DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Determination on Disbanding Toyon Associates CY 2018 NAHE Elimination of Pharmacy Residency Program Optional Group, Case Number: 24-0267G***

As it relates to the participants:
Palomar Health Downtown Campus (Provider Number 05-0115)
FYE: 6/30/2018
Case Number: 23-0362 *and*

OHSU Hospital & Clinics (Provider Number 38-0009)
FYE: 6/30/2018 (no individual case)

Dear Ms. Ellis:

The Provider Reimbursement Review Board ("the Board") has reviewed the subject *optional* group appeal pursuant to correspondence from Toyon Associates, Inc. ("Toyon") dated November 19, 2024. Toyon's correspondence was filed in reply to an earlier Board Request for Information ("RFI") regarding the question of the suitability of the NAHE Elimination of Pharmacy Residency Program issue for the group appeal format. The pertinent facts for this group and the Board's determination are set forth below.

Pertinent Facts:

On **November 27, 2023**, Toyon filed the "Toyon Associates CY 2018 NAHE Elimination of Pharmacy Residency Program Group" under Case No. 24-0267G, which was formed in the Office of Hearings Case & Document Management System ("OH CDMS") without any providers. On the same date, Toyon requested the transfer of the Elimination of Pharmacy Residency Program (NAHE) issue for Palomar Health Downtown Campus from Case No. 23-0362 and directly added OHSU Hospitals and Clinics to the group.

On **September 16, 2024**, Toyon requested the expansion of the group to include an additional calendar year ("CY") 2017. The expansion of the group would allow another provider, White Memorial Medical Center (Prov. No. 05-0103), to transfer its "Disallowance of Clinical Pastoral Education (CPE) Costs" issue for FYE 12/31/2017 to the group.

On **September 20, 2024**, the Board denied Toyon's request for expansion of Case No. 24-0267G to include CY 2017 and the related transfer from Case No. 22-1149. The Board found that the issues in the individual appeal and the group case involved two different programs and the facts and circumstances surrounding each program were likely to be different.

Additionally, the Board questioned the suitability of the NAHE Elimination of Pharmacy Residency Program issue for the group format. The Board noted that the issue seems to be factually specific to each provider since each program may be operated differently and, therefore, could result in differing determinations being rendered by the Board. Therefore, the Board required Toyon to review its pending appeals for the NAHE Elimination of Pharmacy issue and to submit comments in support of why it should remain in the group format or, alternatively, confirm that its groups on this issue should be disbanded.

On **November 19, 2024**, Toyon responded to the Board's request indicating that when the groups were formed, it believed that the various group providers were ". . . connected by a common question of law (as required by 42 C.F.R. § 405.1837). . . ".[1] However, Toyon acknowledged that, in the event the Board did not agree with that reasoning, it would concede to the Board's proposal to disband its NAHE groups. In the case of the subject group's disbandment, Toyon requested that the Board transfer the issue back to the individual appeal for Palomar Health Downtown Campus, Case No. 23-0362 and establish a new individual appeal for OHSU Hospital & Clinics.[2]

On **November 27, 2024**, Case No. 24-0267G was automatically designated to be fully formed, one year after its formation.

Board Determination:

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

With respect to issues suitable for group format, the Board relies on 42 C.F.R. § 405.1837(b), which specifies that two or more providers may file a group for ". . . 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." This is further reflected in Board Rule 12.2, which states, "[t]he matter at issue in the group appeal must involve a single question of fact or interpretation of law, regulation, or CMS Rulings that is common to each provider in the group."

After review of Toyon's response, the Board finds that the NAHE Elimination issue appears to be provider specific as the facts could vary from Provider to Provider, in terms of which schools are participating in the program, the operator of the program and the history of the

[1] NAHE Elimination of Pharmacy Residency Program Group Appeals Response (Nov. 19, 2024).
[2] *Id.*

program, and the handling on the specific cost report.[3] Based on this finding, there does not appear to be a single common issue and therefore, the Board is taking the following actions:

1. The "Elimination of Pharmacy Residency Program (NAHE)" issue for Palomar Health Downtown Campus is hereby returned to the individual appeal, Case No. 23-0362. As preliminary position papers have already been filed in that case, a request for a supplemental preliminary position paper briefing the "Elimination of Pharmacy Residency Program (NAHE)" issue will be issued under separate cover;
2. A new individual appeal will be established for OHSU Hospital & Clinics' CY 2018. The Parties will receive an Acknowledgement & Critical Due Dates notice under separate cover.
3. As there are no remaining providers in Case No. 24-0267G, the case is being closed and removed from the Board's docket.

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

For the Board:

12/3/2024

X Kevin D. Smith, CPA

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

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

[3] Toyon's response to the Board's RFI referenced eleven groups, including the group discussed herein. Due to the varying fact patterns for group participants in each case, the Board will address each group under separate cover.

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Via Electronic Delivery

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

RE: ***Board Determination on Disbanding Dignity Health CY 2014 NAHE Elimination of Pharmacy Residency Program CIRP Group, Case Number: 24-2154GC***

As it relates to the participant:
Mercy General Hospital (Provider Number 05-0017)
FYE: 6/30/2014
Case Number: 19-1937

Dear Ms. Ellis:

The Provider Reimbursement Review Board ("the Board") has reviewed the subject common issue related party ("CIRP") group appeal pursuant to correspondence from Toyon Associates, Inc. ("Toyon") dated November 19, 2024. Toyon's correspondence was filed in reply to an earlier Board Request for Information ("RFI") regarding the question of the suitability of the NAHE Elimination of Pharmacy Residency Program issue for the group appeal format. The pertinent facts for this group and the Board's determination are set forth below.

Pertinent Facts:

On **July 22, 2024**, Toyon filed the "Dignity Health CY 2014 NAHE Elimination of Pharmacy Residency Program Group" under Case No. 24-2154GC, which was formed in the Office of Hearings Case & Document Management System ("OH CDMS") without any providers. On the same date, Moss Adams, LLP requested the transfer of the "Nursing & Allies Health Remove Program Costs" ("*NAHE Elimination of Pharmacy Residency Program*") issue for Mercy General Hospital from its individual appeal, Case No. 19-1937.[1]

On **September 16, 2024**, in Case No. 24-0267G, (an optional group appealing the same issue) Toyon requested the expansion of that calendar year ("CY") 2018 group to include CY 2017. Toyon argued that the expansion of the group would allow another provider, White Memorial Medical Center (Prov. No. 05-0103), to transfer its "Disallowance of Clinical Pastoral Education (CPE) Costs" issue for FYE 12/31/2017 to the group.

[1] Case No. 19-1937 was subsequently closed on August 24, 2024.

On **September 20, 2024**, the Board denied Toyon's request for expansion of Case No. 24-0267G to include CY 2017 because it found that the issues in the individual appeal and the group case involved two different programs and the facts and circumstances surrounding each program were likely to be different.

In that determination, the Board also posed a question regarding the suitability of the NAHE Elimination of Pharmacy Residency Program issue for the group format. The Board noted that the issue seems to be factually specific to each provider since each program may be operated differently and, therefore, could result in differing determinations being rendered by the Board. Therefore, the Board required Toyon to review its pending appeals for the NAHE Elimination of Pharmacy issue and to submit comments in support of why it should remain in the group format or, alternatively, confirm that its groups on this issue should be disbanded.

On **November 19, 2024**, Toyon responded to the Board's request indicating that when the groups were formed, it believed that the various group providers were ". . . connected by a common question of law (as required by 42 C.F.R. § 405.1837). . . ".[2] However, Toyon acknowledged that, in the event the Board did not agree with that reasoning, it would concede to the Board's proposal to disband its NAHE groups. In the case of the subject CIRP group's disbandment, Toyon requested that the Board form a new individual appeal (rather than reinstate Moss Adam's earlier individual case).[3]

Board Determination:

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

With respect to issues suitable for group format, the Board relies on 42 C.F.R. § 405.1837(b), which specifies that two or more providers may file a group for ". . . 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." This is further reflected in Board Rule 12.2, which states, "[t]he matter at issue in the group appeal must involve a single question of fact or interpretation of law, regulation, or CMS Rulings that is common to each provider in the group."

After review of Toyon's response, the Board finds that the NAHE Elimination issue appears to be provider specific as the facts could vary from Provider to Provider, in terms of which schools are participating in the program, the operator of the program and the history of the program, and the handling on the specific cost report.[4] Based on this finding, there does not appear to be a single common issue and therefore, the Board is taking the following actions:

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[2] NAHE Elimination of Pharmacy Residency Program Group Appeals (Nov. 19, 2024).
[3] *Id.*
[4] Toyon's response to the Board's RFI referenced eleven groups, including the group discussed herein. Due to the varying fact patterns for group participants in each case, the Board will address each group under separate cover.

1. A new individual appeal will be established for Mercy General Hospital. The Parties will receive an Acknowledgement & Critical Due Dates notice under separate cover.
2. As there are no remaining providers in Case No. 24-2154GC, the case is being closed and removed from the Board's docket.

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

For the Board:

12/3/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Board Determination on Transfers of SSI Issues to DSH SSI Unduly Narrow Definition of SSI Entitlement CIRP Group, Case Number: 23-1635GC***

Specifically:
Houston Methodist Willowbrook Hospital (Provider Number 45-0844) from Case No. 23-1006
Houston Methodist Baytown Hospital (Provider Number 45-0424) from Case No. 23-1209
Houston Methodist West Hospital (Provider Number 67-0077) from Case No. 23-1466
Houston Methodist Clear Lake Hospital (Provider Number 45-0709) from Case No. 23-1728

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the subject common issue related party ("CIRP") group filed by Quality Reimbursement Services, Inc. ("QRS"/ "Representative.") The pertinent facts regarding the group appeal and the transfer of providers from their respective individual appeals, as well as the Board's Determination, are set forth below.

Pertinent Facts with regard to CIRP Group – Case No. 23-1635GC:

On **August 31, 2023**, QRS filed the CIRP group for Houston Methodist Hospital System ("HMHS") for the calendar year ("CY") 2018 DSH SSI Unduly Narrow Definition of SSI Entitlement issue under Case No. 23-1635GC. The group was formed in the Office of Hearings Case & Document Management System ("OH CDMS") without any providers.

Characterization of DSH SSI Unduly Narrow Definition of SSI Entitlement Group Issue

The group issue statement describes the issue under appeal as:

> The Provider(s) protest(s) CMS's policy of excluding unpaid SSI days from the numerator of the Medicare fraction. Despite CMS's seemingly contrary policy of treating unpaid Part A days as days entitled to benefits under Part A, CMS requires that a beneficiary be paid SSI benefits (or "covered" by SSI) during the period of his or her hospital stay in order for such days to be considered "entitled to supplemental security income benefits" and included in the numerator of the SSI fraction.
>
> CMS does not include days in the numerator of the SSI fraction when individuals were eligible for SSI but did not receive a SSI payment during their hospitalization for such reasons as failure of the beneficiary to have a valid address, representative payee

problems, Medicaid paying for more than 50 percent of the cost of care in a medical facility, or the period of hospitalization is during the first month of eligibility before a cash payment is made. None of these reasons affect the patient's indigency.

CMS's policy of applying different interpretations to the same term, "entitled," used in the same sentence of the statute is the epitome of arbitrary and capricious agency action and must be reversed. *See Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 20 n.1 (D.C. Cir. 2011) (Kavanaugh, J., concurring) ("HHS thus interprets the word 'entitled' differently within the same sentence of the statute. The only thing that unifies the Government's inconsistent definitions of this term is its apparent policy of paying out as little money as possible. I appreciate the desire for frugality, but not in derogation of law."); see also *Walter O. Boswell Mem'l Hosp. v. Heckler*, 749 F.2d 788, 799 (D.C. Cir. 1984) ("It would be arbitrary and capricious for [the Secretary] to bring varying interpretations of the statute to bear, depending upon whether the result helps or hurts Medicare's balance sheets….").

In rulemaking, commenters specifically requested that CMS include other payment codes that identified "entitled" individuals, but the Secretary nonetheless adopted a policy of including only codes that identify people receiving actual SSI cash payment. Id. For example, commenters requested that codes S06 (suspended payment because recipients' whereabouts are unknown based on "undeliverable checks, mail, reports of change or a change of address") and S07 ("checks returned for reasons that are unclear or for reasons other than address or a representative payee problem") be included. CMS refused the suggestion.

Because CMS's treatment of unpaid Part A days as "days entitled to benefits under part A" was upheld by the Supreme Court in *Becerra v. Empire Health Found., for Valley Hosp. Med. Ctr.*, 597 S.Ct. June 24, 2022 WL 227680 (2022), CMS must apply the same interpretation of the word "entitled" in the context of "entitled to supplemental security income benefits." By doing so, CMS will necessarily have to widen the number of SSI status codes it treats as being "entitled to SSI benefits" to encompass not just the three codes CMS currently includes, but all codes that reflect eligibility for SSI benefits.[1]

On **September 6, 2023**, shortly after the group was formed, HMHS transferred two providers into Case No.. 23-1635GC:

- Houston Methodist Willowbrook Hospital ("HM Willowbrook") from Case No. 23-1006; and
- Houston Methodist San Jacinto Hospital ("HM San Jacinto") from Case No. 23-1209.[2]

On **February 19, 2024** and **April 29, 2024**, HMHS transferred two more providers:

- Houston Methodist West Hospital ("HM West") from Case No. 23-1466 and

[1] Group Issue Statement (Aug. 31, 2023).
[2] This hospital is identified as both Houston Methodist San Jacinto Hospital and Houston Methodist Baytown Hospital in OHCDMS.

- Houston Methodist St. John Hospital ("HM St. John") from Case No. 23-1728.[3,4]

Pertinent Facts Relating to Transferred Issues from Individual Appeals

The Providers in Case Nos. 23-1006, 23-1209, 23-1466 and 23-1728 all titled the issue which was transferred to Case No. 23-1635GC, "DSH Payment – SSI Systemic Errors" and each uploaded the same issue statement which included the following language:

> The Providers contend that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww (d)(5)(F)(i). The Providers further contend that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.

Board Determination:

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

Regarding group appeals, the regulation at 42 C.F.R. § 405.1837(a) states:

(a) Right to Board hearing as part of a group appeal: Criteria. A provider (but no other individual, entity, or party) has a right to a Board hearing, as part of a group appeal with

[3] The group has not yet been designated to be fully formed.
[4] This hospital is identified as both Houston Methodist St. John Hospital and Houston Methodist Clear Lake Hospital in OHCDMS.

other providers, with respect to a final contractor or Secretary determination for the provider's cost reporting period, only if—

(1) The provider satisfies individually the requirements for a Board hearing under §405.1835(a) or §405.1835(c), except for the $10,000 amount in controversy requirement in §405.1835(a)(2) or §405.1835(c)(3).
(2) The matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
(3) The amount in controversy is, in the aggregate, $50,000 or more, as determined in accordance with §405.1839 of this subpart.

The Board is bound by the statutes and regulations, including those governing group cases. Specifically, 42 C.F.R. § 405.1837(b)(1) requires that a mandatory group be comprised of two or more providers appealing a common issue. Board Rule 12.2 also references the fact that, "[t]he matter at issue in the group appeal must involve a *single* question of fact or *interpretation* of law, regulation, or CMS Rulings that is common to each provider in the group."[5]

Accordingly, for purposes of the group participants in the appeal of the CY 2018 CIRP group characterized as "DSH SSI Unduly Narrow Definition of SSI Entitlement" in Case No. 23-1635GC the Board finds that the four Providers appealed distinctly a different issue in the individual appeals from which they transferred. Therefore, **the transfers of the DSH Payment – Systemic Errors issues for HM Willowbrook, HM San Jacinto, HM West and HM St. John from their respective individual appeals, Case Nos. 23-1006, 23-1209, 23-1466 and 23-1728 must be denied**, and the issues returned to the respective individual appeals.[6]

The Board finds that the group issue under appeal in Case No. 23-1635GC relates to the exclusion of unpaid SSI days from the Medicare Fraction numerator. It further discusses the definition/ interpretation of the word "entitled," and cites to the Empire case. The issue statements for the four providers are NOT consistent with the Unduly Narrow Definition of SSI Entitlement issue under appeal in the group. Instead, all four providers are appealing the "Baystate" aspect of the SSI Accuracy issue which involves SSI data matching and the potential errors in that process.[7]

Again, the Board finds that the DSH Payment Systemic Errors ("Baystate") issue is not the same as the issue described in the group under Case No. 23-1635GC, which relates to the Supreme Court's *Empire* decision (regarding entitlement to paid and unpaid Part A days).[8] ***After the denial of the four transfers, there are no remaining providers in Case No. 23-1635GC. Therefore, the group is being closed and removed from the Board's docket.*** Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

[5] Board Rules v 3.1 issued Nov. 1, 2021.
[6] All four cases are currently open.
[7] *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008)
[8] *Becerra v. Empire Health Found.*, 142 S. Ct. 2354 (2022).

