forth in § 405.1873(b). Accordingly, it is the Board's position that in these type instances, any Substantive Claim Challenge would be premature. That said, *if subsequent to the Federal Register appeal*

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[41] (Emphasis added.)
[42] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[43] *See* 42 C.F.R. § 405.1873(a),
[44] The preamble to the final rule that adopted the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1973 responded to a comment about appeals from the Federal Register and confirmed that the substantive claim regulations applied to them. 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015). However, this preamble discussion does not address the manner in which they apply. Rather, the response concludes with the following directive in § 405.1873(a)-(b): "if a party to an appeal questions whether there was an appropriate cost report claim for a specific PPS item, the Board must take evidence and argument on that question; issue findings of fact and conclusions of law on such matter; and include those findings and conclusions in both the administrative record and certain types of overall Board decisions." *Id.* at 70570.

being filed, one or more participants files its cost report, then any party may raise a Substantive Claim Challenge regarding those participants and submit argument and evidence supporting their position.

Here, for the above-captioned appeals, no party has asserted that any of the participants in these Federal Register appeals later filed its cost report and failed to properly make a cost report substantive claim for the matter at issue. Rather, the Medicare Contractor has only reserved the right to pursue substantive claim challenges, at some later date after the participants file cost reports for the fiscal periods at issue in these 7 group appeals. This reservation does not trigger § 405.1873(a). In this regard, all of the participants in the above-referenced group cases are appealing the FFY 2024 Federal Register Notice and the cost reports impacted by such notice appear to have not yet been filed to trigger § 413.24(j)'s general substantive payment requirement for cost reports.[45] Accordingly, the Board is not obligated under 42 C.F.R. § 405.1873 to include findings on substantive claim challenges in these cases for any of the participants.

C. Analysis Regarding Appealed Issue

As set forth below, the Board finds that the Secretary's determination to finalize a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals was implemented in a budget neutral manner was made through notice and comment in the form of an uncodified regulation.[46] Specifically, in the preamble to FFY 2020 IPPS Final Rule, the Secretary announced the following wage index issues:

1. "To help mitigate . . . wage index disparities [between high and low wage index hospitals], including those resulting from the inclusion of hospitals with rural reclassifications under 42 CFR 412.103 in the calculation of the rural floor, . . . we . . . reduce the disparity between high and low wage index hospitals by increasing wage index values for certain low wage index hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values to maintain budget neutrality, and changing the calculation of the rural floor . . . .";[47] and

2. "[A]ddressing this systemic issue does not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure."

The Secretary did not incorporate the above new policy setting forth a modification to the wage index calculation determination by finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that there was an increase in the wage index for low wage index hospitals into the Code of Federal Regulations. However, it is clear from the use of the following language in the preamble to the FFY 2020 IPPS Final Rule that the Secretary intended to bind the regulated parties and establish a binding uniform payment policy through formal notice and comment:

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[45] *See* 80 Fed. Reg. at 70556, 70569-70.
[46] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals."
[47] *Id.* at 42326.

> We acknowledge, however, that some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between our proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States. Therefore, given that budget neutrality is required under section 1886(d)(3)(E) of the Act, given that even if it were not required, we believe it would be inappropriate to use the wage index to increase or decrease overall IPPS spending, and given that we wish to consider further the policy arguments raised by commenters regarding our budget neutrality proposal, we are finalizing a budget neutrality adjustment for our low wage hospital policy, but we are not finalizing our proposal to target that budget neutrality adjustment on high wage hospitals. Instead, consistent with CMS's current methodology for implementing wage index budget neutrality under section 1886(d)(3)(E) of the Act and the alternative approach we considered in the proposed rule . . . we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in this rule, is implemented in a budget neutral manner.[48]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but *uncodified* regulation and will refer to the above policy as the "Uncodified Regulation on Wage Index."

While this appeal involves the FFY 2024 IPPS Final Rule, the continuation of this policy was implemented in the same way as it was initially for FFY 2020.[49] The proposed rule did not propose any changes to this policy. The Final Rule for FFY 2024 refers to the responses to comments provided in the FFY 2020 Final Rule, and applied the policy in the same manner as it was applied in FFY 2020.[50] Therefore, the Board finds that this policy continues to be a binding but *uncodified* regulation for FFY 2024.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulation on Wage Index published in the FFY 2024 IPPS Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulation on Wage Index which they allege improperly reduces the standardized amount of 0.2598 percent for FFY 2024. As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in these cases.

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[48] 84 Fed. Reg. at 42331.
[49] 88 Fed. Reg 58640, 58978-58979 (Aug. 28, 2023).
[50] *Id.* at 58980.

D. Board's Decision Regarding the EJR Request

The Board makes the following findings:

1) The Board has jurisdiction over the AWI Issue for the subject year in these cases and that the Providers in these group appeals are entitled to a hearing before the Board;

2) While the Providers appealed cost reporting periods beginning after January 1, 2016, no substantive claim challenges[51] have been filed pursuant to 42 C.F.R. § 405.1873(a) to trigger either Board review under § 405.1873(b) or reporting under § 405.1873(d)(2);

3) Based upon the Providers' assertions regarding the FFY 2024 IPPS Final Rule, there are no findings of fact for resolution by the Board;

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

5) The Board is without the authority to decide the legal question of whether the Uncodified Regulation on Wage Index published in the FFY 2024 IPPS Final Rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified Regulation on Wage Index as published in the FFY 2024 IPPS Final Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes these cases.

Board Members Participating:

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

For the Board:

8/21/2024

X Clayton J. Nix

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

Enclosure: Schedules of Providers

cc: Danelle Decker, National Government Services, Inc. (J-K)
Cecile Huggins, Palmetto GBA (J-J)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Byron Lamprecht, WPS Government Health Administrators (J-5)
Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)

[51] As the Board explained in Board Rule 44.5, "[t]he Board adoption of the term "Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Mr. Murray McGowan
Tenet Healthcare Corporation
14201 Dallas Parkway
Dallas, TX 75254

RE: ***Board Decision – Request for Reconsideration***
Tenet FY 2013 DSH SSI Proxy CIRP Group
Case No. 16-1524GC

Dear Mr. McGowan:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Motion for Reconsideration filed on November 27, 2023 by Tenet Healthcare Corporation in the common issue related party ("CIRP") group under Case No. 16-1524GC. The Board's decision is set forth below.

Background

On **April 29, 2016**, the Board received Tenet's Group Appeal Request. From 2017 through 2020, various participants were added to the group.

On **May 3, 2016**, the Board issued its Group Acknowledgment of the CIRP Group and, among other things, specified that the following "Group Representative Action [Is] Required": "Upon full formation of the group appeal you must so advise the Board in writing. At that time the Board will issue a Critical Due Dates letter which will set up deadlines for the submission of the Schedule of Providers with supporting documentation and a preliminary position paper/proposed Joint Scheduling Order."

On **May 6, 2020**, the final Group Participant was added to the appeal.

On **September 8, 2023**, the Board sent a "CIRP Group Status Request" to the group's representative, Tenet Healthcare Corporation, informing that "[t]he Board has not received confirmation that the group was fully formed; however, no provider had been added to this group since May 6, 2020." The Board's notice informed the group's representative that, pursuant to 42 C.F.R. § 405.1837, the Board will determine a group is fully formed upon *notice from the provider* that the group has been fully formed or require the Group to demonstrate that at least one provider in the group has preserved its right to appeal but has not yet received its final determination.

The Board's CIRP Group Status Request letter issued a deadline to the Group of no later than **October 8, 2023**, to advise the Board whether the group was fully formed or identify any providers that will join the group but have not yet received their final determinations. The Board's CIRP Group Status request letter was clear that a failure to submit a timely response to

the request would result in a dismissal of the case, stating "Failure to submit a timely response to this request ***will*** result in dismissal of the case".[1]

No response was filed by the October 8, 2023 deadline. Accordingly, on **October 11, 2023**, pursuant to 42 C.F.R. § 405.1868, the Board issued a Dismissal for Untimely Filing letter to the group representative and closed the case. In the letter, the Board stated its authority to dismiss the appeal with prejudice in response to a party's failure to comply with Board rules or orders, specifically if a provider fails to meet a filing deadline or other requirement. The letter referenced the prior CIRP Group Status Request letter the Board sent on September 8, 2023, to advise the Group that it was required to submit a status report regarding the full formation of the group by October 8, 2023, and informed that the case was dismissed because the documentation was not submitted by the due date for this request.

On **November 21, 2023,** 44 days past the deadline set in the Status Request, the Group's representative then submitted its CIRP Group Status Response to confirm the Group was fully formed as of that date.

On **November 27, 2023**, the Group filed a Motion for Reconsideration requesting the Board reconsider its dismissal and reinstate the CIRP Group Appeal.

Tenet's Motion for Reconsideration

The Group's representative, Tenet Healthcare Corporation, on behalf of Tenet, requests Reconsideration of the Board's dismissal of the case. Tenet argues its failure to notify the Board the group was fully formed prior to the Board's dismissal was due to the following:

> Our late response to the Board's letter was due to the press of other significant work and deadlines combined with the relatively short, 30-day window that the Board gave us to respond, and we believe it is unfair to dismiss an entire group for all of our hospitals based on an untimely response to a request for confirmation on whether other hospitals would need to join the group. We sincerely apologize for our error, which is an aberration, and respectfully request that the Board reinstate the complete group.[2]

Tenet also contends that the Board's 30-day deadline is inconsistent with other Board deadlines and creates an unfair outcome, stating:

> Regarding the quick turnaround, the Board often gives us substantially longer than 30 days to respond to a Board request. For example, after notifying the Board that a group is complete, we would have 60 days to submit a schedule of providers or rule 20 certification letter to the Board, and position papers would also be

[1] PRRB's CIRP Group Status Request (Sept. 8, 2023) (emphasis added).
[2] Group Request for Reconsideration at 1 (Nov. 26, 2023).

> due to the Board approximately 60 days after notification that the group is complete. In other instances, deadlines are set significantly further out. For example, hearing dates would generally be set many months in advance, and position papers for individual appeals would generally be due 8-9 months after filing the individual appeal. While we have met other group completion deadlines without incident, the short window for response is challenging, especially for a large organization like Tenet consisting of more than 60 hospitals.[3]
>
> Moreover, we believe that it is unfair to dismiss an entire group, containing all of our hospitals' many properly and timely filed appeals, simply because we did not timely respond to a letter asking if any additional providers needed to join the group. The Providers in the group satisfied all jurisdictional requirements for an appeal, properly and timely appealing from notices of program reimbursement with which they were dissatisfied, and the estimated amount in controversy in this case is substantial.[4]

Finally, Tenet contends that with prior requests from the Board, a failure to respond has not been cause for dismissal. The group representative asserts:

> In other instances where the Board has given us short windows to respond to Board requests, the Board has included a statement that failure to response to the request would result not in dismissal, but in the Board taking action without our input.[5]

Board's Decision

The Board hereby denies this CIRP Group's Request for Reconsideration because Tenet failed to timely notify the Board that the group was fully formed, or timely respond to the Board's CIRP Group Status Request letter. Additionally, the Group did not present an argument for good cause, but nonetheless has failed to show good cause for reinstatement under Board Rule 47.3.

Board Rule 47.3 addresses dismissals for failure to comply with Board procedures.

---

[3] *Id.*
[4] *Id.* at 2.
[5] The Group representative included a Board letter dated July 18, 2023, regarding a separate case, Case No. 16-1470GC. In that case, the provider originally filed a CIRP group request for hearing, however only a single provider made up the "group," even after the group representative informed the Board that the group was complete. In the letter, the Board informed the provider that the Board will take action on its own to restructure the appeal from a CIRP group appeal to an individual appeal in order to resolve the jurisdictional impediment, as a CIRP group may not contain only one provider under 42 C.F.R. § 405.1837(b)(1) and Board Rule 12.6.1. The letter provided 15 days for the provider to comment, or the Board would resolve the jurisdictional issue on its own, stating, "Failure of the Representative to respond by the above filing deadline will result in the Board making a ruling without the benefit of the Representative's input."

> **Rule 47 Reinstatement**
>
> **47.1 Motion for Reinstatement**
>
> A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s) (*see* 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (*see* Rule 44 governing motions). The Board will not reinstate an issue(s)/case if the provider was at fault. If an issue(s)/case was remanded pursuant to a CMS ruling (e.g., CMS Ruling 1498-R), the provider must address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board reinstates an issue(s) or case, the provider will have the same rights (no greater and no less) that it had in its initial appeal. . . .
>
> ****
>
> **Board Rule 47.3 states:**
>
> Upon written motion demonstrating good cause, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, administrative oversight, settlement negotiations or a change in representative will not be considered good cause to reinstate. If the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, then the motion for reinstatement must, *as a prerequisite*, include the required filing before the Board will consider the motion.

As set forth below, the Board finds that the Group Representative has failed to establish good cause for reinstating this appeal because it was at fault due to administrative oversight in failing to timely file a response to the Board's CIRP Group Status Letter.

Tenet argues that other pressing deadlines and urgent matters caused their failure to file timely. The Group asserts that, "[o]ur late response to the Board's letter was due to the press of other significant work and deadlines combined with the relatively short, 30-day window that the Board gave us to respond, and we believe it is unfair to dismiss an entire group for all of our hospitals based on an untimely response to a request for confirmation on whether other hospitals would need to join the group.."[6] However, the Group Representative's error is the exact type of administrative oversight that does not meet the Board's standard for good cause.

[6] Group Request for Reconsideration at 7 (Oct. 12, 2023).

Moreover, the Board issued its September 8, 2023 "CIRP Group ***Status*** Request"[7] as this case had been *inactive* for more than 3 years since the last participant was added to the appeal on May 6, 2020.[8] Consistent with this inactivity, the Board warned the group representative that "Failure to submit a timely response to this request ***will*** result in dismissal of the case."[9] Accordingly, based on the lack of activity and no timely response to the Board's status request, the Board had good reason to believe that the appeal was abandoned consistent with Board Rule 41.2.

In conclusion, the Board hereby ***denies*** Tenet's Request for Reconsideration as the Board maintains the Group failed to comply with Board rules and orders. Specifically, the Group failed to meet a filing deadline and does not meet the Board's standards for good cause for reinstatement. Case No. 16-1524GC remains closed.

Board Members Participating:

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

For the Board:

8/23/2024

X Clayton J. Nix

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

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

[7] (Emphasis added.)
[8] Indeed, the Provider's *belated* November 21, 2023 response that the group is fully formed (filed 44 days late) did not include any other providers and, as such, it is unclear why it took the group representative over 3½ years to notify the Board the group is fully formed based on the last provider added more than 3½ years earlier on May 6, 2020. Under the May 3, 2016 Group Acknowledgment, Group Representative was required to advise the Board in writing "Upon full formation of the group appeal." Here, it appears as if the Group Representative waited more than 3½ years to do so after the last participant was added on May 6, 2020, notwithstanding the Board's request for a "CIRP Group Status Request." Rather, the Group Representative failed to timely respond to the Board's Group status Request. Accordingly, the Board had good reason to believe the appeal had been abandoned.
[9] PRRB's CIRP Group Status Request (Sept. 8, 2023) (emphasis added). The Board further notes that the 30-day response period set in this case is significantly more than the minimum 15-day period specified in 42 C.F.R. § 405.1837(e)(1).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision*** **– SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**
MercyOne Waterloo Medical Center (Provider Number 16-0067)
FYE: 06/30/2019
Case Number: 23-1226

Dear Mr. Ravindran and Mr. Lamprecht,

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

Background:

A. ***Procedural History for Case No. 23-1226***

On **September 27, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2019.

On **March 24, 2023**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained two (2) issues:

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

On **November 16, 2023**, the Provider filed its preliminary position paper.

On **January 17, 2024**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 2.

On **February 16, 2024**, the Medicare Contractor filed its preliminary position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 23-0767GC

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.[1]

The Provider is a participant in PRRB Case No. 23-0767G, QRS CY 2019 DSH SSI Unduly Narrow Definition of SSI Entitlement Group, an optional group case appealed by the Provider's representative. The Group Issue Statement in Case No. 23-0767G reads, in part:

> **Statement of the Issue:**
>
> The Provider(s) protest(s) CMS's policy of excluding unpaid SSI days from the numerator of the Medicare fraction. Despite CMS's seemingly contrary policy of treating unpaid Part A days as days entitled to benefits under Part A, CMS requires that a beneficiary be paid SSI benefits (or "covered" by SSI) during the period of his or her hospital stay in order for such days to be considered "entitled to supplemental security income benefits" and included in the numerator of the SSI fraction.
>
> CMS does not include days in the numerator of the SSI fraction when individuals were eligible for SSI but did not receive a SSI payment during their hospitalization for such reasons as failure of the beneficiary to have a valid address, representative payee problems, Medicaid paying for more than 50 percent of the cost of care in a medical facility, or the period of hospitalization is during the first month of eligibility before a cash payment is made. None of these reasons affect the patient's indigency.

[1] Issue Statement at 1 (March 24, 2023).

> CMS's policy of applying different interpretations to the same term, "entitled," used in the same sentence of the statute is the epitome of arbitrary and capricious agency action and must be reversed. *See Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 20 n.1 (D.C. Cir. 2011) (Kavanaugh, J. concurring) ("HHS thus interprets the work 'entitled' differently within the same sentence of the statute. The only thing that unifies the Government's inconsistent definitions of this term is its apparent policy of paying out as little money as possible. I appreciate the desire for frugality, but not in derogation of law."); *see also Walter O. Boswell Mem'l Hosp. v. Heckler*, 749 F.2d 788, 799 (D.C. Cir. 1984) ("It would be arbitrary and capricious for [the Secretary] to bring varying interpretations of the statute to bear, depending upon whether the result helps or hurts Medicare's balance sheets. . . .").
>
> In rulemaking, commenters specifically requested that CMS include other payment codes that identified "entitled" individuals, but the Secretary nonetheless adopted a policy of including only codes that identify people receiving actual SSI cash payment. Id. For example, commenters requested that codes S06 (suspended payment because recipients' whereabouts are unknown based on "undeliverable checks, mail, reports of change or change of address") and S07 ("checks returned for reasons that are unclear or for reasons other than address or a representative payee problem") be included. CMS refused the suggestion.
>
> Because CMS's treatment of unpaid Part A days as "days entitled to benefits under part A" was upheld by the Supreme Court in *Becerra v. Empire Health Found., for Valley Hosp. Med. Ctr.*, 597 S.Ct. June 24, 2022 WL 227680 (2022), CMS must apply the same interpretation of the word "entitled" in the context of "entitled to supplemental security income benefits." By doing so, CMS will necessarily have to widen the number of SSI status codes as it treats as being "entitled to SSI benefits" to encompass not just the three codes CMS currently includes, but all codes that reflect *eligibility* for SSI benefits.[2]

On November 16, 2023, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

[2] Group Issue Statement, Case No. 23-0767G.