As HM Willowbrook, HM San Jacinto, HM West and HM St. John are all under the HMHS parent organization, HMHS or QRS should file a new group appeal for the SSI Systemic Errors issue to which the providers could transfer.

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

FOR THE BOARD:

12/4/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Michael Redmond, Novitas Solutions Inc. c/o GuideWell Source (J-H)
Nan Chi, Houston Methodist Hospital System

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Robert Roth, Esq.
Hooper, Lundy & Bookman, P.C.
401 9th Street NW, Suite 550
Washington, D.C. 20004

RE: ***Notice of Case Closure***
Hackensack Meridian CY 2015 Medicare DSH Medicare/SSI Fraction CIRP Grp.
Case Number: 19-1552GC

Dear Mr. Roth:

The Provider Reimbursement Review Board ("Board") has received the Provider's Notice of Filing of Lawsuit filed with the Board on November 22, 2024, which explains that the Group Representative in the above referenced case filed a Complaint in the District Court for the District of Columbia[1] concerning the same providers and fiscal years. The Board's decision to close the cases, pursuant to 42 C.F.R. § 405.1842(h)(3), is set forth below.

Background:

On **March 28, 2019**, the Providers' Representative filed a CIRP group appeal request to establish this CIRP group case. The appeal request included the following group issue statement:

> **Issue Statement: DSH-SSI Data Matching Issue for FY 2015**
>
> The issue in this CIRP Group Appeal is whether the correct SSI factors were used to calculate the Hospitals' fiscal year ("FY") 2015 Medicare Disproportionate Share Hospital ("DSH") payments. The Hospitals are challenging their FY 2015 DSH payments on the ground that they were unlawfully low because the supplementary security income ("SSI") factors used to calculate these payments were not calculated properly. The SSI factor used for Medicare DSH purposes is calculated from the Medicare/SSI fraction. The statutory authority for how to calculate the Medicare/SSI fraction is set forth at 42 U.S.C. §1395ww(d)(5)(F)(vi)(I), which provides as follows (emphasis added): "the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled

[1] *See* Complaint, *HMH Hospitals Corp. v. Becerra*, Case No. 1:24-cv-03261 (D.D.C.) (Nov. 18, 2024).

> to benefits under Part A of this subchapter and were entitled to supplementary security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under Part A of this subchapter." It has been shown that the Centers for Medicare and Medicaid Services' SSI factors are not always accurate because, *inter alia*, the data matching process does not always yield correct results. *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008), *amended in part*, 587 F. Supp. 2d 37 (D.D.C. Nov. 07, 2008), *judgment entered*, 587 F. Supp. 2d 44 (D.D.C. Dec. 8, 2008). The Hospitals want to assure that the correct SSI factors are used when calculating their DSH and capital DSH payments for FY 2015. ***Although CMS established a new methodology for determining SSI factors in 2010, it is unclear whether DSH payments calculated using this new process are correct***.[2]

The group was established with one participant which transferred from an individual appeal.[3] The issue which was transferred to establish the CIRP group is materially identical to issue statement above except that it does not include the last sentence (which is in bolded text). Two other participants have been transferred from individual appeals and three have been directly added to the group.

On **March 12, 2020**, the Providers' Representative notified the Board that the group was fully formed with these six participants. On **July 30, 2020**, the Providers' Representative filed the final Schedule of Providers. The aggregate estimated amount in controversy for the CIRP group is $755,519.[4]

On **January 20, 2021**, the Board issued the Notice of CIRP Group Fully Formed and Critical Due Dates. As part of this Notice, the Board set deadlines for the Parties to file their preliminary position papers ("PPPs") and included the following instruction regarding the Providers' PPP:

> Group's Preliminary Position Paper – 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 Group 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]

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[2] (All emphasis in original except emphasis in last sentence.)
[3] PRRB Case Number 18-1527.
[4] *See* Final Schedule of Providers; Providers' PPP at 3 (July 20, 2021); Ex. P-3.
[5] (Emphasis added.)

The Providers and the Medicare Contractor timely filed their PPPs on **July 20, 2021** and **October 25, 2021**, respectively. On **February 11, 2022**, the Providers also filed a Response to the Medicare Contractor's PPP pursuant to Board Rule 25.1.3.

On **August 20, 2024**, the Providers filed an advance declaration of potential expert hearing witness with an expert report and stated that certain supporting data was not being filed "with the Board at this time . . . because it contains [PHI/PII]" and cited Board Rule 1.4 entitled "Confidential Information."[6]

On **August 22, 2024**, the Providers filed a Request for Expedited Judicial Review ("EJR"). On **August 29, 2024**, the Medicare Contractor filed a timely response.[7]

On **September 20, 2024**, the Board denied the Request for EJR. It dismissed the two "questions of law" and the *Pomona Valley* sub-issue involving New Jersey data because they were improperly raised in the Request for the first time.[8] The Board also noted that it was limiting the scope of the appeal to those authorities and arguments presented in the Providers' Preliminary Position Paper. The Board also held that the consideration of Providers' evidence in this case would be generally limited to that which was submitted with their Preliminary Position Paper, in accordance with the Board's Rules.[9]

On **October 11, 2024**, the Providers filed a second Request for EJR. On **October 16, 2024**, the Medicare Contractor filed a timely response.

On **October 30, 2024**, the Board denied the Second Request for EJR. It reiterated that the issues raised in the Requests for EJR are distinct from those included in the Providers' appeal request and Preliminary Position Paper, and that the issues raised in the Requests for EJR had not been fully developed in the position paper as required by the applicable regulations and Board Rules. It found that there were still factual issues in dispute, and that the complaints of unavailable data were not raised or fully developed by the Providers as required by the appliable regulations and Board Rules. The Board reiterated that it does have the authority to decide the issue in this appeal, based on the evidence submitted and arguments made as required by the appliable regulations and Board Rules. The Board noted that a Notice of Hearing would be issued under separate cover.[10]

On **November 18, 2024**, the Providers' Representative filed a Complaint in the District Court for the District of Columbia and then notified the Board of this filing on **November 22, 2024**.

Board's Determination to Close Case 19-1552GC:

A. Providers' Federal Complaint was Premature

[6] Advance Notice of Potential Expert Hearing Witness (Aug. 20, 2024).
[7] Board Rule 42.4 (requiring responses to be filed within five (5) business days of the EJR request filing date).
[8] Decision on EJR Request in Case No. 19-1552 at 27 (Sept. 20, 2024).
[9] *Id.*
[10] Decision on Oct. 11, 2024 EJR Request in Case No. 19-1552GC (Oct. 30, 2024).

Providers have the right to judicial review of a final decision of the Board.[11] The denial of the Providers' two Requests for EJR and the Board's decision that it does have the authority to decide the issue in this case are not final determinations. The Providers assert that the Board's decisions denying EJR "renders it futile for the Hospitals to pursue further administrative exhaustion in their Challenge to CMS's calculation of their FY 2015 SSI Fractions"[12] and that "futility of exhausting the administrative review process may be an independently sufficient ground for waiver of the exhaustion requirement."[13]

The Board reiterates that its determination on the scope of the appeal in this case and what evidence the Board would consider was limited due to the Providers' noncompliance with the requirements to fully develop the issue for which it sought EJR. The Providers raised new issues, legal theories, and authorities for the first time in its Requests for EJR, despite the requirements set forth in the applicable regulations and Board Rules to *fully develop* all of those aspects in the Providers' Preliminary Position Paper. The fact that the Providers do not believe they can prove the issue in their case by a preponderance of the evidence based on the arguments and evidence properly before the Board does not render the exhaustion requirement "futile" as characterized by the Providers' Representative, and thus their federal Complaint was premature.

B. Effect of Filing of the Complaint in Federal Court

Even though the Providers' federal Complaint was premature, the regulation at 42 C.F.R. § 405.1842(h)(2) addresses how Provider lawsuits relating to the denial of an EJR request affect Board proceedings:

> (h) Effect of final EJR decisions and lawsuits on further Board proceedings. –
>
> ****
>
> (2) Final decisions denying EJR. If the final decision:
>
> > **(i)** Of the Board denies EJR solely on the basis that the Board determines it has the authority to decide the legal question relevant to the specific matter at issue, the Board must conduct further proceedings on the legal question and issue a decision on the matter at issue in accordance with this subpart.
> >
> > Exception: If the provider(s) file(s) a lawsuit pertaining to the legal question, and for a period that is covered by the Board's decision denying EJR, the Board may not conduct any further proceedings under this subpart on the legal question or the matter at issue before the lawsuit is finally resolved.

[11] 42 C.F.R. § 405.1877(a)(2)
[12] Notice of Filing in Federal Court (Nov. 22, 2024) (attached Complaint at ⁋ 76).
[13] *Id.* at ⁋ 57 (citing *Tataranowicz v. Sullivan*, 959 F.2d 268, 275 (D.C. Cir. 1992)).

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

To confirm the proper application of § 405.1842(h)(3), the Board reviewed the preambles to the proposed rule, dated June 5, 2004,[14] and the May 23, 2008 final rule[15] that promulgated the regulation at 42 C.F.R. § 405.1842(h)(2). The preamble to the proposed rule described this regulation as follows:

> Proposed § 405.1842(h)(2) would specify the effect that a Board or Administrator decision denying EJR would have on the Board's ability to conduct further proceedings on the appeal. First, if the final decision of the Board were to deny EJR solely on the basis that the Board determines that it has the authority to decide the legal question relevant to the specific matter at issue, the Board would be required to conduct further proceedings on the specific legal question and issue a decision on the matter at issue in accordance with this subpart. (An exception to this rule would exist where the provider(s) files a lawsuit pertaining to the legal question; in that situation, the Board would be precluded from conducting any further proceedings on the legal question or the matter at issue before the lawsuit is finally resolved.)[16]

Based on the above explanation regarding the intent and purpose for 42 C.F.R. § 405.1842(h)(2), the Board finds that the Providers' filing of the Complaint in the District Court for the District of Columbia on November 18, 2024 prohibits the Board from conducting any further proceedings in this case.

C. Board Decision and Order

Based on the foregoing, the Board hereby closes case 19-1552GC, consistent with 42 C.F.R. § 405.1842(h)(2), and removes it from the Board's docket. No further proceedings will occur, except upon remand from the Administrator, pursuant to 42 C.F.R. § 405.1877(g)(2).

[14] 69 Fed. Reg. 35716 (June 25, 2004).
[15] 73 Fed. Reg. 30190 (May 23, 2008).
[16] 69 Fed. Reg. at 35731.

Board Members Participating:

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

FOR THE BOARD

12/4/2024

X Kevin D. Smith, CPA

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

cc: Jacqueline Vaughn, Office of the Attorney Advisor
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-L)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
South Baldwin Regional Medical Center, Prov. No. 01-0083, FYE 09/30/2016
Case No. 19-2569

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-2569. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Medicaid Eligible Days payment.

Background

A. *Procedural History for Case No. 19-2569*

On **March 4, 2019,** the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2016. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **August 21, 2019**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained four (4) issues:

1. DSH Payment/SSI Percentage (Provider Specific)[1]
2. DSH SSI Percentage[2]
3. DSH Payment – Medicaid Eligible Days
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 17, 2020**, the Provider transferred Issues 2 and 4 to CHS CIRP groups.

[1] On June 10, 2024, this issue was withdrawn by the Provider.
[2] On March 17, 2020, this issue was transferred to Case No. 19-1409GC
[3] On March 17, 2020, this issue was transferred to Case No. 19-1410GC.

On **August 29, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

On **April 15, 2020**, the Provider timely filed its preliminary position paper. With respect to Issue 3, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days." As a result, the Provider included, as an Exhibit, the original "estimated impact" for this issue of $21,014 based on an *estimated* 50 days.

On **June 2, 2020**, the Medicare Contractor timely filed a Jurisdictional Challenge[5] with the Board over Issues 1 and 3 requesting that the Board dismiss these issues. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **August 11, 2020,** the Medicare Contractor timely filed its preliminary position paper. With regard to Issue 3, the Medicare Contractor's position paper noted that: (1) the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its

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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).

obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position; and (2) the Provider had failed to respond to any of the Medicare Contractor's requests for that Medicaid eligible days listing.

On **January 18, 2023**, the Medicare Contractor filed its 3rd and Final Request for DSH Package in connection with Issue 3. On August 30, 2019, (1st request) and on November 14, 2019 (2nd request), it had previously requested that the Provider send it a DSH package to resolve Issue 3.[6] As no response was received, the Medicare Contractor formally filed the 3rd and Final Request for DSH Package to formally request that a listing of the Medicaid eligible days at issue plus supporting documentation be provided to the Medicare Contractor on or before February 17, 2023 (*i.e.*, within 30 days). Notwithstanding the formal request, the Provider failed to file any response to the Medicare Contractor.

On **November 27, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **November 28, 2023**, 11 months after the MAC submitted its Final Request for DSH Package in connection with Issue 3, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the *caveat* that the "Listing [is] *pending finalization* upon receipt of State eligibility data."[7] The Listing was 15 pages long with roughly 1700 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 1700 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 7 years after the fiscal year at issue had closed***. NOTE—the roughly 1700 included in this belated listing is *exponentially* larger than the original *estimated* impact of 50 days included with the appeal request.

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

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

On **June 10, 2024**, the Provider withdrew Issue 1 – DSH Payment/SSI Percentage (Provider Specific) from the appeal.

On **August 29, 2024,** the Medicare Contractor filed a Jurisdictional Challenge, requesting dismissal of Issue 3: DSH Payment – Medicaid Eligible Days. Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Jurisdictional Challenge. However, the Provider did not file its response until **October 8, 2024**.

As a result of the case transfers and withdrawn issue, there is only one (1) remaining issue in this appeal: Issue 3: DSH – Medicaid Eligible Days.

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[6] Medicare Contractor's Amended Final Position Paper at 3.
[7] (Emphasis added.)

MAC's Contentions
Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC contends that the Provider failed to properly develop its arguments within its preliminary position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25. The MAC argues the Provider has not submitted a Medicaid eligible days listing and therefore, requests the Board dismiss the issue. [8]

Additionally, the MAC contends the Provider is attempting to add the Section 1115 Waiver days issue improperly and untimely. The Section 1115 Waiver days were not part of the initial appeal request and untimely added via its Final Position Paper. [9]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[10] Here, the Provider's Jurisdictional Response was due on September 28, 2024, however it did not file the response until October 8, 2024.

In its untimely filed response, the Provider argues that the language of its appeal request can be read to include 1115 waiver days. The Provider quotes part of its issue statement:

> 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 nd all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[11]

The Provider states that the italicized language "makes clear" that the Provider's issue included 1115 waiver days, and further, there is "no such 'issue'" of 1115 waiver days, they are just "part and parcel" of Medicaid eligible days.[12]

Decision of the Board

A. 1115 Waiver Days

1. Section 1115 Waiver Days

The Board finds that the section 1115 Waiver days issue is not a part of this appeal as it was not

[8] Jurisdictional Challenge at 1.
[9] *Id.*
[10] Board Rule 44.4.3, v. 3.2 (Dec. 2023).
[11] Provider's Jurisdictional Reesponse at 1 (emphasis in original).
[12] *Id.*

properly or timely added. The Provider failed to include section 1115 Waiver days as a cost issue in its appeal request and failed to timely and properly add this additional issue to the appeal. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the section 1115 Waiver days.