Issue #1: Provider Specific

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

The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The 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).[3]

C. Description of Issue 2 in the Appeal Request

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

Statement of Issue

Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation. The Provider appeals the number of 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) that were included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage.

Under section 1886(d)(5)(F)(vi)(II) of the Social Security Action (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. §

[3] Provider's Preliminary Position Paper at 7-8 (Nov. 16, 2023).

> 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).
>
> **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.[4]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the Jewish Hospital case[5] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[6] The Provider then states it is seeking reimbursement for section 1115 waiver days as a part of the Medicaid eligible day issue. Specifically, the Provider states:

> [M]edicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).[7]

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[4] Issue Statement at 2.
[5] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[6] Provider's Preliminary Position Paper at 8.
[7] *Id.* at 8-9.

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue. First, the MAC argues that the Provider has abandoned the SSI realignment sub-issue: "[T]he Provider has abandoned the issue of SSI realignment and, therefore, it should be considered withdrawn. The Provider did not brief this issue within its preliminary position paper. . ."[8] The MAC also argues the appeal is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[9]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH SSI Unduly Narrow Definition of SSI Entitlement issue in PRRB Case No. 23-0767G are considered the same issue by the Board.[10]

Finally, the MAC argues "the Provider did not file a **complete** preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3."[11] The MAC posits that the Provider "failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its Preliminary Position Paper."[12]

---

[8] Jurisdictional Challenge at 6 (Jan. 17, 2024).
[9] *Id*.
[10] *Id*. at 4-5.
[11] *Id*. at 7.
[12] *Id*. at 8.

Issue 2 – DSH Payment – Medicaid Eligible Days

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

> The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.
>
> Within its Provider's preliminary position paper, the Provider makes the broad allegation, ". . . the Provider contends that the total number of days reflected in its' [sic] 2019 cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats their appeal request.[13]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[14] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

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

[13] *Id*. at 11.
[14] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

A. DSH Payment/SSI Percentage (Provider Specific)

The analysis for Issue 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. As set forth below, the Board dismisses both aspects of Issue 1.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Unduly Narrow Definition of SSI Entitlement issue that was appealed in PRRB Case No. 23-0767G.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[15] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[16] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[17]

The Provider's DSH SSI Unduly Narrow Definition of SSI Entitlement issue in group Case No. 23-0767G also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH SSI Unduly Narrow Definition of SSI Entitlement issue in Case No. 23-0767G. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6,[18] the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 23-0767G. Further, any alleged "systemic" issues may not uniformly impact all providers but, as

[15] Issue Statement at 1.
[16] *Id.*
[17] *Id.*
[18] PRRB Rules v. 3.1 (Nov. 2021).

was the case in *Baystate*, may impact the SSI percentage for each provider differently.[19] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 23-0767G.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 23-0767G, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[20]

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

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

[20] (Emphasis added).

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

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

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

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and directs providers to "send an email to the official DSH mailbox" to request DSH data.[22]

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 23-0767G 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.

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

[21] Last accessed Aug. 23, 2024.
[22] Emphasis added.

Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid Eligible Days were not included in the calculations of the DSH calculation. The Provider states Issue 3 as:

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation. The Provider appeals the number of 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) that were included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage.
>
> 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).
>
> **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.[23]

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

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[24]

Board Rule 7.3.1.2 states:

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

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

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[25]

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*.

---

[23] Issue Statement at 2.
[24] Provider's Preliminary Position Paper at 9.
[25] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[26]

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

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

Similarly, with regard to position papers,[27] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[28] 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.[29]

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

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

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

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

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

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

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

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled, consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[30] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. Indeed, without any days identified in the position paper filing, the Board assumes that there are no days or amount in dispute for this issue.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.[31]

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

Accordingly, the DSH Payment – Medicaid Eligible Days issue is dismissed.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 23-0767G and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 23-1226 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 Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

8/23/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Baltimore, MD 21244
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Porter Regional Hospital (Provider Number 15-0035)
FYE: 12/31/2016
Case Number: 21-0113

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 21-0113. Set forth below is the decision of the Board to dismiss the 2 remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) and Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 21-0113*

On **December 27, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2016. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **June 12, 2020**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained four (4) issues:

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

On **October 23, 2020**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position

[1] On January 26, 2021, this issue was transferred to Case No. 19-1409GC.
[2] On August 17, 2023, the Medicare Contractor filed a jurisdictional challenge over Issue 3 and Motion to Dismiss.
[3] On February 1, 2021, the Provider withdrew this issue from the appeal.

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]

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 **January 26, 2021**, the Provider transferred Issue 2 to a CHS CIRP group.

On **February 1, 2021**, the Provider withdrew Issue 4 from the appeal.

On **February 1, 2021**, the Provider also 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.[5] However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days."[6] As a result, the Provider included, as an Exhibit, the original "estimated impact" for this issue of $96,009 based on an *estimated* 150 days.[7]

On **April 29, 2021**, the Medicare Contractor timely filed a Jurisdictional Challenge[8] with the Board over Issue 1, requesting that the Board dismiss this issue. Pursuant to Board Rule 44.4.3,

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[4] (Emphasis added.)
[5] Provider's Preliminary Position Paper ("Provider's PPP") at 8 (Feb. 1, 2021).
[6] *Id.*
[7] Provider's PPP, Exhibit 2 at 3.
[8] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **May 7, 2021**, the Medicare Contractor filed its preliminary position paper. With regard to Issue 3, the Medicare Contractor's position paper noted that the Provider had failed to include a Medicaid eligible days listing with its appeal request or 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.[9]

On **January 5, 2023**, the Medicare Contractor filed a Request for DSH Package in connection with Issue 3. In this filing, the Medicare Contractor noted that, on March 4, 2021, it had previously requested that the Provider send it a DSH package to resolve Issue 3. As no response was received to the first request for a listing of the Medicaid eligible days at issue, plus supporting documentation, the Medicare Contractor included instructions in the second formal notice that the DSH package and Medicaid eligible days listing be provided to the Medicare Contractor on or before February 4, 2023 (*i.e.*, within 30 days). Notwithstanding the formal request, the Provider failed to file any response to the Medicare Contractor.

As no response was received from the Provider, on **August 17, 2023**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to furnish documentation in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); (2) the Provider failed to furnish the Medicaid eligible days listing with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2; and (3) the Provider has effectively abandoned Issue 3.[10] Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** to timely respond to that Motion.

As a result of the case transfer and withdrawn issue, there are two (2) remaining issues in this appeal: Issue 1 (the DSH – SSI Percentage Provider Specific) and Issue 5 (the DSH – Medicaid Eligible Days).

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

[9] Medicare Contractor's Preliminary Position Paper ("Contractor's PPP") at 6-7 (May 7, 2021).
[10] Medicare Contractor's Motion to Dismiss at 4-5 (Aug. 17, 2023).

> 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).[11]

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

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

[11] Issue Statement at 1 (Jun. 12, 2020).

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]

On February 1, 2024, the Board received the Provider's preliminary position paper in 21-0113. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (December 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services,* No. CV-94-0055 (C.D. Cal June 2, 1995), the SSI entitlement of individuals can be ascertained from [s]tate records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the 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).[13]

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

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[12] Group Appeal Issue Statement in Case No. 19-1409GC.
[13] Provider's Preliminary Position Paper at 8-9 (Feb. 1, 2021).

MAC's Contentions

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

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

> According to the Provider's appeal request, Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the portions of Issue 1 related to SSI data accuracy and individuals who are eligible for SSI but did not receive SSI payment are duplicates of Issue 2, which was transferred to Group Case No. 19-1409GC, "CHS CY 2016 DSH SSI Percentage CIRP Group" and should be dismissed.
>
> With respect to the portion of Issue 1 related to SSI data accuracy, the Provider states:
>
> > The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
> >
> > The Provider contends that its' [sic] SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
> >
> > The Provider contends that the SSI percentage issued by CMS is flawed.
>
> With respect to the portion of Issue 1 related to individuals who are eligible for SSI but did not receive SSI payment, the Provider states:
>
> > The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be

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

This component of Issue 1 is repeated by the Provider, word-for-word, within Issue 2.

The MAC contends that the Provider raises the same disputes in Issue 2….

…

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

As previously noted, Issue 2 has been transferred to Group Case No. 19-1409GC. This means that the Provider is appealing an issue from a single final determination in more than one appeal. The Board's Rules are clear on this matter: No duplicate filings. Board Rule 4.6.1, states:

> A provider may not appeal an issue from a single final determination in more than one appeal.[14]

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

> Issue 1 includes the Provider's appeal over SSI realignment. The Provider states:
>
> > The Provider also, hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost

[14] Jurisdictional Challenge at 4-5 (Apr. 29, 2021).

> reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).

SSI realignment is still active in this appeal. Within its preliminary position paper, the Provider states:

> The Provider contends that its' [sic] SSI percentage published by 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 based on the Provider's Fiscal Year End (December 31). (Emphasis Added)

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

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

> A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period[.] (Emphasis Added)

The Provider's right to a Board hearing derives from a MAC or Secretary determination, which is defined at 42 C.F.R. § 405.1801(a):

> [A] determination of the amount of total reimbursement due the provider, pursuant to § 405.1803 following the close of the provider's cost reporting period.

The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[15]

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

Issue 3 – DSH – Medicaid Eligible Days

The MAC also argues in its Motion to Dismiss that the Board should dismiss the DSH – Medicaid Eligible Days issue because the Provider has effectively abandoned the issue:

> Federal Specialized Services, on behalf of the Medicare Administrative Contractor ("MAC"), pursuant to PRRB Rule 44, hereby submits this Motion to the Provider Reimbursement Review Board ("PRRB" or "Board") requesting that Issue 3, Disproportionate Share Hospital Payment - Medicaid Eligible Days, be dismissed from the appeal, and in support thereof, states as follows:
>
> 1. This individual appeal was received by the Board on June 12, 2020.
>
> 2. For the Disproportionate Share Hospital Payment - Medicaid Eligible Days ("Medicaid Eligible Days") issue the Provider contends:
>
>   The Provider requests that the MAC review the Medicaid eligible days listing being sent under separate cover and provide a sample listing as soon as practicable.
>   Further, upon completion of that review, the Provider requests that the MAC administratively resolve this issue by computing the Medicaid Fraction using patient days applicable to all Medicaid eligible patients to comply with the decisions of the Federal Courts and HCFAR 97-2.
>
> 3. The Provider submitted its complete Preliminary Position Paper on February 1, 2021. Well over two years have passed since the Provider submitted its Preliminary Position Paper, and at no time did it submit a listing for review. Its Preliminary Position Paper failed to specify the number of additional days to which it contends it is entitled. Rather, the Preliminary Position Paper included Exhibit 1, which states in total:
>
>   ELIGIBILITY LISTING
>   (NOT INCLUDED –
>   BEING SENT UNDER SEPARATE COVER)
>
> 4. On March 4, 2021, the MAC submitted its request for a DSH package via upload through OH-CDMS. The MAC stated its

interest in resolving the issue administratively by reviewing additional Medicaid eligible days. The MAC also informed that it had yet to receive anything.

5. The MAC did not receive a response to its March 2021 inquiry. On January 5, 2023, the MAC submitted its Final Request for DSH Package via upload through OH-CDMS. The MAC asked that the Provider submit several items that would customarily be submitted with a DSH package or, if such documentation is unavailable, a response in accordance with Board Rules 7.3.1.2 and 25.2.2. The MAC asked for a response before February 4, 2023. No response was received.

6. To date, despite the representation in its Preliminary Position Paper, the Provider has failed to respond to the MAC's request for documentation and has otherwise failed to tender to the MAC an eligibility listing or necessary documentary support for the additional Medicaid eligible days to which it asserts it is entitled.

7. PRRB Rule 7 mandates that a provider either submit supporting documentation or describe why such documentation is unavailable, stating:

> The provider must support the determination being appealed and the basis for its dissatisfaction for ***each*** issue under appeal consistent with 42 C.F.R. §405.1835(b) or (d) as applicable. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.

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

8. PRRB Rule 25.2.1 states that "the parties must exchange ***all*** available documentation as exhibits to fully support your position."

9. PRRB Rule 25.2.2 describes the requirements for unavailable and omitted documents, stating:

> 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.

10. Providers have the affirmative duty and burden to supply all required documentation and State validation of any additional Medicaid eligible days being claimed. The controlling regulation, 42 C.F.R. § 413.24(c), *Adequacy of cost information*, states:

> 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.

11. Pursuant to 42 C.F.R § 412.106(b)(4)(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.

12. HCFA Ruling 97-2 (the "Ruling") allows for the adjustment of the Medicare disproportionate share payment to include days for patients that were eligible for medical assistance under a State Medicaid plan, whether the hospital received payment for the inpatient hospital services or not. However, the Ruling is explicit in its provision that providers bear the burden of proof and must verify with the State that a patient was eligible for Medicaid during each day of the stay. Providers are responsible for and must furnish appropriate documentation to substantiate the number of patient days claimed. The Ruling anticipates that providers will obtain and maintain the requisite documentation on an ongoing basis. Patient days that cannot be verified by State Medicaid records to have fallen

within a period wherein the patient was eligible for Medicaid cannot be counted.

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

Wherefore, the MAC respectfully requests that the Board make the following findings and enter an Order providing as follows:

a. That the Provider has failed to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable.

b. That the Provider has made affirmative statements in its Preliminary Position Paper that it was submitting such supporting documentation to the MAC.

c. That the Provider's failure to furnish such documentation (or describe why such documentation is unavailable) is in violation of PRRB Rules 7, 25.2.1 and 25.2.2.

d. That the Provider has effectively abandoned its claim for additional Medicaid Eligible Days.

e. That the Provider's claim for additional Medicaid Eligible Days is therefore dismissed.

f. That the only remaining issues in the case are Issue 1, Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific) including SSI Realignment, to which the MAC filed a jurisdictional challenge on April 29, 2021, and Issue 4, Two Midnight Census IPPS Payment Reduction. The Provider indicated it was withdrawing Issue 4 pursuant to its Preliminary Position Paper cover letter. [16]

[16] Medicare Contractor's Motion to Dismiss at 2-5 (Jun. 21, 2023).

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[17] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

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

Decision of the Board

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

As set forth below, the Board hereby ***dismisses*** the Provider's two (2) remaining issues.

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. *First Aspect of Issue 1*

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

[17] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

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

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 19-1409GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 21-0113 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[21], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[22] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors are specific to this provider.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 19-1409GC, 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"[23] but fails to explain how that can be done, explain how that information is relevant, and whether such a review was done for purposes of the year in question, consistent with its obligations under Board Rule 25.2.[24]

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[18] Issue Statement at 1.
[19] *Id.*
[20] *Id.*
[21] PRRB Rules v. 2.0 (Aug. 2018).
[22] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[23] Provider's PPP at 8.
[24] It is also not clear whether this is a systemic issue for CHS providers in the same state subject to the CIRP rules or something that is provider specific because, if it was a common systemic issue, it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case, per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

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."[25] 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.[26]

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

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

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

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[25] PRRB Rule 23.3 v. 2.0.
[26] (Italics and underline emphasis added.)

https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh. [27]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data.[28]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 19-1409GC.

Accordingly, *based on the record before it*,[29] the Board finds that the SSI Provider Specific issue in Case No. 21-0113 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 its initial appeal or the position papers.

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[27] Last accessed Aug. 26, 2024.
[28] Emphasis added.
[29] Again, the Board notes that the Provider failed to respond to the Jurisdictional Challenge and the Board must make its determination based on the record before it.

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:

> **7.3.2 No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

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

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

Therefore, the regulations require the parties to fully brief the merits of each issue in 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:

[30] (Bold emphasis added.)

Rule 25 Preliminary Position Papers[31]

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

25.1 Content of Position Paper Narrative

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

25.1.1 The Provider's Position Paper

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

* * *

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4.

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

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 October 23, 2020 included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[32]

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

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

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

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

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

On February 1, 2021, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[33] 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 $96,009 based on an estimated 150 days). The Provider's complete briefing of this issue in its position paper is as follows:

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

[32] (Emphasis added.)
[33] Provider's Preliminary Position Paper at 8 (Feb. 1, 2021).

> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[34]

In its Motion to Dismiss, the Medicare Contractor asserts that the Provider has failed to submit a list of additional Medicaid eligible days and neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Notably, the Medicare Contractor sent two separate requests for the Provider's list of Medicaid Eligible days (and also discussed the lack of the listing in the Medicare Contractor's own position paper filing). The first notice was sent to the Provider on March 4, 2021 and the second request was sent to the Provider on January 5, 2023, *seven years after the end of the Provider's cost reporting period*. The Medicare Contractor

[34] Provider's PPP at 7-8.

also informed the Provider in its final request for information that the deadline to respond was February 4, 2023.[35] The Provider failed to file any response to the final request.

Due to the non-responsiveness of the Provider, on **August 17, 2023**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish the list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2 (or when requested by the Medicare Contractor two separate times after that). The Medicare Contractor thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the regulations and the Board Rules.[36]

Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** to timely respond to that Motion by the September 17, 2023 filing deadline (*i.e.*, 30 days after August 17, 2023).

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

Pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[37] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provider the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

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

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.[38]

* * * * *

Based on the foregoing, the Board has dismissed the two (2) remaining issues in this case – (Issues 1 and 3). As no issues remain, the Board hereby closes Case No. 21-0113 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:

8/26/2024

X Kevin D. Smith, CPA

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

cc: Byron Lamprecht, WPS Government Health Administrators (J-8), Wilson Leong, FSS

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Gregory N. Etzel, Esq.
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Houston, TX 77002

RE: ***Request to Reconsider Dismissal and Accept Late-Filed Preliminary Position Paper***
Albany Medical Center CY 2019 Medicare DSH Part C Days Errors CIRP Group
PRRB Case No. 23-1135GC

Dear Mr. Etzel,

The Provider Reimbursement Review Board ("Board") has reviewed the Request for Reconsideration of Dismissal and Acceptance of Late-Filed Preliminary Position Paper submitted by the Group Representative on June 29, 2024. The decision of the Board is set forth below.

Pertinent Facts

On March 14, 2023, the group appeal was filed for the Medicare DSH Part C Days Errors – Medicare/Medicaid Fraction issue to establish this common issue related party ("CIRP") group. On **April 20, 2024**, the Group Representative informed the Board that the group was fully formed.

On **April 26, 2024**, the Board notified the group its critical due dates and required documents, which included a deadline of June 25, 2024, for the Provider to file its Preliminary Position Paper. The Board's notice further cautioned that Providers that failure to timely file its position paper would result in dismissal:

> The parties must meet the following due dates regardless of any outstanding jurisdictional challenges, motions, or subpoena requests. If the Group misses any of its due dates, the Board will dismiss the appeal.

This cautionary notice is consistent with Board Rule 23.4 entitled "Failure to Timely File" which states: "Accordingly, if neither a PJSO nor the provider's preliminary position paper is filed by the filing due date, the Board will dismiss the case."

The Providers failed to file their Preliminary Position Paper by the June 25, 2025 deadline. Accordingly, on **June 26, 2024**, the Board dismissed this case for untimely filing of a preliminary portion paper or proposed joint scheduling order by the **June 25, 2024** filing deadline.

On **June 29, 2024**, the Group Representative filed its request seeking to have Board reinstate the appeal and accept the late filing of their Preliminary Position Paper.

Providers' Position

The Providers filed their request asking the Board to use its "inherent discretionary power" to reconsider its dismissal and accept the late filed Preliminary Position Paper.[1] The Group Representative explains that the reason for the late filing is due to an error in the Group Representatives' docketing system, the Board's critical due date notification letter "was not identified and tied into the docketing calendar."[2] The Providers argue that accepting the Preliminary Position Paper with a few days delay would offer no prejudice to the MAC or advantage to the Providers, and that it would not impact the Board's time in adjudication of the matters at issue because the issue is one of many appeals contesting the same Medicare DSH Part C Days Errors. Due to the similarity of the issue with other provider groups, it would likely be consolidated with other appeals for hearing purposes, easing the administrative burden.

The Providers states that permitting the late filing promotes justice by allowing the Group Appeal to continue without unduly punishing for an error with no substantive impact on the matter's administration. In consideration of the Providers' appealing the cost reporting year at issue in a timely manner and the fact their position is consistent with already existing appeals. The Provider believes the Board's "mechanical and immediate dismissal imposes a punishment" in contrast to there being no reciprocal penalty for MACs for similar infractions.[3]

Board's Analysis and Decision

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

Failure to comply with the Board's deadline for submission of a required filing can be found at 42 C.F.R. § 405.1868:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.
>
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—
>
> (1) Dismiss the appeal with prejudice;

[1] Request for Reconsideration at 2 (June 29, 2024).
[2] *Id.* at 1.
[3] *Id.* at 2.

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

Board Rule 47.1 (Dec. 2023) governs motions to reinstate an issue:

> A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s) (*see* 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (*see* Rule 44 governing motions). ***The Board will not reinstate an issue(s)/case if the provider was at fault.*** If an issue(s)/case was remanded pursuant to a CMS ruling (*e.g.*, CMS Ruling 1498-R), the provider must address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board reinstates an issue(s) or case, the provider will have the same rights (no greater and no less) that it had in its initial appeal. These requirements also apply to Rule 47.2 below.[4]

More specifically, Board Rule 47.3 governs Dismissals for Failure to Comply with Board Procedures:

> Upon written motion demonstrating good cause, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, ***administrative oversight***, settlement negotiations or a change in representative will not be considered good cause to reinstate. If the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, then the motion for reinstatement must, as a prerequisite, include the required filing before the Board will consider the motion.[5]

The Board generally will not reinstate an appeal that was closed due to untimely filing based on the fault of the provider (such as administrative oversight) except for good cause. The Group Representative did not provide any "good cause" to explain why the preliminary paper deadline was missed, notwithstanding the Board's instructions in the Notice of Critical Due Dates and Board Rule 23.4. The Group Representative's explanation for untimely filing was due to a docketing system error, which is clearly administrative oversight, and is therefore, the Group Representative's fault. Board Rule 47.1 and 47.3 state the Board will not reinstate an issue if the Provider was at fault and administrative oversight is not "good cause" to reinstate. As such, the

[4] Emphasis added.
[5] Emphasis added.

Board denies the request for reconsideration and Case No. 23-1135GC remains closed. In issuing its denial, the Board notes that its dismissal is consistent with numerous cases in which federal courts have upheld the Board's authority to dismiss cases for failure of the provider(s) to timely file position papers or other Board filings.[6]

Board Members Participating:

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

8/27/2024

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

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

[6] *Kaiser Found. Hosps. v. Sebelius*, 649 F.3d 1153 (9th Cir. 2011) (upholding dismissal for failure to file preliminary position paper); *Baptist Mem'l Hosp.-Golden Triangle v. Sebelius*, 566 F.3d 226 (2009) (upholding dismissal for failure to file preliminary position paper); *High Country Home Health Inc. v. Thompson*, 359 F.3d 1307 (10th Cir. 2004); *Inova Alexandria Hosp. v. Shalala*, 244 F.3d 342, 351 (4th Cir. 2001) (upholding dismissal for failure to file preliminary or final position papers and stating "The Hospital argues that the Board irrationally concluded that administrative oversight is not a valid excuse. We disagree. Because the Hospital's failure to file timely position papers was due to circumstances entirely within its own control, the Board had a rational basis for its decision."); *UHI, Inc. v. Thompson*, 250 F.3d (6th Cir. 2001); *Lutheran Med. Ctr. v. Burwell*, No. 14-VC-731, 2016 WL 3882896 (E.D. N.Y. July 13, 2016); *Rapid City Reg. Hosp. v. Sebelius*, 681 F. Supp. 2d 56 (D.D.C. 2010) (upholding dismissal for failure to file preliminary position paper and citing to "the general proposition that legitimate procedural rules can be relied upon to control the Board's docket by dismissing appeals that are not timely filed" (citations omitted) and upholding Board denial based on the); *S.C. San Antonio Inc. v. Leavitt*, No. SA-07-CA-527-OG, 2008 WL 4816611(W.D. Tex. Sept. 30, 2008); *Lutheran Med. Ctr. v. Thompson*, No. 02-CV- 6144, 2006 WL 2853870 (E.D. N.Y. Oct. 2, 2006); *Novacare, Inc. v. Thompson*, 357 F. Supp. 2d 268, 272-273 (D.D.C. 2005) (upholding denial of reinstatement where the Board explained that "failure to communicate clearly with its counsel was insufficient basis to justify reinstatement"); *Saint Joseph Hosp. v. Shalala*, No. 99-C7775, 2000 WL 1847976 (N.D. Ill. Dec. 15, 2000). *See also Memorial Hosp. of S. Bend v. Becerra*, No. 20-3461, 2022 WL 888190 at *10 (D.D.C. Mar. 25, 2022); *Akron Gen. Med. Ctr. v. Azar*, 836 Fed. Appx. 13 (D.C. Cir. 2021), *aff'g*, 414 F. Supp. 3d 73 (D.D.C. 2019).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Gregory N. Etzel, Esq.
Morgan, Lewis & Bockius LLP
1000 Louisiana Street, Suite 4000
Houston, TX 77002

RE: ***Request to Reconsider Dismissal and Accept Late-Filed Preliminary Position Paper***
Albany Medical Center CY 2019 Medicare DSH SSI Ratio Baystate Errors CIRP Grp.
Case No. 23-1137GC

Dear Mr. Etzel,

The Provider Reimbursement Review Board ("Board") has reviewed the Request for Reconsideration of Dismissal and Acceptance of Late-Filed Preliminary Position Paper that the Group Representative filed on June 29, 2024. The decision of the Board is set forth below.

Pertinent Facts

On March 14, 2023, the group appeal was filed for the 2019 SSI *Baystate* errors issue to establish this common issue related party ("CIRP") group. On **April 20, 2024**, the Group Representative informed the Board that the group was fully formed.

On **April 26, 2024**, the Board notified the group its critical due dates and required documents, which included a deadline of June 25, 2024, for the Providers to file their Preliminary Position Paper. The Board's notice further cautioned that Providers that failure to timely file its position paper would result in dismissal:

> The parties must meet the following due dates regardless of any outstanding jurisdictional challenges, motions, or subpoena requests. If the Group misses any of its due dates, the Board will dismiss the appeal.

This cautionary notice is consistent with Board Rule 23.4 entitled "Failure to Timely File" which states: "Accordingly, if neither a PJSO nor the provider's preliminary position paper is filed by the filing due date, the Board will dismiss the case."