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

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) how and why the provider believes Medicare payment must be determined differently for each disputed item…[13]

Board Rule 7[14] elaborated on this regulatory requirement instructing providers:

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

[13] 42 C.F.R. § 405.1835(b).
[14] v. 2 (Aug. 2018).

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

Board Rule 8[15] explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: dual eligible Medicare Part A/Medicaid, dual eligible Medicare Part C/Medicaid, SSI data matching, state/program specific general assistance days, ***Section 1115 waiver days (program/waiver specific)***, and observation bed days.[16]

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.[17] 42 C.F.R. § 405.1835(e) provides in relevant part:

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

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

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

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[15] *Id*.
[16] (Emphasis added).
[17] *See* 73 Fed. Reg. 30190 (May 23, 2008).

2000.[18] Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program ***and*** not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction.[20] In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

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

[18] 65 FR 47054, 47087 (Aug. 1, 2000).

B. DSH Payment – Medicaid Eligible Days

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

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

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

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

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[19]

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:

[19] (Bold emphasis added.)

Rule 25 Preliminary Position Papers[20]

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

25.1 Content of Position Paper Narrative

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

25.1.1 The Provider's Position Paper

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

25.2 Position Paper Exhibits

25.2.1 General

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

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on August 29, 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.[21]

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

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

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

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

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

On April 15, 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.[22] 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 $21,000 based on an estimated 50 days). The Provider's complete briefing of this issue in its position paper is as follows:

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

[21] (Emphasis added.)
[22] Provider's Preliminary Position Paper at 11 (May 4, 2020).

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

The Medicare Contractor sent three (3) separate requests for the Provider's list of Medicaid Eligible days (and also discussed the lack of the listing in the Medicare Contractor's own position paper filing). The first notice was sent to the Provider on August 30, 2019, and the second request was sent to the Provider on November 14, 2019. The third, final request was filed formally with the Board in OH CMDS on January 18, 2023, *six years after the end of the Provider's cost reporting period*. The Medicare Contractor also informed the Provider in its final request for information that the deadline to respond was February 17, 2023.

On November 28, 2023 (10 months after the deadline to respond to the MAC's final request), QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the caveat that the "Listing [is] pending finalization upon receipt of State eligibility data." The Listing was 15 pages with roughly 1700 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 1700 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 7 years after the fiscal year at issue had closed***. NOTE—the roughly 1700 included in this belated listing is *exponentially* larger than the original estimate of 50 days included with the appeal request. Regardless, this filing was more than 10 months past the deadline for responding to the MAC's final request *and, more importantly,* ***was roughly 3½ years past the deadline for including it with its preliminary position paper*** since the position paper deadline was April 17, 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 merely one day after the Provider changed its designated representative to QRS does not excuse the Provider for its failure to include the information with its preliminary position paper. 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 28, 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); (b) *why* the listing of the roughly 1700 days was not previously available, *in whole or in part* (*i.e.*, it is not clear why the Provider failed to identify a single day at issue until more than 4 years after this appeal was filed and more than 7 years after the fiscal year at issue had closed); and (c) why the listing still was ***not*** a "*final*" listing at this late date.

3. Neither the Board Rules nor the August 29, 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* 1700 days listed in the alleged "Supplement" is, without explanation, *exponentially* larger than the original estimated 100 days included with the appeal request).[23]

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[24] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provider the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[25]

* * * * *

Based on the foregoing, the Board has dismissed the remaining issue in this case – Issue 3. As no issues remain, the Board hereby closes Case No. 19-2569 and removes it from the Board's

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

[24] (Emphasis added.)

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

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

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

Board Members Participating:

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

For the Board:

12/4/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Baylor Scott & White Medical Center – Marble Falls, Prov. No. 67-0108
FYE 05/31/2016
Case No. 19-1173

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-1173. Set forth below is the decision of the Board to dismiss the 2 remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) and Uncompensated Care ("UCC") payments.

Background

A. *Procedural History for Case No. 19-1173*

On **July 31, 2018,** the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2016. The Provider is commonly owned by Baylor Scott & White Health ("BS&W").

On **January 23, 2019,** BS&W filed the Provider's individual appeal request. The initial Individual Appeal Request contained ten (10) issues:

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

[1] On August 20, 2019, this issue was transferred to Case No. 19-2456GC.
[2] On August 20, 2019, this issue was transferred to Case No. 19-2457GC.
[3] On August 20, 2019, this issue was transferred to Case No. 19-2458GC.
[4] On October 25, 2024, this issue was withdrawn by the Provider.
[5] On August 20, 2019, this issue was transferred to Case No. 19-2459GC.

7. DSH – Dual Eligible Days Medicaid Fraction[6]
8. DSH – Uncompensated Care
9. 2 Midnight Rule[7]
10. Standardized Payment Amount[8]

As the Provider is commonly owned/controlled by BS&W, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **August 20 & 21, 2020**, the Provider transferred Issues 2, 3, 4, 6, 7, 9, and 10 to BS&W CIRP groups.

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

On **January 14, 2020,** the Medicare Contractor timely filed its preliminary position paper.

On **May 10, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **September 12, 2024**, the Provider timely filed its final position paper.

On **October 9, 2024**, the Medicare Contractor timely filed its final position paper.

On **October 16, 2024,** the Medicare Contractor filed a Jurisdictional Challenge, requesting dismissal of Issues 1, 5, and 8. Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Jurisdictional Challenge. However, the Provider ***failed*** to timely respond to the Jurisdictional Challenge.

On **October 25, 2024**, the Provider withdrew Issue 5 – DSH – Medicaid Eligible Days from the appeal.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-2456GC – BS&W Health CY 2016 DSH SSI Percentage CIRP Group

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

> The Provider contends that 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.

[6] On August 20, 2019, this issue was transferred to Case No. 19-2460GC.
[7] On August 21, 2019, this issue was transferred to Case No. 19-2461GC.
[8] On August 20, 2019, this issue was transferred to Case No. 19-2462GC.

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

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

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

[9] Issue Statement at 1 (Jan. 23, 2019).
[10] Group Appeal Issue Statement in Case No. 19-2456GC.

On September 12, 2024, the Board received the Provider's final position paper in 19-1173. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a full and complete set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. See 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in Baystate Medical Center v. Leavitt, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates 10 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).[11]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $6,814.

MAC's Contentions

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

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

[11] Provider's Final Position Paper at 9-10 (Sep. 12, 2024).

The MAC additionally states that the Provider did not file a complete preliminary or final position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25 and 27.[12]

Issue 8 – UCC Distribution Pool

The MAC argues "that the Board does not have jurisdiction over the UCC DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2)."[13] The MAC requests the Board "follow the lead of the D.C. Circuit Court of Appeals in Tampa General and dismiss the instant appeal for lack of jurisdiction."[14]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[15] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

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*

[12] Medicare Contractor's Jurisdictional Challenge at 2 (Oct. 16, 2024)
[13] *Id.* at 19.
[14] *Id.* at 23.
[15] Board Rule 44.4.3 (Dec. 2023).

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Case No. 19-2456GC.

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

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 19-2456GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 19-1173 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 19-2456GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[19], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

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

To this end, the Board also reviewed the Provider's Preliminary and Final Position Papers to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 19-2456GC, but instead refers to systemic *Baystate* data

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[16] Issue Statement at 1.
[17] *Id.*
[18] *Id.*
[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).

matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records" but fails to explain how it can, explain how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2.[21] Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Aug. 29, 2018), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[22]

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

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

[22] (Italics and underline emphasis added.)

> 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. 19-2456GC.

Accordingly, *based on the record before it*, the Board finds that the SSI Provider Specific issue in Case No. 19-1173 and the group issue from the BS&W CIRP group under Case No. 19-2456GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

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

B. UCC Distribution Pool

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

1. *Bar on Administrative Review*

[23] Last accessed Nov. 27, 2024.
[24] (Emphasis added).

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

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[25]
>
> (B) Any period selected by the Secretary for such purposes.

2. Interpretation of Bar on Administrative Review

a. Tampa General v. Sec'y of HHS

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs*. ("*Tampa General*"),[26] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[27] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[28] The D.C Circuit also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[29]

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[25] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[26] 830 F.3d 515 (D.C. Cir. 2016).
[27] 89 F. Supp. 3d 121 (D.D.C. 2015).
[28] 830 F.3d 515, 517.
[29] *Id.* at 519.

The D.C. Circuit went on to address the provider's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[30]

b. DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[31] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[32] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that it had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, the D.C. Circuit found the same relationship existed with regard to the methodology used to generate the estimates.[33]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[34] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[35] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[36] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a

[30] *Id.* at 521-22. *See also Yale New Haven Hosp. v. Becerra*, 56 F.4th 9 (2nd Cir. 2022) (citing to *Tampa General*"); *Ascension Providence v. Becerra*, No. 21-cv-369, 2023 WL 2042176 (N.D. Ind. 2023) (citing to *Tampa General*").
[31] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[32] *Id.* at 506.
[33] *Id.* at 507.
[34] 514 F. Supp. 249 (D.D.C. 2021).
[35] *Id.* at 255-56.
[36] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).

subsequent cost report that was a full twelve months.[37] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[38]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[39]

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[40] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.[41] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[42]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which

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[37] *Id.* One provider had a cost report for the 6-month period from July 1, 2011 to December 31, 2011 and another for the 12-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the 9-month period from October 1, 2011 to June 30, 2012 and another for the 12-month period from July 1, 2012 to June 30, 2013.
[38] *Id.*
[39] *Id.* at 262-64.
[40] *Id.* at 265.
[41] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[42] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).

requires a violation of a clear statutory command.[43] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

d. Ascension Borgess Hospital v. Becerra

Even more recently, the D.C. Circuit revisited, once again, the judicial and administrative bar on review of uncompensated care DSH payments again in *Ascension Borgess Hospital v. Becerra* ("*Ascension*").[44] In *Ascension*, the providers sought an order declaring the Worksheet S-10 audit protocol was unlawful, vacating the payments based on the Worksheet S-10 audit, requiring the Secretary to recalculate those payments, and setting aside the Board decisions refusing to exercise jurisdiction over their appeals.[45] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the providers claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."[46] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[47] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[48]

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

* * * * *

Based on the foregoing, the Board has dismissed the two (2) remaining issues in this case – (Issues 1 and 8). As no issues remain, the Board hereby closes Case No. 19-1173 and removes it

[43] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[44] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[45] *Id*. at *4.
[46] *Id.* at *9.
[47] 139 S. Ct. 1804 (2019).
[48] *Ascension* at *8 (bold italics emphasis added).

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

Board Members Participating:

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

For the Board:

12/4/2024

X Ratina Kelly

Ratina Kelly, CPA
Acting Chair
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Baltimore, MD 21244 1850
410-786-2671

Via Electronic Delivery

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

RE: ***Board Determination on Disbanding Dignity Health CY 2017 NAHE Elimination of Pharmacy Residency Program CIRP Group, Case Number: 24-1276GC***

As it relates to participants:

Provider Name	*Provider Number*	*FYE*	*Case #*	*Ind. Appeal Status*
Mercy Medical Center Redding	*05-0280*	*6/30/2017*	*20-1817*	*Open*
Mercy San Juan Medical Center	*05-0516*	*6/30/2017*	*21-0726*	*Open*
Mercy General Hospital	*05-0017*	*6/30/2017*	*21-1254*	*Open*
St. Joseph's Medical Center of Stockton	*05-0084*	*6/30/2017*	*21-1255*	*Open*
St. Joseph's Hospital & Medical Center	*03-0024*	*6/30/2017*	*22-0974*	*Closed 2/13/2024*

Dear Ms. Ellis:

The Provider Reimbursement Review Board ("the Board") has reviewed the subject common issue related party ("CIRP") group appeal pursuant to correspondence from Toyon Associates, Inc. ("Toyon") dated November 19, 2024. Toyon's correspondence was filed in reply to an earlier Board Request for Information ("RFI") regarding the question of the suitability of the NAHE Elimination of Pharmacy Residency Program ("NAHE Elimination") issue for the group appeal format. The pertinent facts for this group and the Board's determination are set forth below.

Pertinent Facts:

On **February 12, 2024**, Toyon filed the "Dignity Health CY 2017 NAHE Elimination of Pharmacy Residency Program Group" under Case No. 24-1276GC, which was formed in the Office of Hearings Case & Document Management System ("OH CDMS") without any providers.

On the same date, Moss Adams, LLP requested the transfer of the following NAHE Elimination issues to the group:

Issue description	**Provider**	**From Case No.**
Nursing and Allied Health Removal of Program Costs	Mercy Medical Center Redding	20-1817
Nursing & Allied Health Edu-Removal of Pharmacy Residency	Mercy San Juan Medical Center	21-0726
Adj to remove NAHE cost on provider operated pharmacy resid	Mercy General Hospital	21-1254
Adj removed NAHE pass thru costs, provider operated program	St Joseph's Medical Center	21-1255
Nursing and Allied Health- Removal of Program Costs	St. Joseph's Hospital & Medical Center	22-0974[1]

On **September 16, 2024**, in Case No. 24-0267G, (an optional Toyon group appealing the same issue) Toyon requested the expansion of the calendar year ("CY") 2018 group to include CY 2017. Toyon argued that the expansion of the group would allow another provider, White Memorial Medical Center (Prov. No. 05-0103), to transfer its "Disallowance of Clinical Pastoral Education (CPE) Costs" issue for FYE 12/31/2017 to the group.

On **September 20, 2024**, the Board denied Toyon's request for expansion of Case No. 24-0267G to include CY 2017 because it found that the issues in the individual appeal and the group case involved two different programs and the facts and circumstances surrounding each program were likely to be different.

In that determination, the Board also posed a question regarding the suitability of the NAHE Elimination issue for the group format. The Board noted that the issue seems to be factually specific to each provider since each program may be operated differently and, therefore, could result in differing determinations being rendered by the Board. Therefore, the Board required Toyon to review its pending appeals for the NAHE Elimination issue and to submit comments in support of why it should remain in the group format or, alternatively, confirm that its groups on this issue should be disbanded.

On **November 19, 2024**, Toyon responded to the Board's request indicating that when the NAHE Elimination groups were formed, it believed that the various group providers were ". . . connected by a common question of law (as required by 42 C.F.R. § 405.1837). . . ".[2] However, Toyon acknowledged that, in the event the Board did not agree with that reasoning, it would concede to the Board's proposal to disband its NAHE groups. In the case of the subject CIRP group's disbandment, Toyon requested that the Board transfer the issue back to the Providers' open individual appeals and create a new case for the one case that was closed.[3]

[1] After the transfer of the NAHE Elimination issue, Case No. 22-0974 was closed as there were no remaining issues.
[2] NAHE Elimination of Pharmacy Residency Program Group Appeals (Nov. 19, 2024).
[3] *Id.*

Board Determination:

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

With respect to issues suitable for group format, the Board relies on 42 C.F.R. § 405.1837(b), which specifies that two or more providers may file a group for ". . . 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." This is further reflected in Board Rule 12.2, which states, "[t]he matter at issue in the group appeal must involve a single question of fact or interpretation of law, regulation, or CMS Rulings that is common to each provider in the group."

After review of Toyon's response, the Board finds that the NAHE Elimination issue appears to be provider specific as the facts could vary from Provider to Provider, in terms of which schools are participating in the program, the operator of the program and the history of the program, and the handling on the specific cost report.[4] Based on this finding, there does not appear to be a single common issue and therefore, the Board is taking the following actions:

1. Transferring the NAHE Elimination issues from Case No. 24-1276GC back to the pending individual appeals, Case Nos. 20-1817, 21-0726, 21-1254 and 21-1255. Rather than create a new individual appeal, the Board is electing to reinstate the earlier appeal for St. Joseph's Hospital & Medical Center under Case No. 22-0974.[5]
2. As there are no remaining providers in Case No. 24-1276GC, the case is being closed and removed from the Board's docket.