The Providers failed to file their Preliminary Position Paper by the June 25, 2025 deadline. Accordingly, on **June 26, 2024**, the Board dismissed this case for untimely filing of a preliminary portion paper or proposed joint scheduling order by the June 25, 2024 deadline.

On **June 29, 2024**, the Group Representative filed its request seeking to have the Board reinstate the appeal and accept the late filing of their Preliminary Position Paper.

Providers' Position

The Providers filed their request asking the Board to consider using its "inherent discretionary power" to reconsider its dismissal of this CIRP group and accept their late-filed Preliminary Position Paper.[1] The Group Representative explains that the reason for the late filing is due to an error in the Group Representatives' docketing system, the Board's critical due date notification letter "was not identified and tied into the docketing calendar."[2] The Providers argue that accepting the Preliminary Position Paper with a few days delay would offer no prejudice to the MAC or advantage to the Providers, and that it would not impact the Board's time in adjudication of the matters at issue because the issue is one of many appeals contesting the same Medicare DSH Part C Days Errors. Due to the similarity of the issue with other provider groups, it would likely be consolidated with other appeals for hearing purposes, easing the administrative burden.

The Providers states that permitting the late filing promotes justice by allowing the Group Appeal to continue without unduly punishing for an error with no substantive impact on the matter's administration. In consideration of the Providers' appealing the cost reporting year at issue in a timely manner and the fact their position is consistent with already existing appeals. The Provider believes the Board's "mechanical and immediate dismissal imposes a punishment" in contrast to there being no reciprocal penalty for MACs for similar infractions.[3]

Board's Analysis and Decision

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

Failure to comply with the Board's deadline for submission of a required filing can be found at 42 C.F.R. § 405.1868:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.
>
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—
>
> (1) Dismiss the appeal with prejudice;

[1] Request for Reconsideration at 2 (June 29, 2024).
[2] *Id.* at 1.
[3] *Id.* at 2.

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

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The Board generally will not reinstate an appeal that was closed due to untimely filing based on the fault of the provider (such as administrative oversight) except for good cause. The Provider did not provide any "good cause" to explain why the preliminary paper deadline was missed notwithstanding the Board's instructions in the Notice of Critical Due Dates and Board Rule 23.4. The Group Representative's explanation for untimely filing was due to a docketing system error, which is clearly administrative oversight, and is therefore, the Group Representative's fault. Board Rule 47.1 and 47.3 state the Board will not reinstate an issue if the Provider was at

[4] (Emphasis added.)
[5] (Emphasis added.)

fault and administrative oversight is not "good cause" to reinstate. As such, the Board denies the request for reconsideration and Case No. 23-1137GC remains closed. In issuing its denial, the Board notes that its dismissal is consistent with numerous cases in which federal courts have upheld the Board's authority to dismiss cases for failure of the provider(s) to timely file position papers or other Board filings.[6]

Board Members Participating:

Clayton J. Nix, Esq.
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For the Board:

8/27/2024

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

[6] *Kaiser Found. Hosps. v. Sebelius*, 649 F.3d 1153 (9th Cir. 2011) (upholding dismissal for failure to file preliminary position paper); *Baptist Mem'l Hosp.-Golden Triangle v. Sebelius*, 566 F.3d 226 (2009) (upholding dismissal for failure to file preliminary position paper); *High Country Home Health Inc. v. Thompson*, 359 F.3d 1307 (10th Cir. 2004); *Inova Alexandria Hosp. v. Shalala*, 244 F.3d 342, 351 (4th Cir. 2001) (upholding dismissal for failure to file preliminary or final position papers and stating "The Hospital argues that the Board irrationally concluded that administrative oversight is not a valid excuse. We disagree. Because the Hospital's failure to file timely position papers was due to circumstances entirely within its own control, the Board had a rational basis for its decision."); *UHI, Inc. v. Thompson*, 250 F.3d (6th Cir. 2001); *Lutheran Med. Ctr. v. Burwell*, No. 14-VC-731, 2016 WL 3882896 (E.D. N.Y. July 13, 2016); *Rapid City Reg. Hosp. v. Sebelius*, 681 F. Supp. 2d 56 (D.D.C. 2010) (upholding dismissal for failure to file preliminary position paper and citing to "the general proposition that legitimate procedural rules can be relied upon to control the Board's docket by dismissing appeals that are not timely filed" (citations omitted) and upholding Board denial based on the); *S.C. San Antonio Inc. v. Leavitt*, No. SA-07-CA-527-OG, 2008 WL 4816611(W.D. Tex. Sept. 30, 2008); *Lutheran Med. Ctr. v. Thompson*, No. 02-CV- 6144, 2006 WL 2853870 (E.D. N.Y. Oct. 2, 2006); *Novacare, Inc. v. Thompson*, 357 F. Supp. 2d 268, 272-273 (D.D.C. 2005) (upholding denial of reinstatement where the Board explained that "failure to communicate clearly with its counsel was insufficient basis to justify reinstatement"); *Saint Joseph Hosp. v. Shalala*, No. 99-C7775, 2000 WL 1847976 (N.D. Ill. Dec. 15, 2000). *See also Memorial Hosp. of S. Bend v. Becerra*, No. 20-3461, 2022 WL 888190 at *10 (D.D.C. Mar. 25, 2022); *Akron Gen. Med. Ctr. v. Azar*, 836 Fed. Appx. 13 (D.C. Cir. 2021), *aff'g*, 414 F. Supp. 3d 73 (D.D.C. 2019).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Leslie Goldsmith, Esq.
Bass, Berry & Sims, PLC
1201 Pennsylvania Avenue, NW, Suite 300
Washington, D.C. 20004

RE: ***Expedited Judicial Review Decision***
Case Number: 22-1271GC - *Yale-New Haven CY 2019 Capital DSH CIRP Group*
Case Number: 23-1683G - *Bass, Berry & Sims, PLC CY 2021 Capital DSH Group*

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the July 30, 2024 consolidated request for expedited judicial review[1] ("EJR") for the above-referenced optional and common issue related party ("CIRP") group appeals. The decision with respect to EJR is set forth below.[2]

Issue under Dispute

In these group cases, the Providers are challenging:

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

Background:

Under the inpatient prospective payment system ("IPPS"), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for operating costs ("operating IPPS") as set forth at § 1395ww(d); and one for capital costs ("capital IPPS") as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to

[1] Providers' Petition for Expedited Judicial Review (July 30, 2024) ("Request for EJR").
[2] The Request for EJR encompasses six (6) group cases. On August 2, 2024, pursuant to Board Rule 44.6 (2023), the Medicare Contractor's representative made a filing which indicated that it would be submitting substantive claim challenges in Case Nos. 23-1580G, 23-1581GC, 24-1931GC, & 24-2168GC. The Board will address the EJR requests for those four (4) group cases under separate cover.
[3] Request for EJR at 1.

create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.[4] This case focuses on the capital IPPS.

1. Geographic Reclassification

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

2. Operating DSH Adjustment Under Operating IPPS

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

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

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

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

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

3. Capital DSH Adjustment Under Capital IPPS

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

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

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

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

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

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

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

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

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

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

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

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

[18] *Id* at 43377.

> properly focuses on those hospitals that serve a large disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries**.[19]

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

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

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

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

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

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

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

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

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

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

> *Comment*: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review

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

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

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

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

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

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

[24] *Id*. at 43452-53.

submitted to the MGCRB and certain criteria are met.[25] IPPS hospitals are reclassified per BBRA § 401 are often referred to as "§ 401 hospitals."

On August 1, 2000, the Secretary published the interim final rule to, in part, implement BBRA § 401 and stated in the preamble that a hospital reclassified as rural pursuant to § 401 is treated as rural for ***all*** purposes under operating IPPS, including the DSH adjustment for operating IPPS:

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

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

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

[25] BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).
[26] 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added.)

process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).

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

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

****

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

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

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

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

Neither the August 1, 2000 interim final rule nor the FY 2001 IPPS Final Rule explicitly discussed the impact on capital DSH adjustments under capital IPPS. However, through operation of the cross-reference in 42 C.F.R. § 412.320(a) to § 412.63(a) in the phrase "the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area", it would appear that hospitals reclassified from

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

urban to rural were ***not*** eligible for capital DSH adjustments under capital IPPS. In this regard, the Board notes that, following the 2000 rulemaking process, § 412.63(a)-(b) (2001) read, in pertinent part:

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

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

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

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

The Office of Management and Budget publishes information on core-based statistical areas ("CBSAs") and the Secretary has used this information for purposes of defining labor market areas for use in the wage index for operating IPPS.[31] On June 6, 2003, OMB announced the new CBSAs, comprised of metropolitan statistical areas ("MSAs") and the new Micropolitan Areas based on Census 2000 data.[32]

On August 11, 2004, the Secretary published the FY 2005 IPPS Final Rule and this rule finalized revisions to the operating IPPS regulations to both implement MMA § 401 as well as adopt

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

OMB's new CBSA designations.[33] With respect to implementing MMA § 401, the Secretary revised 42 C.F.R. § 412.63 to apply only to years through 2004 and added a new § 412.64 to implement MMA § 401 for federal rates for FYs 2005 forward. Specifically, § 412.64 reads in pertinent part:

> **§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.**
>
> (a) *General rule*. CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the following definitions apply:
>
> (i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.
>
> (ii) The term *urban area* means—
>
> (A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or
>
> (B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.
>
> (C) The term *rural area* means any area outside an urban area.
>
> (D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

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

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

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

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

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a ''disproportionate share hospital'' for the purposes of capital prospective payments <u>if either of the following conditions is met</u>:
>
> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

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

> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64.[36]

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

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

> Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB's new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.
>
> ****
>
> The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those

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

> additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.
>
> ****
>
> As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.[37]

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

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

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

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

> These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in

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

> FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.
>
> These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).
>
> We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.[41]

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

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

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

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

> (ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.
>
> **(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.[43]**

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

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

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

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

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[43] (Bold emphasis added.)
[44] 621 F.Supp.3d 13 (D.D.C. 2021).
[45] *Id.* at 25 (citations omitted).
[46] *Id.* at 18-19.
[47] 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a "§ 401" hospital.
[48] *Toledo* at 19.
[49] *Id.* at 19-20.
[50] *Id.* at 21.

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

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

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

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

   - "The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006."[54]

   - "[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements."[55]

   - "The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp*., 797 F.3d at 1161 (upholding Secretary's regulation where the Secretary explained why 'added precision' 'would not justify the added complication') (quotation omitted)."[56]

   - "The agency cannot 'entirely fail[ ] to consider' the "relevant data" and the factors that Congress directed it to review. *State Farm*, 63 U.S. at 43. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did he take costs into account at all."[57]

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

[51] *Id.* at 22.
[52] *Id.* at 23-25.
[53] *Id.* at 29.
[54] *Id.*
[55] *Id.*
[56] *Id.*
[57] *Id.*

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

Providers' Request for EJR

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

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

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

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

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[58] *Id.* at 30.
[59] *Id.*
[60] Request for EJR at 7.
[61] *Id.*
[62] *See id.* at 7-8.
[63] *Id.* at 8 (citing 70 Fed. Reg. 47278, 47437 (Aug. 12, 2005)).
[64] *Id.*
[65] *Id.* at 8-9.

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

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

Board Decision

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

1. Jurisdiction – Appropriate Cost Report Claim (FYEs Prior to December 31, 2016)

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[71] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[72] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement ("NPR") issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports

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[66] *Id.* at 9.
[67] *Id.* at 10-12 (citing 88 Fed. Reg. 58640, 59117, 59334 (Aug. 28, 2023).
[68] *Id.* at 10.
[69] *See* 42 C.F.R. § 405.1867.
[70] Request for EJR at 10-12.
[71] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[72] *Id.* at 70555.

beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). Since all the participants in cases 23-1210G & 23-1645GC have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

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

Based on its review of the record, the Board finds that each of the participants in these group appeals filed their appeals within 180 days of the issuance of their respective final determinations, or within 180 days after the twelve month period in which the Medicare Contractor was to issue a final determination,[73] as required by 42 C.F.R. § 405.1835; that the providers in each case appealed the issue in their respective appeals' and that the Board is not precluded by regulation or statute from reviewing the issue in these appeals. Finally, in each case, the amount in controversy meets the $50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3).

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

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

> (1) In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), must include an appropriate claim for the specific item, by either—

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

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

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

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

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

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

the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[74] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[75] In these two group cases, the Medicare Contractor has failed to file a Substantive Claim Challenge[76] within the time frame specified by Board Rule 44.5.1 (2021) for any of the Providers with FYEs December 31, 2016 or later. In fact, the Medicare Contractor's response to the EJR Request (filed August 2, 2024) specifically noted that it would not be filing any jurisdictional or substantive claim challenges in Cases 22-1271GC and 23-1683G.

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[77] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

3. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that the participants in cases 22-1271GC and 23-1683G are entitled to a hearing before the Board;

2) Board review of whether the Providers' cost reports included an appropriate claim for a specific item as required by 42 C.F.R. § 405.1873(a) has not been triggered;

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

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

---

[74] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[75] *See* 42 C.F.R. § 405.1873(a).
[76] Board Rule 44.5 states: "The Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."
[77] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."

5) It is without the authority to decide the legal question of whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' EJR Request for the issue and the subject years in cases 22-1271GC and 23-1683G. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the case.

Board Members Participating:

Clayton J. Nix, Esq.
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Ratina Kelly, CPA
Nicole A. Musgrave, Esq.
Shakeba DuBose, Esq.

FOR THE BOARD:

8/28/2024

X Kevin D. Smith, CPA

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

Enclosure: Schedules of Providers
cc: Danelle Decker, National Government Services, Inc. (J-K)
Cecile Huggins, Palmetto GBA (J-J)
Scott Berends, Esq., FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Blvd., Ste. 700
Los Angeles, CA 90064-1582

RE: ***Request for Reconsideration of Decision***
Case No. 24-0341, *et al.* (*see* Appendix A listing 11 cases)

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("Board") has reviewed the eleven (11) above-referenced appeals in response to the Request for Reconsideration filed by Blumberg, Ribner, Inc. ("Blumberg"). As set forth below, the Board ***declines*** to reopen and reconsider its original February 29, 2024 determination and, as a result, ***denies*** the Request for Reconsideration.

Background

Blumberg, Ribner, Inc. ("Blumberg Ribner") represents a number of Providers which are challenging the Treatment of Part C Days as appealed from the Final Rule that the Secretary of Health and Human Services ("Secretary") published in the June 9, 2023 Federal Register ("June 2023 Final Rule").

On **December 4, 2023**, Blumberg Ribner filed 11 appeal requests on behalf of the Providers concerning the June 2023 Final Rule as it relates to the Providers' yet-to-be-finalized FY 2004-2013 Medicare disproportionate share hospital ("DSH") reimbursement.[1]

The Providers in the individual and group appeals all involve fiscal years ranging from 2004 to 2013. The ***sole*** issue in each of these appeals is "whether the Retroactive Rule, which pertains to the calculation of Disproportionate Share payments from Medicare to hospitals who serve a disproportionate number of low-income patients, is invalid and void because it impermissibly provides for 'retroactive' change in CMS's policy to include Medicare Part C patient days, (also known as 'Medicare Advantage') in the Medicare/SSI Fraction Denominator for fiscal years prior to 2014."[2] In the June 2023 Final Rule, the Secretary adopted and finalized its policy to include Part C days in the SSI fraction as used in the DSH calculation for Part C discharges occurring prior to October 1, 2013. As noted, the Blumberg Ribner-represented Providers challenge this policy, as well as the procedural and substantive validity of the rule.[3]

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] Issue Statement at 1 in Case No. 24-0341. Each of the Issue Statements in the 11 Blumberg Ribner appeals referenced in this memo are materially identical.
[3] 88 Fed. Reg. 37772 (June 9, 2023).

On **February 29, 2024**, the Board dismissed the Providers' appeals and found that the Part C Policy issued in the June 2023 Final Rule that the Providers appealed for the fiscal years at issue is not an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835(a). Further, the Board determined that even if the June 2023 Final Rule was an appealable "final determination" under 42 U.S.C. § 1395oo(a)(1)(A)(ii), the Providers' appeal requests failed to meet the content requirements under the relevant provisions of 42 C.F.R. §§ 405.1837(c) and 405.1836(b) based on its failure to demonstrate that the June 2023 Final Rule was, in fact, a payment determination *retroactively* applicable to them for the fiscal years at issue consistent with the terms of that Final Rule.

On **April 25, 2024**, Blumberg Ribner, on behalf of Providers, filed a Request for Reconsideration presenting arguments to oppose both of the Board's findings.

Issue in Dispute

Each of the 11 above-captioned cases had the same issue statement, which reads, in part:

> This is an appeal to challenge and invalidate the Final Rule that the Secretary of Health and Human Services ("Secretary") published June 9, 2023, 88 Fed. Reg. 37772 (June 9, 2023) ("Retroactive Rule"), and to challenge and invalidate the SSI Ratio published on or about October 16, 2023 ("CMS 1739F SSI Ratio").
>
> The main issue is whether the Retroactive Rule, which pertains to the calculation of Disproportionate Share payments from Medicare to hospitals who serve a disproportionate number of low-income patients, is invalid and void because it impermissibly provides for "retroactive" change in CMS's policy to include Medicare Part C patient days, (also known as "Medicare Advantage") in the Medicare/SSI Fraction Denominator for fiscal years prior to 2014. Because the Retroactive Rule is the basis of the calculations underlying the CMS 1739F SSI Ratio, the CMS 1739F SSI Ratio must also fail for all of the following reasons.