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

For the Board:

12/5/2024

X Kevin D. Smith, CPA

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

[4] Toyon's response to the Board's RFI referenced eleven groups, including the group discussed herein. Due to the varying fact patterns for group participants in each case, the Board will address each group under separate cover.

[5] The Board notes that the preliminary position papers filed in all five individual appeals briefed the NAHE Elimination issue. Therefore, there is no need to request supplemental briefs. Case No. 21-1254 remains scheduled for a hearing on August 6, 2025; Case Nos. 21-1255, 21-0726, 20-1817 and 22-0974 are not yet scheduled for hearings.

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

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Via Electronic Delivery

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

RE: ***Board Determination on Disbanding Dignity Health CY 2015 NAHE Elimination of Pharmacy Residency Program CIRP Group, Case Number: 24-2155GC***

As it relates to the participant:
Mercy General Hospital (Provider Number 05-0017)
FYE: 6/30/2015
Case Number: 20-0305

Dear Ms. Ellis:

The Provider Reimbursement Review Board ("the Board") has reviewed the subject common issue related party ("CIRP") group appeal pursuant to correspondence from Toyon Associates, Inc. ("Toyon") dated November 19, 2024. Toyon's correspondence was filed in reply to an earlier Board Request for Information ("RFI") regarding the question of the suitability of the NAHE Elimination of Pharmacy Residency Program issue for the group appeal format. The pertinent facts for this group and the Board's determination are set forth below.

Pertinent Facts:

On **July 22, 2024**, Toyon filed the "Dignity Health CY 2015 NAHE Elimination of Pharmacy Residency Program Group" under Case No. 24-2155GC, which was formed in the Office of Hearings Case & Document Management System ("OH CDMS") without any providers. On the same date, Moss Adams, LLP requested the transfer of the "Adjustment to remove NAH costs based on provider program" ("NAHE Elimination") issue for Mercy General Hospital from its individual appeal, Case No. 20-0305.[1]

On **September 16, 2024**, in Case No. 24-0267G, (an optional group appealing the same issue) Toyon requested the expansion of that calendar year ("CY") 2018 group to include CY 2017. Toyon argued that the expansion of the group would allow another provider, White Memorial Medical Center (Prov. No. 05-0103), to transfer its "Disallowance of Clinical Pastoral Education (CPE) Costs" issue for FYE 12/31/2017 to the group.

[1] Case No. 20-0305 was subsequently closed on October 25, 2024.

On **September 20, 2024**, the Board denied Toyon's request for expansion of Case No. 24-0267G to include CY 2017 because it found that the issues in the individual appeal and the group case involved two different programs and the facts and circumstances surrounding each program were likely to be different.

In that determination, the Board also posed a question regarding the suitability of the NAHE Elimination of Pharmacy Residency Program issue for the group format. The Board noted that the issue seems to be factually specific to each provider since each program may be operated differently and, therefore, could result in differing determinations being rendered by the Board. Therefore, the Board required Toyon to review its pending appeals for the NAHE Elimination of Pharmacy issue and to submit comments in support of why it should remain in the group format or, alternatively, confirm that its groups on this issue should be disbanded.

On **November 19, 2024**, Toyon responded to the Board's request indicating that when the groups were formed, it believed that the various group providers were ". . . connected by a common question of law (as required by 42 C.F.R. § 405.1837). . . ".[2] However, Toyon acknowledged that, in the event the Board did not agree with that reasoning, it would concede to the Board's proposal to disband its NAHE groups. In the case of the subject CIRP group's disbandment, Toyon requested that the Board form a new individual appeal (rather than reinstate Moss Adam's earlier individual case).[3]

Board Determination:

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

With respect to issues suitable for group format, the Board relies on 42 C.F.R. § 405.1837(b), which specifies that two or more providers may file a group for ". . . 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." This is further reflected in Board Rule 12.2, which states, "[t]he matter at issue in the group appeal must involve a single question of fact or interpretation of law, regulation, or CMS Rulings that is common to each provider in the group."

After review of Toyon's response, the Board finds that the NAHE Elimination issue appears to be provider specific as the facts could vary from Provider to Provider, in terms of which schools are participating in the program, the operator of the program and the history of the program, and the handling on the specific cost report.[4] Based on this finding, there does not appear to be a single common issue and therefore, the Board is taking the following actions:

---

[2] NAHE Elimination of Pharmacy Residency Program Group Appeals (Nov. 19, 2024).
[3] *Id.*
[4] Toyon's response to the Board's RFI referenced eleven groups, including the group discussed herein. Due to the varying fact patterns for group participants in each case, the Board will address each group under separate cover.

1. A new individual appeal will be established for Mercy General Hospital, with the sole issue being the "Elimination of pharmacy residency program." The Parties will receive an Acknowledgement & Critical Due Dates notice under separate cover.
2. As there are no remaining providers in Case No. 24-2155GC, the case is being closed and removed from the Board's docket.

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

For the Board:

12/5/2024

X Kevin D. Smith, CPA

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

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

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Lisa Ellis
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Glenn Bunting
Moss Adams, LLP
2882 Prospect Park Drive, Suite 300
Rancho Cordova, CA 95670

RE: ***Board Determination on Disbanding Dignity Health CY 2016 NAHE Elimination of Pharmacy Residency Program CIRP Group, Case Number: 24-2156GC***

As it relates to participants:

Provider Name	*Provider Number*	*FYE*	*Case #*	*Representative*
St. Joseph's Hospital & Medical Center	*03-0024*	*6/30/2016*	*19-2309*	*Moss Adams*
St. Joseph's Medical Center of Stockton	*05-0084*	*5/31/2016*	*19-2119*	*Moss Adams*
Mercy General Hospital	*05-0017*	*6/30/2016*	*20-1379*	*Toyon Associates*[1]
Mercy San Juan Medical Center	*05-0516*	*6/30/2016*	*20-1374*	*Moss Adams*

Dear Ms. Ellis and Mr. Bunting:

The Provider Reimbursement Review Board ("the Board") has reviewed the subject common issue related party ("CIRP") group appeal pursuant to correspondence from Toyon Associates, Inc. ("Toyon") dated November 19, 2024. Toyon's correspondence was filed in reply to an earlier Board Request for Information ("RFI") regarding the question of the suitability of the NAHE Elimination of Pharmacy Residency Program ("NAHE Elimination") issue for the group appeal format. The pertinent facts for this group and the Board's determination are set forth below.

Pertinent Facts:

On **July 22, 2024**, Toyon filed the "Dignity Health CY 2016 NAHE Elimination of Pharmacy Residency Program Group" under Case No. 24-2156GC, which was formed in the Office of Hearings Case & Document Management System ("OH CDMS") without any providers.

[1] On October 30, 2024, Toyon Associates was designated to be the authorized representative in Case No. 20-1379.

On the same date, Moss Adams, LLP requested the transfer of the following NAHE Elimination issues to the group:

Issue description	Provider	From Case No.
Adjustment to remove NAH costs based on provider program	St. Joseph's Hospital & Medical Center	19-2309
Adjustment to remove NAH costs based on provider program	St Joseph's Medical Center of Stockton	19-2119
Nursing & Allied Health-Removal of Pharmacy Residency Program	Mercy General Hospital	20-1379
Nursing & Allied Health Edu- Removal of Pharmacy Residency	Mercy San Juan Medical Center	20-1374

On **September 16, 2024**, in Case No. 24-0267G, (an optional Toyon group appealing the same issue) Toyon requested the expansion of the calendar year ("CY") 2018 group to include CY 2017. Toyon argued that the expansion of the group would allow another provider, White Memorial Medical Center (Prov. No. 05-0103), to transfer its "Disallowance of Clinical Pastoral Education (CPE) Costs" issue for FYE 12/31/2017 to the group.

On **September 20, 2024**, the Board denied Toyon's request for expansion of Case No. 24-0267G to include CY 2017 because it found that the issues in the individual appeal and the group case involved two different programs and the facts and circumstances surrounding each program were likely to be different.

In that determination, the Board also posed a question regarding the suitability of the NAHE Elimination issue for the group format. The Board noted that the issue seems to be factually specific to each provider since each program may be operated differently and, therefore, could result in differing determinations being rendered by the Board. Therefore, the Board required Toyon to review its pending appeals for the NAHE Elimination issue and to submit comments in support of why it should remain in the group format or, alternatively, confirm that its groups on this issue should be disbanded.

On **November 19, 2024**, Toyon responded to the Board's request indicating that when the NAHE Elimination groups were formed, it believed that the various group providers were ". . . connected by a common question of law (as required by 42 C.F.R. § 405.1837). . . ".[2] However, Toyon acknowledged that, in the event the Board did not agree with that reasoning, it would concede to the Board's proposal to disband its NAHE groups. In the case of the subject CIRP group's disbandment, Toyon requested that the Board transfer the issue back to the Providers' open individual appeals.[3]

[2] NAHE Elimination of Pharmacy Residency Program Group Appeals (Nov. 19, 2024).
[3] *Id.*

Board Determination:

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

With respect to issues suitable for group format, the Board relies on 42 C.F.R. § 405.1837(b), which specifies that two or more providers may file a group for ". . . 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." This is further reflected in Board Rule 12.2, which states, "[t]he matter at issue in the group appeal must involve a single question of fact or interpretation of law, regulation, or CMS Rulings that is common to each provider in the group."

After review of Toyon's response, the Board finds that the NAHE Elimination issue appears to be provider specific as the facts could vary from Provider to Provider, in terms of which schools are participating in the program, the operator of the program and the history of the program, and the handling on the specific cost report.[4] Based on this finding, there does not appear to be a single common issue and therefore, the Board is taking the following actions:

1. Transferring the NAHE Elimination issues from Case No. 24-2156GC back to the pending individual appeals, Case Nos. 20-1379, 20-1374, 19-2309 and 19-2119.[5]
2. As there are no remaining providers in Case No. 24-2156GC, the case is being closed and removed from the Board's docket.

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

For the Board:

12/5/2024

X Kevin D. Smith, CPA

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

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

[4] Toyon's response to the Board's RFI referenced eleven groups, including the group discussed herein. Due to the varying fact patterns for group participants in each case, the Board will address each group under separate cover.

[5] The Board notes that the preliminary position papers filed in all four individual appeals briefed the NAHE Elimination issue. Therefore, there is no need to request supplemental briefs. The cases remain scheduled for hearing dates as follows: Case No. 20-1379 - July 16, 2025; Case No. 19-2119 – June 10, 2025; Case No. 19-2309- April 17, 2025; Case No. 20-1374 is not yet scheduled for a hearing date.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Houston Methodist West Hospital, Prov. No. 67-0077, FYE 12/31/2014
Case No. 19-0551

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-0551. 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 Medicaid Eligible Days payments.

Background

A. *Procedural History for Case No. 19-0551*

On **July 11, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2014. The Provider is commonly owned by Houston Methodist Hospital System ("Houston Methodist").

On **December 21, 2018**, Houston Methodist Hospital its individual appeal request. The initial Individual Appeal Request contained ten (10) issues:

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

[1] On March 19, 2024, this issue was dismissed from the appeal because the Board found the issue duplicative of the issue presented in Group Case No. 19-0205GC and there was no final determination from which the Provider could appeal the SSI realignment portion of the issue.
[2] On July 11, 2019, this issue was transferred to Case No. 19-0205GC.
[3] On July 11, 2019, this issue was transferred to Case No. 19-0209GC.
[4] On July 11, 2019, this issue was transferred to Case No. 19-0195GC.

6. DSH Medicaid Fraction / Medicare Managed Care Part C Days[5]
7. DSH Medicaid Fraction / Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[6]
8. DSH Capital Payment[7]
9. Bad Debts[8]
10. Standardized Payment Amount[9]

As the Provider is commonly owned/controlled by Houston Methodist Hospital System, 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 11, 2019**, the Provider transferred Issues 2, 3, 4, 6, 7, and 10 to Houston Methodist Hospital System CIRP groups. On **February 29, 2024**, the Provider withdrew Issues 8 and 9 from the appeal. **On March 19, 2024**, the Board dismissed Issue 1 from the appeal because the Board found the issue duplicative of the issue presented in Group Case No. 19-0205GC and there was no final determination from which the Provider could appeal the SSI realignment portion of the issue.

As a result of the case transfers, withdrawals, and dismissal there is only one remaining issue in this appeal: Issue 5 (DSH – Medicaid Eligible Days).

On **January 14, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[10]

On **August 9, 2019**, the Provider timely filed its preliminary position paper. With respect to Issue 5, the Provider argued that the provider was seeking reimbursement for an additional 285

[5] On July 11, 2019, this issue was transferred to Case No. 19-0206GC.
[6] On July 11, 2019, this issue was transferred to Case No. 19-0235GC.
[7] On February 29, 2024, the Provider withdrew this issue from the appeal.
[8] On February 29, 2024, the Provider withdrew this issue from the appeal.
[9] On July 11, 2019, this issue was transferred to Case No. 19-2200GC.
[10] (Emphasis added.)

Medicaid Eligible days, however "documentation necessary to pursue DSH was not available from the State of Texas in time to include all DSH/Medicaid Eligible Days on the cost report."[11] However, Provider did not later file a list of Medicaid Eligible days and no explanation was included explaining why that listing was not included with the position paper filing. Provider states, "the number expressed [in its position paper] may not be the number presented at hearing or settlement, but at this time the Provider is seeking to include an additional 286 Medicaid Eligible Days in its cost report."[12]

On **December 12, 2019**, the Medicare Contractor filed its preliminary position paper. With regard to Issue 5, the Medicare Contractor's position paper noted that the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position.

On **March 6, 2024**, the Provider filed its Final Position Paper. In this filing, the Provider included the issue of Section 1115 waiver days, which was not previously included as part of Issue 5, DSH Medicaid Eligible Days, in its Preliminary Position Paper, or initial filing of the appeal.

On **April 29, 2024**, the Medicare Contractor timely filed a second Jurisdictional Challenge over Issue 5, DSH Medicaid Eligible Days, the only remaining issue in this appeal.

On **May 9, 2024**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **November 23, 2024**, almost 6 months after the deadline for responding to Medicare Contractor's second Jurisdictional Challenge of Issue 5, QRS filed a "Redacted Medicaid Eligible Days Listing Submission" The Listing was 17 pages and did not include a total count of Medicaid eligible days. QRS' filing did not explain why the listing (again 17 pages) was being submitted at this late date, ***almost 10 years after the fiscal year at issue had closed***.

MAC's Contentions

The MAC contends that the Provider has failed to file a complete preliminary position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25. The Provider never submitted a list of traditional Medicaid eligible days in question to the MAC nor was a listing included in the preliminary or final position paper, as required. A complete list (if it exists) should have been made available to the MAC.

Further, the MAC asserts that the Provider is attempting to untimely add the Section 1115 waiver days issue through the listing and Impact Calculation within its final position paper. The MAC requests that this issue be dismissed.

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[11] Provider's Preliminary Position Paper at 5 (Aug. 9, 2019).
[12] *Id.* at 6.

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[13] The Provider filed a Jurisdictional Response on **August 12, 2024**, almost four months past the deadline to do so. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

The Provider's response only addressed the Medicare Contractor's challenge of the Provider's add of the Section 1115 Waiver Days issue to the appeal as part of its Final Position Paper. The Provider argued the following in its Jurisdictional Response:

> Although the MAC complains that the Provider is attempting to untimely add the "issue" of section 1115 waiver days, MAC Jurisdictional Challenge at 7, there exists no such "issue." Section 1115 waiver days are part and parcel of Medicaid eligible days. And whereas the MAC states that it "contends that the Section 1115 Wavier Days issue is one component of the DSH issue," MAC Jurisdictional Challenge at 9, 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 "sub-issues" 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.

Decision of the Board

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

As set forth below, the Board hereby ***dismisses*** the Provider's remaining issue, Issue 5, DSH – Medicaid Eligible Days.

[13] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

A. DSH Payment – Medicaid Eligible Days

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

Board Rule 7.3.1.2 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.[14]

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.

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.

[14] (Bold emphasis added.)

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

> **Rule 25 Preliminary Position Papers**[15]
>
> **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**

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

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on January 14, 2019 included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 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.[16]

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 August 9, 2019, the Provider filed its preliminary position paper in which stated that "documentation necessary to pursue DSH was not available from the State of Texas in time to include all DSH/Medicaid Eligible Days on the cost report."[17] The Provider's complete briefing of this issue in its position paper is as follows:

> **HMWH Position:**

[16] (Emphasis added.)
[17] Provider's Preliminary Position Paper at 5 (Aug. 9, 2019).

> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> 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.
>
> HMWH is seeking reimbursement for an additional 285 Medicaid Eligible days. The Provider, in this appeal, contends that the documentation necessary to pursue DSH was not available from the State of Texas in time to include all DSH/Medicaid Eligible Days on the cost report.

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 remain unavailable, in accordance with Board Rule 25.2.2.

The Medicare Contractor's Jurisdictional Challenge requests dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish the list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2. The Medicare Contractor argues that the Provider 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.[18]

Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Jurisdictional Challenge. However, the Provider ***failed*** to timely respond to the Jurisdictional Challenge by the May 29,

[18] *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.

2024 filing deadline (*i.e*., 30 days after April 29, 2024). The Provider responded to the Jurisdictional Challenge on August 12, 2024, nearly four months past the deadline to do so.

However, on November 23, 2024 (more than 6 months after the deadline to respond to the Jurisdictional Challenge), QRS filed a "Redacted Medicaid Eligible Days Listing Submission." The Listing was 17 pages with no total count of Medicaid eligible days. QRS' filing did not explain why the listing of so many days was being submitted at this late date, ***almost 10 years after the fiscal year at issue had closed***. NOTE—the days included in this belated listing was provided ***roughly 5 years past the deadline for including it with its preliminary position paper*** since the position paper deadline was August 18, 2019.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* 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 failed to provide the necessary supporting documentation for those days.

The fact that the Listing was filed six 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 Jurisdictional Challenge. Board Rule 5.2 makes clear that "the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings." Moreover, the Board rejects the Provider's attempt to include the November 23, 202 filing, the "Redacted Medicaid Eligible Days Listing" because:

1. The Redacted Medicaid Eligible Days listing was filed roughly ***more than 5 years*** *after the deadline* for that exhibit to be included with its preliminary position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)). Indeed, the Provider failed to timely reply to the Medicare Contractor's Jurisdictional Challenger over Issue 5 and the listing was filed ***more than 6 months*** *after the deadline* for filing a response to the Jurisdictional Challenge over Issue 5.

2. The listing fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); (b) *why* the listing was not previously available, *in whole or in part* (*i.e*., it is not clear why the Provider failed to identify a single day at issue until almost 6 years after this appeal was filed and almost 10 years after the fiscal year at issue had closed).

3. Neither the Board Rules nor the January 14, 2019 Case Acknowledgment and Critical Due Dates permit the Provider to file a redacted listing as a supplement to its preliminary position paper.

4. Given the fact that the *material* facts (*e.g.*, the listing for the days at issue) and all available exhibits were required to be part of the position paper filing, if the Board were to accept the late filing of a Redacted Listing, it would need to be either be a *refinement* of its preliminary position paper or a supplement of documents that were identified in the preliminary position paper as being unavailable consistent with Board Rule 25.2.2. However, neither the preliminary position paper nor the late filed listing identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the "Redacted Listing" cannot be considered a refinement of the position paper since no specific days or listing were included with the preliminary position paper.[19]

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

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[21]

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[19] *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."

[20] (Emphasis added.)

[21] *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.

* * * * *

Based on the foregoing, the Board has dismissed the final remaining issue in this case – (Issue 5). As no issues remain, the Board hereby closes Case No. 19-0551 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

12/6/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

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RE: ***Board Determination on Reconsideration of Dismissal of Single Participant Group & Reopening of Status & Expansion of Later Year CIRP***

BS&W Health CY 2008 IPPS Understated Standardized Payment Amount CIRP Group
Case Number: 20-1974GC and

BS&W Health CYs 2011-2013 IPPS Understated Standardized Payment Amount CIRP Group
Case Number: 19-2455GC

Specifically, Baylor Scott & White Medical Center Lake Pointe (Provider Number 45-0742)

Dear Mr. Ravindran and Mr. Redmond:

In response to a November 21, 2024 request for reconsideration, the Provider Reimbursement Review Board ("the Board") has reviewed the subject common issue related party ("CIRP") group cases. The pertinent facts and the Board's determinations are set forth below.

Pertinent Facts:

On **August 12, 2020**, QRS filed the "BS&W Health CY 2008 IPPS Understated Standardized Payment Amount CIRP Group" under Case No. 20-1974GC in the Office of Hearings Case & Document Management System ("OH CDMS").[1] The group was established without any providers.

[1] Related groups were filed for the BS & W Health CY 2008 DSH SSI Percentage, DSH SSI Fraction Dual Eligible Days, Medicaid Fraction Dual Eligible Days, Medicaid Fraction Managed Care Part C Days & SSI Fraction Managed Care Part C Days.

On **August 21, 2020**, BS&W Health ("BS&W") requested the transfer of the Standardized Payment Amount issue from Case No. 20-0593, an individual appeal for Baylor Scott & White Medical Center Lake Pointe ("Lake Pointe"/Prov. No. 45-0742) for FYE 05/31/2008.

On **August 12, 2021**, a year after its formation, QRS certified Case No. 20-1974GC to be fully formed with Lake Pointe as the only participant.[2]

Because the regulation at 42 C.F.R. § 405.1837(b) requires that a CIRP group have two or more providers, the Board issued a Request for Information ("RFI") on **October 21, 2021,** in which it requested the Parties to comment on its proposal to expand a later multi-year year CIRP group for the IPPS Understated Standardized Payment Amount issue, Case No. 19-2455GC. The Board explained that, by expanding the later year BS&W Health CIRP group to include CY 2008, Lake Pointe could be transferred from Case Nos. 20-1974GC, allowing the single participant group to be closed.

On **October 29, 2021**, the Medicare Contractor ("MAC") filed its response to the Board's RFI in the related CY 2008 CIRP groups.[3] The MAC noted that Tenet Healthcare appeared to be the home office for the provider up until May 31, 2009. (*The MAC pointed out that Lake Pointe was a participant in two separate SSI CIRP groups for CY 2008: a Tenet group under Case No. 14-3154GC and a BS&W Health CIRP under Case No. 20-1969GC*.)

On **November 5, 2021**, QRS replied to the Board's RFI and concurred with the initial proposal to expand the CY 2011 & 2013 CIRP Group, Case No. 19-2455GC. QRS' response did not address the MAC's concerns regarding Tenet's ownership of Lake Pointe during the CY 2008.

Consequently, on **April 5, 2022**, the Board issued a revised RFI requiring ***all*** Parties, including Tenet Health and BS&W Health, to address the potential disposition of Lake Pointe's CY 2008 group issues in relation to Tenet Health's ownership during that time. On **April 19, 2022**, Tenet Health filed its response to the Board's revised RFI indicating that "[t]here exists no Tenet 2008 CIRP group appeal for is (*IPPS Standardized Payment Amount*) issue as Tenet is not intending to pursue this matter for the CY 2008."

On **May 26, 2022**, QRS responded to the Board's revised RFI and advised that it had conferred with both Tenet Health and Tenet Health's legal department, and all agreed the appeal rights for Lake Pointe's 5/31/2008 period belong to BS&W Health.[4] Therefore, QRS requested that Lake Pointe remain a participant in the BS&W Health CY 2008 IPPS Understated Standardized

---

[2] The related CY 2008 BS&W Health CIRP groups under Case Nos. 20-1969GC, 20-1971GC and 20-1973GC were also certified to be fully formed with Lake Pointe as the sole participant. The Board will address each of those single participant groups under separate cover.

[3] The Standardized Amount issue was not specifically addressed in the MAC's response.

[4] QRS provided no evidence in support of the Parties' concurrence regarding Lake Pointe's appeal rights other than its statement.

Payment Amount CIRP group under Case No. 20-1974GC.[5] QRS' correspondence did not address the fact that Lake Pointe was the sole provider in the CY 2008 BS&W Health CIRP groups.

On **October 25, 2024**, the Board issued its determination in Case No. 20-1974GC. The Board found that, not only had QRS not met its burden of proof regarding the ownership of Lake Pointe, but based on the evidence available, Lake Pointe's appeal rights were controlled by Tenet up until as late as 2018. Consequently, based on Tenet's ownership of Lake Pointe during CY 2008, and Tenet's statements that it was not pursuing the IPPS Standardized Amount issue for CY 2008, Lake Pointe was dismissed from the group. As there were no remaining participants in the group, Case No. 20-1974G was closed.

On **November 21, 2024**, QRS filed a request for reconsideration in which it requested the reinstatement of Case No. 20-1974GC. In its request, QRS provided proof in the form of an email dated May 24, 2022, in which Tenet indicated its agreement that Lake Pointe's appeal rights belong to BS& W. Again, QRS failed to address the fact that Case No. 20-1974GC had been designated as fully formed with only a single participant.[6]

Board Determination:

Regardless of QRS' continued failure to address the single participant impediment in Case No. 20-1974GC, the Board has reconsidered its previous dismissal of the group based on the corroborating support QRS has *finally* provided. Based on this evidence, the Board agrees to:

1. Reinstate the single participant "BS&W Health CY 2008 IPPS Understated Standardized Payment Amount CIRP Group," Case No. 20-1974GC;
2. Reopen the status of, and expand, the "BS & W Health CYs 2011 - 2013 IPPS Understated Standardized Payment Amount CIRP Group," Case No. 19-2455GC, to include CY 2008;[7]
3. Consolidate Case No. 20-1974GC into the expanded group, Case No. 19-2455GC;
4. Rename Case No. 19-2455GC the "BS & W CYs 2008 & 2011-2013 IPPS Understated Standardized Payment Amount CIRP Group;
5. Redesignate Case No. 19-2455GC to be fully formed; and

[5] QRS' response also requested that Lake Pointe remain a participant in Case Nos. 20-1971GC and 20-1973GC for the BS&W Health CY 2008 SSI & Medicaid Fraction Dual Eligible Days issues; Case No. 20-1969GC for the BS&W Health CY 2008 SSI Percentage issue and that its individual appeal under Case No. 20-0593 remain pending for the eligible days issue.

[6] QRS also requested that the April 19, 2022 filing submitted by Tenet regarding ownership be stricken from the record because it pre-dated the May 24, 2022 email confirmation. The Board has considered this request but finds that Tenet's April 19, 2022 correspondence supports the reasoning behind the Board's previous decision to dismiss and, therefore, remains part of the record. The Board's reconsideration determination provides clarification of the facts.

[7] As noted herein, QRS previously agreed to the proposed expansion of Case No. 19-2455GC in correspondence dated November 5, 2021. QRS certified that there were no relevant regulatory or factual changes between CYs 2008 and 2011 thru 2013 for the Standardized Amount issue.

6. Dismiss Case No. 20-1974GC as there are no remaining participants.

In order to effectuate the consolidation of the two groups in OH CDMS, a confirmation will be issued under separate cover.

Finally, the Board puts QRS on notice that the reinstatement of Case No. 20-1974GC (*and its subsequent consolidation into the reopened/expanded CIRP group*) is being granted as a one-time courtesy.[8] In the future, the Board will not consider changing its treatment of any case simply because QRS finally decides it will provide previously requested evidence, as was the circumstance here.

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

For the Board:

12/9/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Federal Specialized Services

[8] This one-time courtesy extends to the determination in Case No. 20-1969GC which will be addressed under separate cover.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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410-786-2671

Via Electronic Delivery

Isaac Blumberg
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Los Angeles, CA 90064-1582

RE: ***Notice of Dismissal***
Blumberg Ribner, Inc. 1498-R3 Unreasonable Delay Appeals
Case Numbers: 24-2301 *et al.* (41 Cases – *See* **Appendix A**)

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the forty-one (41) individual cases listed in **Appendix A**. The providers are appealing the publication of CMS Ruling 1498-R3 on the basis that CMS has failed to issue Notices of Program Reimbursement ("NPRs") in a reasonable amount of time. The decision of the Board to ***dismiss*** the appeals is set forth below.

Procedural history:

The Final Determination being appealed in these forty-one (41) cases is CMS Ruling 1498-R3 dated March 4, 2024.[1] The appeal requests all contain one issue: "Appeal of Ruling 1498-R3 for Unreasonable Delay." The Issue Statement is ten pages long and can be summarized as follows:

- Providers have submitted requests to realign their SSI Fractions with their cost reporting periods (rather than the default alignment with the federal fiscal year) pursuant to 42 C.F.R. § 412.106(b)(3), which would result in the recalculation of their DSH payment;[2]
- The Providers allege that CMS has acquiesced the methodology for calculating SSI Fractions and processing realignment requests for fiscal years 2004 and prior in *Northeast Hosp. Corp. v. Sebelius*, and that this acquiescence was specifically acknowledged in CMS Ruling 1498-R2;[3]
- The Providers contend that "if hospitals previously requested realignment within three years of their original NPRs and there were no SSI appeals or remands, then those hospitals would receive realignment based on the original SSI fractions calculated before CMS Ruling 1498[-R]";[4]

[1] *Available at* https://www.cms.gov/files/document/cms-1498-r3.pdf.
[2] *See, e.g.,* PRRB Case 24-2301, Statement of Issue at ⁋⁋ 1, 19.
[3] *Id.* at ⁋⁋ 1 (citing 657 F.3d 1, 16-17 (D.C. Cir. 2011)), 6.
[4] *Id.* at ⁋ 7.

- The Providers then detail a number of CMS Transmittals and Rulings that delayed the processing of its request for realignment and argue that this unreasonably delayed determination and payment for the Providers;[5]
- The Providers reiterate that they have requested realignment of their SSI Fractions in accordance with CMS' instructions, but that CMS has not taken any action in response to the requests;[6]
- The Providers complain that *Northeast Hosp. Corp. v. Sebelius* and CMS Ruling 1498-R2 explained how its SSI Fraction should be calculated, but the numerous unreasonable delays and halts in processing its request for realignment has taken so long that, now, CMS Ruling 1498-R3 requires realignment in a manner that is different (and presumably less favorable to the Providers; it is now based on "total days" and not "covered days");[7]
- The Providers argue that this delay violated the Administrative Procedure Act's requirement to act within a reasonable time frame and, had CMS done so, Providers' realignment requests would have been processed pursuant to *Northeast Hosp. Corp. v. Sebelius* and CMS Ruling 1498-R2 long before 1498-R3 became effective;[8]
- The relief requested by the Providers is that "CMS should be estopped from further delay of determining and paying the realignments under the policies articulated in the Northeast Decision";[9]
- The Providers make several arguments as to why the delays and policies (some retroactive) described above are unreasonable, arbitrary and capricious, overbroad, violate notice-and-comment rulemaking requirements, or otherwise violate the APA or some other provision of law.[10]

The Providers claim:

> The PRRB has jurisdiction of this appeal because the Providers have not received a final determination on a timely basis, pursuant to 42 U.S.C. §1395oo(a)(1)(B) (authorizing appeal to the PRRB when a provider "has not received such final determination from such intermediary on a timely basis after filing such report"); 42 C.F.R. § 405.1835(c) (permitting appeal to the PRRB based on untimeliness when a contractor has not issued a final determination for a cost reporting within 12 months of receipt).[11]

With regard to the Board's jurisdiction, the Providers also argue that CMS Ruling 1498-R3 is an appealable "final determination," citing *Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 141 (D.C.