Based on the following rationale, the Providers contended that the Board had jurisdiction over these appeals:

> For each specific matter and question included in the request, the Board has jurisdiction under 42 CFR § 405.1840 over each matter at issue, all as stated in the accompanying appeal. The Retroactive Rule is an appealable final determination under 42 USC Section 1395oo(a)(1)(A)(ii), [because] there are NO other variables in calculating the DSH payment missing from the Final Rule. Especially because the Final Rule expressly states that the Part C Days have been correctly shown in the Medicare Fraction

> Denominator for the determination of DSH payments to the providers, there are no other determinations or variables on which the Provider's ultimate DSH payment depends if the Final Rule is implemented. The Final Rule IS an appealable final determination "as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title" (as set forth in 42 U.S.C. § 1395oo(a)(1)(A)(ii)) or as the "the total amount of reimbursement due the provider" (as set forth in 42 C.F.R. § 405.1835(a)).[4]

Blumberg Ribner's Request for Reconsideration:

On April 25, 2024, the Providers filed a Motion for Reconsideration, summarizing their main arguments to request reconsideration of the Dismissal as follows:

> The Dismissal hinges on two related findings whereby the Board determined that there was a failure of jurisdiction due to prematurity/lack of finality, and what amounts to a failure of proof regarding the "content requirements." More specifically:
>
> - The Board ruled that "the Part C policy issued in the June 2023 Final Rule that the Providers appealed for the fiscal years at issue is not an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835(a)." Dismissal, at 22.
>
> - The Board inconsistently ruled that even if there was a final determination, the Appeal "failed to meet the content requirements under the relevant provisions of 42 C.F.R. § 405.1837(c) and 405.1835(b) based on its failure to demonstrate that the June 2023 Final Rule was, in fact, a payment determination *retroactively* applicable to them for the fiscal years at issue consistent with the terms of the Final Rule." *Id.*

First, the Providers argue that the Final Rule *is* an appealable final determination. Additionally, the Providers contend they have a right to appeal 1739-F to the Board without waiting for Revised Notices of Program Reimbursement. Further, the Providers argue that the request for reconsideration should be granted because section 1395oo permits providers to prospectively appeal what they will receive as payment for services provided to eligible patients.

The Providers also assert they have met all content requirements in both the initial appeal and in their Request for Reconsideration, but they do say:

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[4] *Id.*

> [F]or purposes of removing the "lack of content" objection asserted by the Board, Providers are supplementing here their evidentiary submission including the prior NPR's appeals, remands and calculations. Notably, the calculation of the differential in reimbursement impact is formulaic, no mystery, and is attached for each of the subject Providers as attachment Exhibits 1 – 4.

The Providers then argue that the Board fails to consider how the regulatory history behind the June 2023 Final Rule, the litigation in *Allina I* and *Allina II*, taken with the Secretary's decision to adopt a retroactive policy regarding the treatment of Medicare Part C days, basically the rule in question, show that "all elements of the rule are complete."

The Providers add to their Request for Reconsideration an additional argument, stating the Board makes "selective use of inapposite case law, particularly its misplaced reliance on *Memorial Hospital,* [which] demonstrates the arbitrary nature of its dismissal and renders the dismissal ripe for reconsideration."[5]

Further, the Providers assert that a Provider may appeal a Final Rule without a specific payment determination and satisfy the requirements under 42 USC § 1395oo(a)(I)(A)(ii). Similarly, the Providers address the Board's argument related to the Providers' failure to meet content requirements by making the following contentions:

> The choice not to include NPRs and related back-up should not have been any part of the Dismissal. That said, however, such supporting documentation is provided herewith at Exhibits 1-3. As set forth above, the provision of this supporting documentation, regardless of whether it is required or not, by itself justifies reconsideration.
>
> The Board further based its Dismissal on the argument that evidentiary "minimum content requirements" were not satisfied. (Dismissal at 19-20). Here, the Board goes beyond the evidentiary proof issue, citing 42 C.F.R. sections 405.1835 and 405.1837 for the proposition that there must be information presented about other pending appeals to demonstrate that "the Board can exercise jurisdiction over an appeal" (Dismissal at 19) and that there is an appeal of a "final contractor or Secretary determination" (*id.,* at 20). Specifically, the Board states that, "… each of these Providers have alleged that it has pending before the MAC another appeal of the same Part C days issue; however, it is unclear why the Providers were remanded as alleged (*e.g.,* remanded pursuant to a Court Order vs. remanded pursuant to CMS Ruling 1498-R) and what the parameters of those remands is. (Dismissal, at 14).

[5] Request for Reconsideration at 6.

> Again, although debatable that it is actually required under the rubric set forth above, the information regarding the other appeals will be provided herewith in Exhibits 1-4. This alone is sufficient grounds for reconsideration.

Decision of the Board:

The Board ***declines*** to exercise its discretion to reopen and reconsider its original February 29, 2024 determination and, as a result, ***denies*** the Request for Reconsideration. The Providers have not raised any arguments regarding the appealability of the June 2023 Final Rule that are not addressed by the Board in its original decision.[6] In declining to reopen and reconsider, the Board declines to reopen the record to consider the sufficiency[7] of additional evidence on the *potential* applicability of the June 2023 Final Rule to the Providers in order to address an ***alternative*** basis for dismissal in the Board's decision, particularly when: (1) that decision makes clear that the Providers had no right to appeal in the first instance; and (2) as thoroughly explained in the Board's decision, that *belated* documentation should have been part of the appeals in the first instance pursuant to the *claims filing requirements*[8] at 42 C.F.R. §§ 405.1835(b)(1) and 405.1837(c)(1)[9] (to the extent the Providers had any right to appeal the June 2023 Final Rule). In denying the request to reopen and reconsider, the Board again cites to the following excerpt which confirms that, if the June 2023 Final Rule is applicable to them, then the Providers will have appeal rights from an NPR or RNPR to be issued pursuant to that Rule:

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[6] For example, page 17 of the Board's decision: (1) compares the D.C. District Court's *unpublished* 2022 decision in *Memorial Hosp. of South Bend, Ind. v. Becerra*, No. 20-3461, 2022 WL 888190 (D.D.C. Mar. 25, 2022) ("*Memorial Hospital*") to the D.C. District Court's *unpublished* 2023 decision in *Battle Creek Health Sys. v. Becerra*, No. 17-0545, 2023 WL 7156125 (D.D.C. Oct. 31, 2023) ("*Battle Creek*"); and (2) explains in footnote 60 why the Board determined that the *Memorial Hospital* decision is the better persuasive authority.

[7] As explained in the Board's February 29, 2024 determination, the Board's concern is rooted in the failure of the Providers to demonstrate that the June 2023 Final Rule would be retroactively applied to each relevant cost reporting period. The February 29, 2024 determinations further discusses how the Providers' initial appeals did not provide documentary evidence to confirm whether the Providers' relevant cost reports remain open or have yet been finally settled and, as such, failed to demonstrate that the June 2023 Final Rule was a "final … determination ***for the provider's cost reporting period***" which involved "*reimbursement* ***due the provider***." In declining to reopen, the Board has not reviewed the additional documentation included with the reconsideration request and, if it were to do so, it would need to resolve concerns about the sufficiency of that documentation (*e.g.*, simply providing copies of NPRs, RNPRs and EJR Requests would not necessarily establish the retroactive applicability of the June 2023 Final Rule to a particular provider for a particular fiscal year). Again, this was explained in the Board's February 29, 2024 determination.

[8] 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), 405.1837(c) (addressing certain other claims-filing requirements).

[9] In each of these group appeals, the Providers filed certification that the group was fully formed on the same days as the group appeal was filed. Under Board Rule 20.1, the Providers were required to file certification within 60 days to confirm that the case contains all jurisdictional documentation (including the claims filing requirement as discussed in *supra* note 8). However, the Providers failed to comply with that request and, as such, the file stands on its own.

> Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions contained in the NPRs or revised NPRs.* Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights.* Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised NPRs will provide hospitals with a vehicle to appeal the new final action* even if the Medicare fraction or DSH payment does not change numerically.[10]
>
> ****
>
> *When the Secretary's treatment of Part C days in this final action is reflected in **NPRs and revised NPRs**, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation **by appealing those NPRs and revised NPRs***. While some providers have already received the reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings.[11]

Accordingly, the above-captioned eleven (11) appeals remain closed. 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:

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

For the Board:

8/29/2024

X Clayton J. Nix

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

cc: Lorraine Frewert, Noridian Healthcare Solutions, c/o CGS Administrators (J-E)
Michael Redmond, Novitas Solutions, Inc. (J-H)
Danelle Decker, National Government Services, Inc. (J-K)
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Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson Leong, FSS

[10] 88 Fed. Reg. at 37788 (emphasis added).
[11] *Id.* (emphasis added).

Appendix A
Listing of 11 Blumberg, Ribner Providers' Appeals

24-0341	Scripps Mercy Hospital (05-0077), FFY 2004
24-0342	Scripps Mercy Hospital (05-0077), FFY 2005
24-0343GC	East Texas Reg'l HS CY 2012 East Tex. RHS 2012 Challenge to 1739F CIRP Grp.
24-0344G	Blumberg Ribner CY 2006 BRI Indep Hospitals Challenge to CMS1739F Group
24-0345G	Blumberg Ribner CY 2007 BRI Indep Hospitals Challenge to CMS1739F Group
24-0346G	Blumberg Ribner CY 2008 BRI Indep Hospitals Challenge to CMS1739F Group
24-0347G	Blumberg Ribner CY 2009 BRI Indep Hospitals Challenge to CMS1739F Group
24-0348G	Blumberg Ribner CY 2010 BRI Indep Hospitals Challenge to CMS1739F Group
24-0349G	Blumberg Ribner CY 2011 BRI Indep Hospitals Challenge to CMS1739F Group
24-0350G	Blumberg Ribner CY 2012 BRI Indep Hospitals Challenge to CMS1739F Group
24-0351	East Texas Medical Center Athens (45-0389), FFY 2013