[5] *Id.* at ¶¶ 8-18.
[6] *Id.* at ¶¶ 20-23.
[7] *Id.* at ¶ 27.
[8] *Id.* at ¶¶ 28-29.
[9] *Id.* at ¶ 32.
[10] *Id.* at ¶¶ 33-47.
[11] *Id.* at ¶ 48.

Cir. 1986), *Cape Cod Hospital v. Sebelius*, 630 F.3d 203 (2011), and *Battle Creek Health System v. Becerra*, Civil Action No. 17-0545 (CKK) (D.D.C. 2023).[12]

Relevant Law:

The procedural background and arguments presented in the cases set forth in **Appendix A** are very similar to those presented in *Alameda County Med. Ctr. v. Becerra* ("*Alameda*").[13]

In *Alameda*, forty-six (46) hospitals filed an action in the District Court for the District of Columbia alleging that they had been waiting for decades to receive their DSH adjustments on cost reports submitted before 2014.[14] They argued that the failure to issue final NPRs constituted an unreasonable delay in violation of the APA, but the court ultimately found it lacked jurisdiction over the hospitals' claims.[15]

The court summarized the relevant litigation and rulemaking surrounding the DSH adjustment, beginning with the errors and omissions recognized in the DSH payment calculations in *Baystate Med. Ctr .v. Leavitt*.[16] It recounted CMS' acquiescence to that decision in 2010 with the issuance of CMS Ruling 1498-R, which ordered the Board to remand appeals raising *Baystate* errors for DSH adjustment recalculations. But neither *Baystate* nor 1498-R addressed a very specific scenario: when hospitals had requested their SSI fractions be calculated on their cost reporting periods (rather than the federal fiscal year) (*i.e.*, a "realignment"), should the 1498-R recalculations be based on the "realigned" cost reporting period or the federal fiscal year? So, in 2017, CMS issued a transmittal that vacated previous realignments, told the Medicare Contractors to recalculate SSI fractions based on the federal fiscal year, and hospitals could request a realignment following those recalculations. Separately, in 2020, CMS paused processing DSH adjustments for cost periods prior to October 1, 2013 following the Supreme Court's decision in *Azar v. Allina Health Services*.[17] Indeed, the agency issued a Technical Direction Letter, and later CMS Ruling 1739-R, instructing the Medicare Contractors to pause pre-2014 cost report settlements pending rulemaking to address the ruling in *Allina*.[18]

The hospitals in *Alameda* received their NPRs and appealed to the Board based on issues later addressed in *Baystate*. Their claims were remanded pursuant to 1498-R, and some hospitals later either requested a realignment or simply that their new NPRs be issued promptly. They ultimately filed suit in March 2023 because they had still not received payments for fiscal years ranging from 1988 to 2005.[19] The hospitals in *Alameda* sought mandamus relief under § 706(1) of the APA, alleging undue delay in processing their revised payment determinations on remand.

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[12] *Id.* at ¶¶ 50-52.
[13] 2024 WL 3536620 (D.D.C. 2024).
[14] *Id.* at *1.
[15] *Id.*
[16] 545 F. Supp. 2d 20 (D.D.C. 2008), *amended in part*, 587 F. Supp. 2d 37 (D.D.C. 2008).
[17] 587 U.S. 566 (2019).
[18] 2024 WL 3536620 at *2.
[19] *Id.* at *3.

The court first looked to whether it had substantive jurisdiction over the claims under § 405(h) of the Medicare Act, noting this jurisdiction is more limited than general "federal question" jurisdiction. Section 405(h) channels most Medicare claims through an agency review system, which requires a hospital first present its claim to the secretary, and then fully exhaust any administrative remedies prescribed by the Secretary.[20] It was undisputed that the hospitals in *Alameda* satisfied the presentment requirement, but also that they came directly to federal court rather than pursue any administrative remedies after their claims were remanded post-*Baystate*. The hospitals argued that this failure to exhaust their remedies was appropriate because there was no mechanism to obtain relief from the Board for unreasonable delay in receiving their NPRs or realignments, but the court noted that there ***is*** a mechanism, found in 42 U.S.C. § 1395oo(a)(1)(B), to appeal to the Board if a hospital does not receive a final determination in a timely manner.[21] The hospitals did not show that they pursued this remedy or that it was otherwise foreclosed.

The court rejected two more of the hospitals' arguments that attempted to excuse their failure to exhaust. First, in *Shalala v. Ill. Council on Long Term Care, Inc.*,[22] the Supreme Court stated that § 405(h) of the Medicare Act does not apply when doing so would mean no review at all, rather than simply channel review, through the agency. It also stated that inconvenience alone is insufficient, and that the hardship must result in *complete* preclusion of review.[23] But the court in *Alameda* found the hospitals did not show how channeling their undue delay claim through the agency would result in a complete preclusion of review.[24]

Second, the hospitals argued that the exhaustion requirement was waivable under a four-part test set forth in *Tataranowicz v. Sullivan*.[25] The court questioned the continued validity of this test following *Shalala v. Ill. Council on Long Term Care, Inc.*, but also noted that the first prong of the four-part test rendered the hospitals' request to be impermissible. The first prong of the test is that judicial resolution of a claim cannot interfere with the agency's efficient functioning, but the court noted that calculating the Plaintiffs' revised payments before many other hospitals was impermissible interference.[26]

Finally, the court noted that mandamus jurisdiction derived from 28 U.S.C. § 1361 is not precluded by § 405(h) of the Medicare Act. But this would require the hospitals to have shown there was a "clear and indisputable right to relief," and the court in *Alameda* found the hospitals did not make such a showing. When used as the basis for a court to assert mandamus jurisdiction, claims of unreasonable delay are evaluated under the factors set forth in

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[20] *Id.* at *4 (citations omitted).
[21] *Id.* (citing 42 U.S.C. § 1395oo(a)(1)(B)).
[22] 529 U.S. 1 (2000).
[23] *Id.* at 19, 20-23.
[24] 2024 WL 3536620 at *5.
[25] 959 F.2d 268, 275 (D.C. Cir. 1992).
[26] 2024 WL 3536620 at *5.

Telecommunications Research & Action Center v. F.C.C. ("TRAC").[27] The court in *Alameda* found that the attempt to assert mandamus jurisdiction based on the delay in receiving an NPR was defeated by factor four: the effect of expediting delayed action on agency activities of a higher or competing priority. "That factor prohibits relief where court-ordered relief would merely put the claimant at 'the head of the queue [and] would simply move all others back one space and produce no net gain.'"[28] The *Alameda* court found the hospitals were seeking special treatment in attempting to "move to the front of the line" and thus denied the request for mandamus relief.[29]

Decision of the Board:

The Providers' appeals in the instant cases and the action brought by the hospitals in *Alameda* are similar; the biggest difference being that the Providers here filed appeals with the Board and the hospitals in *Alameda* did not (they filed directly in federal court).

Like some of the hospitals in *Alameda*, the Providers here requested a realignment, but the same Transmittals and Rulings discussed in *Alameda* have delayed the issuance of Providers' updated SSI Fractions and resultant revised DSH payments. The substantive arguments made by the Providers in these cases about this delay were rejected by the court in *Alameda*.

As the court in *Alameda* held, the Providers must pursue its administrative remedies – *i.e.*, file claims with the Board – before seeking relief in federal court. The Board only has jurisdiction over an appeal if the Provider filed their appeal from a final determination. The Providers here concede that they have not received a Notice of Program Reimbursement. Indeed, that is the crux of its argument, that it has taken too long to get NPRs with the realignment of their SSI Fractions for the FYs at issue. The Board also has limited jurisdiction over appeals where a Medicare Contractor fails to issue an NPR in a timely manner. A Provider may obtain a hearing before the Board, but only if it files its appeal within 180 days after the twelve-month period in which the Medicare Contractor was to issue a final determination, as required by 42 C.F.R. § 405.1835.[30] The Providers' appeals do not meet these criteria.

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[27] 750 F.2d 70 (D.C. Cir. 1984).
[28] 2024 WL 3536620 at *5 (quoting *Mashpee Wampanoag Tribal Council, Inc. v. Norton*, 336 F.3d 1094, 1100 (D.C. Cir. 2003) (citations omitted)).
[29] *Id.* at *5-6.
[30] 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.

Instead, the Providers are appealing from CMS Ruling 1498-R3, which the Board finds is not a final determination. That ruling simply instructs Medicare Contractors on *how* to calculate SSI Fractions for pending appeals or open cost reports. It does not include any hospital-specific SSI Fractions which would dictate or determine the final amount of payment due to the Provider.

42 U.S.C. § 1395oo(a)(1)(A)(ii) allows an appeal from a Secretary determination. Specifically, this statutory provision allows an appeal if a provider:

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

Pursuant to 42 C.F.R. § 405.1835(a)(1), an individual provider generally has a right to a hearing before the Board "with respect to a final contractor or Secretary determination ***for the provider's cost reporting period***"[31] if:

- It "is dissatisfied *with the contractor's final determination of the total amount of reimbursement* ***due the provider***, as set forth in the contractor's written notice specified under § 405.1803."[32] In other words, providers must appeal from a "final determination" that impacts payment for the period under appeal.[33]

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

- The amount in controversy is $10,000 or more.[34]

Satisfying the criteria set out in 42 C.F.R. § 405.1835(a) is required before the Board can exercise jurisdiction over an appeal.[35]

> (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) . . .

[31] 42 C.F.R. § 405.1835(a) (emphasis added).
[32] 42 C.F.R. § 405.1835(a)(1) (emphasis added).
[33] *See also* 42 U.S.C. § 1395oo(a)(1)(A); *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-146 (D.C. Cir. 1986) (stating: "Viewing the amendments as a whole, we are inescapably drawn to the same conclusion as the District Court: § 1395oo (a) 'clearly contemplates two different kinds of appeal. One begins when the intermediary issues an NPR; the other, when the intermediary issues a notice of ***what will be paid*** *under the PPS system*.' . . . . Under PPS, in contrast, ***payment amounts*** are independent of current costs and *can be determined with finality* prior to the beginning of the cost year. Id. § 412.71(d). Thus a year-end cost report is not a report which is necessary ***in order for the Secretary to make PPS payments***, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal." (emphasis added and citations omitted)).
[34] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[35] 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claim filing requirements such as timelines or filing deadlines. However, whether an appeal

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

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing in the manner prescribed by the Board, and the request must include the elements described in paragraphs (b)(1) through (4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (2), or (3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.
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> (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.
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> (2) **For each specific item under appeal**, a separate explanation of why, and a description of how, the provider is dissatisfied **with the specific aspects of the final . . . determination under appeal**, including an account of all of the following:
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> (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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> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
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> (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**.[36]

was timely is not a jurisdictional requirement but rather is a claim filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013). *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*. Similarly, the Board notes that 42 C.F.R. § 405.1835(b) addresses claim filing requirements.

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

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

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

Unlike DRG rates and other adjustments such as the wage index,[37] a hospital's eligibility for a DSH payment (and, if eligible, the amount of that payment) during a particular fiscal year is not ***prospectively*** set or determined as part of the relevant IPPS final rule. In this regard, 42 U.S.C. § 1395ww(d)(5)(F) refers to the DSH adjustment being calculated "with respect to a [hospital's] cost reporting period" and uses days associated with inpatients stays *occurring during that cost reporting period*.[38] To this end, DSH eligibility ***and*** payment, if any, is determined, calculated, and finalized *annually* through the cost report audit/settlement process as made clear in 42 C.F.R. § 412.106(i) which sets forth the following instructions regarding the determination of a hospital's eligibility for a DSH payment for each fiscal year and, if so, how much:

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

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

> hospital's eligibility for payment under this section.[39]

The Secretary makes clear that this regulation is based on "our ***longstanding*** *process* of making ***interim*** *eligibility* determinations for Medicare DSH payments *with* ***final*** *determination* ***at cost report settlement***."[40] Examples of other adjustments to IPPS payment rates that are based, in

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

[40] 78 Fed. Reg. at 50627. *See also* Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2807.2(B)(5) (last revised Aug. 1993, Transmittal 371) (stating: "*At* ***final*** ***settlement*** *of the cost report*, the intermediary determines the final disproportionate share adjustment based on the actual bed size and disproportionate share patient percentage for the cost reporting period." (emphasis added)). In the preamble to the FY 2014 IPPS Final Rule, the Secretary discussed the DSH eligibility and payment process and the following are excerpts from that discussion:

> *Comment*: Several commenters requested that CMS undertake additional audits to verify the data used to compute the 25-percent empirically justified Medicare DSH payment adjustments. Other commenters requested that CMS grant additional time for hospitals to verify the data and adjust their cost reports to ensure that the data used to compute the adjustment are accurate and up to date. Some commenters requested that CMS establish procedures to allow a hospital initially determined not to be eligible for Medicare DSH payments to begin receiving empirically justified Medicare DSH payments if data become available that indicate that the hospital would be eligible.
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> *Response*: As we have emphasized, we are maintaining the well-established methodology and payment processes used under the current Medicare DSH payment adjustment methodology for purposes of making the empirically justified Medicare DSH payment adjustments. Hospitals are quite familiar with the cost reporting requirements and auditing procedures employed under the current Medicare DSH payment adjustment methodology. Hospitals are also familiar with the current process of determining **interim eligibility** for Medicare DSH payments **with final determination at cost report settlement**. Therefore, we do not believe that it would be warranted to add additional complexity to these procedures by adopting any of these recommendations.
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> For the reasons discussed above regarding the empirically justified Medicare DSH payments [*i.e.*, the DSH payment calculation made under 42 U.S.C. § 1395ww(d)(5)(F)], we do not believe that it is necessary or advisable to depart from our longstanding process of making interim eligibility determinations for Medicare DSH payments with final determination at cost report settlement. As we discuss in greater detail in section V.E.3.f. of the preamble to this final rule, we will make interim eligibility determinations based on data from the most recently available SSI ratios and Medicaid fractions prior to the beginning of the payment year. We will then make final determinations of eligibility at the time of settlement of each hospital's cost report.
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whole or in part, on certain data/costs claimed on the as-filed cost report and then determined and reimbursed through the cost report audit and settlement process include bad debts,[41] direct graduate medical education ("GME"),[42] and indirect GME.[43]

Similarly, the Board declines to follow D.C. District Court's decision in *Battle Creek*[44] and instead finds the D.C. District Court's 2022 decision in *Memorial Hospital* to be instructive. The Providers in *Memorial Hospital* appealed ***the publication of their DSH SSI Fractions*** (which is one step *after* the case at hand where Provider is appealing CMS Ruling 1498-R3 adopting/finalizing a policy ***prior to*** the publication of the DSH SSI Fractions reflecting that Ruling[45]). The providers in *Memorial Hospital* argued that there are certain instances where a provider can appeal prior to receiving an NPR and gave citations to certain D.C. Circuit cases in support. However, the D.C. District Court distinguished these cases because "the secretarial determination at issue was either

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> Therefore, we proposed that, at cost report settlement, the fiscal intermediary/MAC will issue a notice of program reimbursement that includes a determination concerning whether each hospital is eligible for empirically justified Medicare DSH payments and, therefore, eligible for uncompensated care payments in FY 2014 and each subsequent year. In the case where a hospital received interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year on the basis of estimates prior to the payment year, but is determined to be ineligible for the empirically justified Medicare DSH payment at cost report settlement, the hospital would no longer be eligible for either payment and CMS would recoup those monies. For a hospital that did not receive interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year, but at cost report settlement is determined to be eligible for DSH payments, the uncompensated care payment for such a hospital is calculated based on the Factor 3 value determined prospectively for that fiscal year.

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

[41] 42 C.F.R. §§ 412.2(f)(4), 412.115(a) (stating: "An additional payment is made to each hospital in accordance with § 413.89 of this chapter for bad debts attributable to deductible and coinsurance amounts related to covered services received by beneficiaries.).

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

[43] 42 C.F.R. §§ 412.2(f)(2), 412.105. *See also* PRM 15-1 § 2807.2(B)(6) (stating: "*At **final settlement** of the cost report*, the intermediary determines the indirect teaching adjustment based on the actual number of full time equivalent residents and average daily census for the cost reporting period. (emphasis added)).

[44] The Board recognizes that, in *Battle Creek*, the D.C. District Court addressed a jurisdictional issue involving DSH SSI fractions ***similar to*** the jurisdictional issue that the *same* Court (different judge) issued in *Memorial Hospital* but reached a different conclusion. However, the Board disagrees with the *Battle Creek* decision and maintains that *Memorial Hospital* is a better-reasoned decision and, in particular, provides a more thoughtful analysis and application of the D.C. Circuit's decision in *Washington Hospital*. Indeed, the *Battle Creek* decision does not even discuss (much less, reference) the *Memorial Hospital* decision that was issued 19 months earlier by a different judge in the ***same*** Court. Finally, *Battle Creek* is distinguishable from the case at hand. *Battle Creek* addressed whether the publication of SSI fractions is a final determination. In contrast, Provider did not appeal the publication of SSI fractions but rather a CMS Ruling adopting and finalizing the policy at issue ***prior to*** the issuance of new SSI fractions to be used in the *alleged* yet-to-be issued revised NPR for FY 1990.

[45] Provider's appeal request is very clear that it was filed to appeal from the publication of CMS Ruling 1498-R3, as opposed to appeal from the subsequent publication of SSI fractions. To this end, the Board notes that 42 C.F.R. § 405.1835(b)(3) requires an appeal request to include a copy of the final determination being appealed, and the Provider here included a copy of CMS Ruling 1498-R3.

the only determination on which payment depended or clearly promulgated as a final rule."[46] The D.C. District Court ultimately agreed with the Board that this was not an appealable final determination. In its discussion, the D.C. District Court agreed with the Secretary that the publication of the SSI ratios, *even if the publication of the SSI fractions had been issued as "final,"* could and would not be a final determination "as to the amount of payment" because the SSI fractions are "just one of the variables that determines whether hospitals receive a DSH payment ***and***, ***if so***, *for how much*."[47] The D.C. District Court concluded:

> A challenge to *an* ***element*** *of payment* under 42 U.S.C. § 1395oo(a)(1)(A)(ii) is ***only*** *appropriate* ***if***, as the D.C. Circuit has explained, "*the Secretary ha[s] firmly established '****the only variable factor*** in the final determination as to the amount of payment under § 1395ww(d).'" *Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807, 811 (D.C. Cir. 2001) (quoting *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 147 (D.C. Cir. 1986)) (emphasis added); *see also Samaritan Health Serv. v. Sullivan*, 1990 WL 33141 at *3 (9th Cir. 1990) (unpublished table decision) ("We have held that if the Secretary's classification of a hospital effectively fixes the hospital's reimbursement rate, then that decision is a 'final determination' as referred to 42 U.S.C. § 1395oo(a)(1)(A)(ii).").[48]

Accordingly, the Court upheld the Board's decision to dismiss because the DSH SSI fraction was only one of the variables that determine whether a hospital receives a DSH payment (and, if so, for how much) and the publication of a hospital's SSI fraction is not a determination as to the amount of payment received.[49]

This is what makes these cases distinguishable from the facts presented in the D.C. Circuit's decisions in *Washington Hospital* where the determination that was appealed finalized the only hospital-specific variable used in setting the per-patient payment amount. Specifically, the hospitals in *Washington Hospital* appealed their "Final Notice of Base Period Cost and Target Amount Per Discharge" and the D.C. Circuit found: (a) "the ***only variable*** *factor* in the final determination as to the amount of payment under § 1395ww(d) is the hospital's target amount . . . .";[50] and (b) "That amount is the per-patient amount calculated under § 1395ww(d) and is final once the Secretary has published the DRG amounts (as he has) and finally determined the hospital's target amount. Here each of the hospitals has received a 'Final Notice of Base Period Cost and Target Amount per Discharge.' The statute requires no more to trigger the hospital's right to appeal PPS Payments to the PRRB."[51]

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[46] 2022 WL 888190 at *8.
[47] *Id.* at *9 (emphasis added).
[48] *Id.* at *8.
[49] *Id.* at *9.
[50] 795 F.2d at 147 (emphasis added).
[51] *Id.* at 148 (footnote omitted).

Similar to the D.C. District Court's decision in *Memorial Hospital*, while the policy at issue in these cases was promulgated/finalized in the issuance of CMS Ruling 1498-R3, it is ***not*** a "final determination" as to the amount of the DSH payment to be received by Providers for the FYs at issue. Rather, 1498-R3 reflects "just one of the variables that determines whether hospitals receive a DSH payment [for the relevant fiscal year] ***and***, ***if so***, *for how much*"; and any "***final*** *payment* determination"[52] on whether a hospital receives a DSH payment for a particular fiscal year and, if so, for how much *is made during the cost report audit/settlement process as explained at 42 C.F.R. § 412.106(i)*.[53] In this regard, the Board again notes that 1498-R3 did not make a determination on any specific hospital's DSH eligibility or the amount of its DSH payment. Rather, as it relates to these appeals, the Ruling adopts a policy that is to be applied *retroactively* but only to certain hospitals and makes clear that *new SSI percentages* would be calculated or recalculated.

Conclusion:

The Providers in the cases listed in **Appendix A** have not received Revised NPRs with revised SSI fractions based on their realignment requests for the FYs at issue from which they could appeal. Nor did the Providers timely appeal the failure of the Medicare Contractor to issue a timely determination pursuant to 42 C.F.R. § 405.1835(c). Additionally, the substantive arguments for the basis of this appeal about the lawfulness of the delay have already been rejected by *Alameda.* Accordingly, the Board finds it is appropriate to dismiss the appeals listed in **Appendix A** and remove them from the Board's docket, since satisfying the criteria set out in 42 C.F.R. § 405.1835(a) is required before the Board can exercise jurisdiction over an appeal,[54] and since Providers have failed to demonstrate in their hearing requests that those criteria have been met for the years under appeal.[55] The Board further notes that three of the providers are appealing cost reporting periods which are congruent with the federal fiscal year (ending on 9/30), and thus, any requested realignment would have no effect on settlement, and the appeal would have $0 amount in controversy.[56] These cases could also be dismissed for not meeting the necessary amount in controversy, as this is the only issue in these cases.

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

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[52] 42 C.F.R. § 412.106(i)(2) (emphasis added).
[53] 2022 WL 888190 at *9 (emphasis added).
[54] 42 C.F.R. § 405.1840(a), (b).
[55] 42 C.F.R. § 405.1835(b).
[56] Case Numbers 24-2326, 24-2327, and 24-2390 identify providers with FYE of 9/30 (1999 and/or 2000). If the providers' cost reporting period (ending 9/30) is the same as the federal fiscal year (ending 9/30) there would be no realignment of the SSI percentage possible, as the data used would be exactly the same in both cases.

Board Members:

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

For the Board:

12/9/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq. Federal Specialized Services
Danelle Decker, National Government Services, Inc. (J-K)
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Byron Lamprecht, WPS Government Health Administrators (J-5)
Judith Cummings, CGS Administrators (J-15)
Dean Wolfe, Noridian Healthcare Solutions (J-F)

Appendix A
(41 Cases)

Case No.	Case Name
24-2301	*Richmond University Medical Center (33-0028), FYE 12/31/1990*
24-2312	*East Texas Medical Center (45-0083), FYE 10/31/2000*
24-2318	*East Texas Medical Center (45-0083), FYE 10/31/1994*
24-2319	*Crouse Hospital (33-0203), FYE 12/31/1999*
24-2320	*Valley Medical Center (50-0088), FYE 12/31/1999*
24-2321	*Valley Medical Center (50-0088), FYE 12/31/2001*
24-2322	*Valley Medical Center (50-0088), FYE 12/31/2003*
24-2326	*Scripps Mercy Hospital (05-0077), FYE 09/30/1999*
24-2327	*Scripps Mercy Hospital (05-0077), FYE 09/30/2000*
24-2335	*East Jefferson General Hospital (19-0146), FYE 12/31/2003*
24-2336	*Kingsbrook Jewish Medical Center (33-0201), FYE 12/31/2001*
24-2337	*Brookdale Hospital Medical Center (33-0233), FYE 12/31/1997*
24-2347	*Pomona Valley Hospital Medical Center (05-0231), FYE 12/31/1989*
24-2348	*Pomona Valley Hospital Medical Center (05-0231), FYE 12/31/1991*
24-2349	*Pomona Valley Hospital Medical Center (05-0231), FYE 12/31/1992*
24-2350	*Pomona Valley Hospital Medical Center (05-0231), FYE 12/31/1993*
24-2351	*Pomona Valley Hospital Medical Center (05-0231), FYE 12/31/1994*
24-2352	*Pomona Valley Hospital Medical Center (05-0231), FYE 12/31/1997*
24-2353	*Pomona Valley Hospital Medical Center (05-0231), FYE 12/31/1999*
24-2354	*Pomona Valley Hospital Medical Center (05-0231), FYE 12/31/2000*
24-2355	*Pomona Valley Hospital Medical Center (05-0231), FYE 12/31/2002*
24-2356	*Pomona Valley Hospital Medical Center (05-0231), FYE 12/31/2003*
24-2365	*Touro Infirmary (19-0046), FYE 12/31/1994*
24-2367	*Lenox Hill Hospital (33-0119), FYE 12/31/2002*
24-2368	*Kuakini Medical Center (12-0007), FYE 06/30/1995*
24-2369	*Jamaica Hospital Medical Center (33-0014), FYE 12/31/2000*
24-2378	*The Queens Medical Center (12-0001), FYE 06/30/2001*
24-2379	*The Queens Medical Center (12-0001), FYE 06/30/2002*
24-2380	*The Queens Medical Center (12-0001), FYE 06/30/2004*
24-2381	*California Pacific Medical Center - Van Ness Campus (05-0047), FYE 12/31/1998*
24-2382	*California Pacific Medical Center - Mission Bernal (05-0055), FYE 06/30/2002*
24-2390	*Scripps Memorial Hospital - Chula Vista (05-0270), FYE 09/30/2000*

24-2391	*Pomona Valley Hospital Medical Center (05-0231), FYE 12/31/1995*
24-2392	*Pomona Valley Hospital Medical Center (05-0231), FYE 12/31/1998*
24-2393	*Mount Sinai Beth Israel (33-0169), FYE 12/31/2000*
24-2394	*Sutter Medical Center - Sacramento (05-0108), FYE 12/31/1997*
24-2400	*Bethesda North (36-0179), FYE 06/30/1998*
24-2404	*Sutter Medical Center - Sacramento (05-0108), FYE 12/31/1990*
24-2405	*Sutter Medical Center - Sacramento (05-0108), FYE 12/31/1993*
24-2413	*Sutter Memorial Hospital (05-0109), FYE 12/31/1993*
24-2414	*HCA Houston Healthcare Tomball (45-0670), FYE 06/30/1998*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Heather Mogden
Hall, Render, Killian, Heath & Lyman, P.C.
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Milwaukee, WI 53202

RE: ***Notice of Dismissal***
Hall Render DSH SSI Data Match RNPR CIRP and Optional Groups
Case Numbers: 25-0457GC *et al.* (65 Cases – *See* **Appendix A**)

Dear Ms. Mogden:

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the Common Interest Related Party ("CIRP") and Optional Group cases listed in **Appendix A**. The groups are appealing an SSI Data Match issue from Revised Notices of Program Reimbursement ("RNPRs"). The decision of the Board to ***dismiss*** the appeals is set forth below.

Procedural history:

The Group Issue in this case is related to "DSH SSI Data Match" and is described as follows:

> The failure of the Fiscal Intermediary and the Centers for Medicare and Medicaid Services (CMS) to properly determine the ratio of patient days for patients entitled to Medicare Part A and Supplemental Security Income (SSI) benefits (excluding any State supplementation) to patient days for patients entitled to Medicare Part A (Medicare Proxy or Fraction) for the Provider in its Disproportionate Share Hospital (DSH) eligibility determination and payment calculation, including any related impact on capital DSH. The Provider asserts that the Medicare Proxy is improperly understated due to a number of factors, including CMS's inaccurate and improper matching or use of data along with policy changes to determine both the numerator of the Medicare Part A SSI patient days in the numerator of the fraction and the total Medicare Part A patient days in the denominator, as utilized in the calculation of the Medicare percentage of low income patients for purposes of DSH.[1]

The Providers note that the Board issued a decision in *Baystate* which identified flaws in the compilation of Medicare SSI days, and that this decision was upheld by the District Court for the District of Columbia in 2008. The Providers also explain that, in 2010, CMS issued Ruling

[1] *E.g.*, Case 25-0457GC, Issue Description for DSH SSI Data Match Issue.

1498-R in response to the *Baystate* decision which sets forth a revised data match process, but that they believe errors still exist in this process, such as the failure to include all Dual Eligible patient days in the Medicare fraction numerator.[2]

Relevant Law:

A. RNPR Appeals

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

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

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

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

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

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[2] *Id.*
[3] *See also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).
[4] 42 C.F.R. § 405.1889(b)(1).

B. Retroactive Part C Rule, Resulting RNPRs, and Associated Appeal Rights

i. Medicare DSH Payment

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

The PPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[7] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[8]

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

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

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

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[5] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[6] *Id.*
[7] *See* 42 U.S.C. § 1395ww(d)(5).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[11] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[12] (Emphasis added.)

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

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[14]

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

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

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

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

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as

[13] 42 C.F.R. § 412.106(b)(2)-(3).
[14] (Emphasis added.)
[15] 42 C.F.R. § 412.106(b)(4).
[16] of Health and Human Services.

> of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that are associated with Medicare patients. Therefore, since that time we have been including HMO days in SSI/Medicare percentage [of the DSH adjustment].[17]

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

With the creation of Medicare Part C in 1997,[19] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal years 2001-2004.[20]

No further guidance regarding the treatment of Part C days in the DSH calculation was provided until the 2004 Inpatient Prospective Payment System ("IPPS") proposed rules were published in the Federal Register. In that notice the Secretary stated that:

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .*[21]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to

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[17] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[18] *Id.*
[19] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization has a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[20] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).
[21] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (italics emphasis added).

include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[22] In response to a comment regarding this change, the Secretary explained that:

> *. . . we do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[23]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[24] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[25] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[26]

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[22] 69 Fed. Reg. at 49099.
[23] *Id.* (emphasis added).
[24] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[25] *Id*. at 47411.
[26] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

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

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

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

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[37] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

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[27] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[28] 746 F. 3d 1102 (D.C. Cir. 2014).
[29] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[30] *Id.* at 2011.
[31] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[32] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[33] 139 S. Ct. 1804 (2019).
[34] *Id.* at 1817.
[35] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[36] 139 S. Ct. at 1814.
[37] 85 Fed. Reg. 47723 (Aug. 6, 2020).

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[38]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[39] The June 2023 Final Rule provides the following guidance on the extent to which it is to be applied *retroactively*:

> [T]he Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports.[40]

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

> ***The Ruling was not intended to cut off appeal rights and will not operate to do so***. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that

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

> providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[41]

Finally, the following excerpts from the June 9, 2023 Final Rule discuss a hospital's right to challenge the Part C days policy adopted therein:

1. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[42]

2. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and ***will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary will likewise receive NPRs or revised NPRs reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and **the new or revised NPRs will provide hospitals with a vehicle to appeal the new final action *even if the Medicare fraction or DSH payment does not change numerically***."[43]

3. "When the Secretary's treatment of Part C days in this final action is reflected in NPRs and revised NPRs, providers, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], **will be able to challenge the agency's interpretation by appealing those NPRs and revised NPRs.** While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, **the**

[41] 88 Fed. Reg. at 37788 (bold emphasis added).
[42] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[43] *Id.* at 37788 (emphasis added).

> **issuance of new NPRs and revised NPRs pursuant to remands under the Ruling <u>are not reopenings</u>.**"[44]

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

<u>Decision of the Board:</u>

42 C.F.R. § 405.1889 governs the scope of appeals once a contractor determination is "reopened as provided in § 405.1885[.]" In this circumstance, Providers have *limited* appeal rights and are only able to appeal issues or matters that were "specifically revised" in the RNPRs.

The appeal rights detailed in the June 9, 2023 Final Rule specifically limit a provider's appeal rights to specific matters related to the actual RNPR (*i.e.*, the Part C Days policy). First, the Secretary made clear that the Part C Days rule could be appealed following the issuance of a new NPR or RNPR "***<u>even if the Medicare fraction or DSH payment does not change numerically.</u>***"[45] Thus, the new rule could be appealed even if the treatment of Part C Days was not "specifically revised."

The appeal rights, however, are strictly limited to the policy related to the treatment of Part C days. Following the issuance of a RNPR, the Secretary stated that Providers "***will have appeal rights <u>with respect to the treatment of Part C days in the calculation of the DSH fractions</u> contained in the NPRs or revised NPRs***[,]" "**<u>will be able to challenge the agency's interpretation</u>** [of the treatment of Part C days in this final action] by appealing those NPRs and revised NPRs[,]" and further stated that they "**can challenge <u>the reasonableness of the Secretary's interpretation set forth in</u> <u>this final action</u>**."[46]

<u>Conclusion:</u>

The issue being appealed in the sixty-five (65) cases listed in **Appendix A** is related to the SSI Data Match process and its impact on the Medicare Fraction (*i.e.*, the exclusion of Dual Eligible Days from the Medicare fraction's numerator). The appeals were taken from RNPRs that were issued specifically to reflect and implement the treatment of Part C days as set forth in the June 23, 2023 Final Rule, but the Providers have not briefed any Part C Days issues. The RNPRs make no changes at all to the Provider's payment or cost report related to the SSI Data Match process or Dual Eligible Days in the Medicare Fraction. The Board finds that (1) the RNPRs did not "specifically revise" anything related to the SSI Data Match process or Dual Eligible Days and thus, pursuant to 42 C.F.R. § 405.1889(b)(1), that issue is beyond the scope of any appeal from the RNPRs, and (2) the only appeal rights afforded from the RNPRs as set forth in the June

[44] *Id.* (emphasis added).
[45] *Id.* (emphasis added).
[46] *Id.* at 37787-88 (emphasis added).

23, 2023 Final Rule are to challenge the treatment of Part C Days in the RNPRs. Based on the foregoing, the Board hereby ***dismisses*** the sixty-five (65) CIRP and optional group appeals listed in **Appendix A** and removes them from the Board's docket.

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

Board Members:

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

For the Board:

12/9/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq. Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-5 & J-8)
Cecile Huggins, Palmetto GBA (J-J)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Judith Cummings, CGS Administrators (J-15)
Dean Wolfe, Noridian Healthcare Solutions (J-F)

Appendix A
(65 Cases)

Case No.	Case Name
25-0457GC	*Community Health Network CY 2009 DSH SSI Data Match RNPR CIRP Group*
25-0416GC	*LifePoint Health CY 2010 DSH SSI Data Match RNPR CIRP Group*
25-0404GC	*Community Health Network CY 2012 DSH SSI Data Match RNPR CIRP Group*
25-0400GC	*IU Health CY 2007 DSH SSI Data Match RNPR CIRP Group*
25-0399GC	*Community Health Network CY 2014 DSH SSI Data Match RNPR CIRP Group*
25-0388GC	*IU Health CY 2010 DSH SSI Data Match RNPR CIRP Group*
25-0360GC	*ProMedica Health CY 2012 DSH SSI Data Match RNPR CIRP Group*
25-0358GC	*ProMedica Health CY 2011 DSH SSI Data Match RNPR CIRP Group*
25-0355GC	*Parkview Health CY 2010 DSH SSI Data Match RNPR CIRP Group*
25-0322G	*Hall Render CY 2012 DSH SSI Data Match RNPR Group*
25-0319GC	*St. Elizabeth Healthcare CY 2010 DSH SSI Data Match RNPR CIRP Group*
25-0318GC	*IU Health CY 2008 DSH SSI Data Match RNPR CIRP Group*
25-0315GC	*IU Health CY 2009 DSH SSI Data Match RNPR CIRP Group*
25-0314GC	*Community Health Network CY 2010 DSH SSI Data Match RNPR CIRP Group*
25-0294GC	*Parkview Health CY 2009 DSH SSI Data Match RNPR CIRP Group*
25-0291GC	*Parkview Health CY 2008 DSH SSI Data Match RNPR CIRP Group*
25-0286GC	*Beacon Health CY 2013 DSH SSI Data Match RNPR CIRP Group*
25-0278GC	*Community Health Network CY 2011 DSH SSI Data Match RNPR CIRP Group*
25-0266GC	*LifePoint Health CY 2011 DSH SSI Data Match RNPR CIRP Group*
25-0264GC	*LifePoint Health CY 2014 DSH SSI Data Match RNPR CIRP Group*
25-0259GC	*Baptist Healthcare KY CY 2013 DSH SSI Data Match RNPR CIRP Group*
25-0256GC	*Baptist Healthcare KY CY 2011 DSH SSI Data Match RNPR CIRP Group*
25-0243GC	*Valley Health CY 2010 DSH SSI Data Match RNPR CIRP Group*
25-0232GC	*Ascension Health CY 2010 DSH SSI Data Match RNPR CIRP Group*
25-0222GC	*St. Elizabeth Healthcare CY 2013 DSH SSI Data Match RNPR CIRP Group*
25-0218GC	*St. Elizabeth Healthcare CY 2012 DSH SSI Data Match RNPR CIRP Group*
25-0214GC	*St. Elizabeth Healthcare CY 2011 DSH SSI Data Match RNPR CIRP Group*
25-0211GC	*Franciscan Alliance CY 2013 DSH SSI Data Match RNPR CIRP Group*
25-0209GC	*Franciscan Alliance CY 2011 DSH SSI Data Match RNPR CIRP Group*
25-0200GC	*LifePoint Health CY 2013 DSH SSI Data Match RNPR CIRP Group*
25-0147GC	*Community Health Network CY 2013 DSH SSI Data Match RNPR CIRP Group*
25-0136GC	*Powers Health CY 2012 DSH SSI Data Match RNPR CIRP Group*

25-0131GC	*Powers Health CY 2011 DSH SSI Data Match RNPR CIRP Group*
25-0086GC	*Ascension Health CY 2009 DSH SSI Data Match RNPR CIRP Group*
25-0078GC	*LifePoint Health CY 2012 DSH SSI Data Match RNPR CIRP Group*
25-0062GC	*IU Health CY 2013 DSH SSI Data Match RNPR CIRP Group*
25-0058G	*Hall Render CY 2010 DSH SSI Data Match RNPR Group*
25-0056G	*Hall Render CY 2009 DSH SSI Data Match RNPR Group*
25-0054G	*Hall Render CY 2008 DSH SSI Data Match RNPR Group*
25-0039GC	*Ascension Health CY 2008 DSH SSI Data Match RNPR CIRP Group*
24-2804G	*Hall Render CY 2014 DSH SSI Data Match RNPR Group*
24-2748GC	*Ascension Health CY 2012 DSH SSI Data Match RNPR CIRP Group*
24-2745GC	*Ascension Health CY 2013 DSH SSI Data Match RNPR CIRP Group*
24-2743GC	*Ascension Health CY 2014 DSH SSI Data Match RNPR CIRP Group*
24-2741GC	*Ascension Health CY 2011 DSH SSI Data Match RNPR CIRP Group*
24-2665GC	*Parkview Health CY 2013 DSH SSI Data Match RNPR CIRP Group*
24-2660G	*Hall Render CY 2011 DSH SSI Data Match RNPR Group*
24-2659G	*Hall Render CY 2013 DSH SSI Data Match RNPR Group*
24-2655GC	*Parkview Health CY 2012 DSH SSI Data Match RNPR CIRP Group*
24-2648GC	*Parkview Health CY 2011 DSH SSI Data Match RNPR CIRP Group*
24-2629GC	*Beacon Health CY 2012 DSH SSI Data Match RNPR CIRP Group*
24-2536GC	*IU Health CY 2012 DSH SSI Data Match RNPR CIRP Group*
24-2531GC	*IU Health CY 2011 DSH SSI Data Match RNPR CIRP Group*
25-0717GC	*ScionHealth CY 2013 DSH SSI Data Match RNPR CIRP Group*
25-0646GC	*Franciscan Alliance CY 2010 DSH SSI Data Match RNPR CIRP Group*
25-0633GC	*Premier Health Partners CY 2013 DSH SSI Data Match RNPR CIRP Group*
25-0627GC	*Premier Health Partners CY 2012 DSH SSI Data Match RNPR CIRP Group*
25-0621GC	*Premier Health Partners CY 2008 DSH SSI Data Match RNPR CIRP Group*
25-0600GC	*Premier Health Partners CY 2011 DSH SSI Data Match RNPR CIRP Group*
25-0597GC	*Premier Health Partners CY 2009 DSH SSI Data Match RNPR CIRP Group*
25-0514GC	*LifePoint Health CY 2009 DSH SSI Data Match RNPR CIRP Group*
25-0510GC	*ProMedica Health CY 2010 DSH SSI Data Match RNPR CIRP Group*
25-0509GC	*LifePoint Health CY 2008 DSH SSI Data Match RNPR CIRP Group*
25-0508GC	*ProMedica Health CY 2009 DSH SSI Data Match RNPR CIRP Group*
25-0506GC	*ProMedica Health CY 2008 DSH SSI Data Match RNPR CIRP Group*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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Michael Redmond, Manager
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RE: ***Board Determination on Reconsideration of Dismissal of Single Participant Group & Reopening of Status & Expansion of Later Year CIRP***

BS&W Health CY 2008 DSH SSI Percentage CIRP Group
Case Number: 20-1969GC and

Scott & White 2009 SSI Days CIRP Group
Case Number: 14-1211GC

Specifically, Baylor Scott & White Medical Center Lake Pointe (Provider Number 45-0742)

Dear Mr. Ravindran and Mr. Redmond:

In response to a November 21, 2024 request for reconsideration, the Provider Reimbursement Review Board ("the Board") has reviewed the subject common issue related party ("CIRP") group cases. The pertinent facts and the Board's determinations are set forth below.

Pertinent Facts:

On **August 12, 2020**, QRS filed the "BS&W Health CY 2008 DSH SSI Percentage CIRP Group" under Case No. 20-1969GC in the Office of Hearings Case & Document Management System ("OH CDMS").[1] The group was established without any providers.

On **August 21, 2020**, BS&W Health ("BS&W") requested the transfer of the DSH SSI Percentage issue from Case No. 20-0593, an individual appeal for Baylor Scott & White Medical Center Lake Pointe ("Lake Pointe"/Prov. No. 45-0742) for FYE 05/31/2008.

[1] Related groups were filed for the BS & W Health CY 2008 DSH SSI Fraction Dual Eligible Days, Medicaid Fraction Dual Eligible Days, IPPS Understated Standardized Payment Amount, Medicaid Fraction Managed Care Part C Days & SSI Fraction Managed Care Part C Days.

On **August 12, 2021**, a year after its formation, QRS certified Case No. 20-1969GC to be fully formed with Lake Pointe as the only participant.[2]

Because the regulation at 42 C.F.R. § 405.1837(b) requires that a CIRP group have two or more providers, the Board issued a Request for Information ("RFI") on **October 21, 2021,** in which it requested the Parties to comment on its proposal to expand a later year CIRP group for the SSI Percentage issue, Case No. 14-1211GC. The Board explained that, by expanding the later year BS&W Health CIRP group to include CY 2008, Lake Pointe could be transferred from Case No. 20-1969GC, allowing the single participant group to be closed.

On **October 29, 2021**, in response to the Board's RFI, the Medicare Contractor ("MAC") noted that Lake Pointe was a participant in two separate groups for the CY 2008 SSI issue:

- Case No. 14-3154GC (Tenet 2008 Post 1498-R DSH SSI Proxy CIRP) and
- Case No. 20-1969GC (BS&W Health CY 2008 DSH SSI Percentage CIRP Group).

Therefore, the MAC recommended that, based on Tenet's ownership of Lake Pointe for CY 2008, Case No. 20-1969GC be dismissed as a duplication of Case No. 14-3154GC.[3]

On **November 5, 2021**, QRS replied to the Board's RFI and concurred with the initial proposal to expand the CY 2009 CIRP Group, Case No. 14-1211GC. QRS' response did not address the MAC's concerns regarding Tenet's ownership of Lake Pointe during the CY 2008, nor did it address the duplication of Lake Pointe's participation in the two SSI groups under Case Nos. 14-3154GC and 20-1969GC.

Consequently, on **April 5, 2022**, the Board issued a revised RFI requiring ***all*** Parties, including Tenet Health and BS&W Health, to address the potential disposition of Lake Pointe's CY 2008 group issues in relation to Tenet Health's ownership during that time.[4] Both the MAC, on **April 8, 2022**, and Tenet Health, on **April 19, 2022**, filed responses to the Board's revised RFI indicating that Lake Pointe should remain a participant in the Tenet 2008 Post 1498-R DSH SSI Proxy CIRP Group under Case No. 14-3154GC.

On **May 26, 2022**, QRS responded to the Board's revised RFI and advised that it had conferred with both Tenet Health and Tenet Health's legal department, and all agreed the appeal rights for Lake Pointe's 5/31/2008 period belong to BS&W Health.[5] Therefore, QRS requested that Lake

---

[2] The related CY 2008 BS&W Health CIRP groups under Case Nos. 20-1971GC, 20-1973GC and 20-1974GC were also certified to be fully formed with Lake Pointe as the sole participant. The Board will address each of those single participant groups under separate cover.

[3] Response to Request for Information at 1-2 (Oct. 29, 2021).

[4] Ropes & Gray, LLP became the authorized representative of Case No. 14-3154GC on September 7, 2023.

[5] QRS provided no evidence in support of the Parties' concurrence regarding Lake Pointe's appeal rights other than its statement.

Pointe remain a participant in the BS&W Health CY 2008 SSI Percentage CIRP group under Case No. 20-1969GC.[6] QRS' correspondence did not address the fact that Lake Pointe was the sole provider in the CY 2008 BS&W Health CIRP groups.

On **October 29, 2024**, the Board issued its determination in Case No. 20-1969GC. The Board found that, not only had QRS not met its burden of proof regarding the ownership of Lake Pointe, but based on the evidence available, Lake Pointe appeared to be controlled by Tenet for the period in question.[7] Based on Board Rule 4.6.1 which indicates that Providers may not appeal an issue from a single determination in more than one appeal, the Board found that Lake Pointe was properly included in Tenet's CIRP group under Case No. 14-3154GC and therefore, Case No. 20-1969GC was dismissed.[8]

On **November 21, 2024**, QRS filed a request for reconsideration in which it requested the reinstatement of Case No. 20-1969GC. In its request, QRS provided proof in the form of an email dated May 24, 2022, in which Tenet indicated its agreement that Lake Pointe's appeal rights belong to BS& W. Again, QRS failed to address the fact that Case No. 20-1969GC had been designated as fully formed with only a single participant.[9]

Board Determination:

Regardless of QRS' continued failure to address the single participant impediment in Case No. 20-1969GC, the Board has reconsidered its previous dismissal of the group based on the corroborating support QRS has *finally* provided. Based on this evidence, the Board agrees to:

1. Dismiss Lake Pointe from Tenet's group, Case No. 14-3154GC;
2. Reinstate the single participant "BS&W Health CY 2008 DSH SSI Percentage CIRP Group," Case No. 20-1969GC;
3. Reopen and expand the "Scott & White 2009 SSI Days CIRP Group,"[10] Case No. 14-1211GC, to include CY 2008;[11]

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[6] QRS' response also requested that Lake Pointe remain a participant in Case Nos. 20-1971GC and 20-1973GC for the BS&W Health CY 2008 SSI & Medicaid Fraction Dual Eligible Days issues; Case No. 20-1974GC for the BS&W Health CY 2008 IPPS Understated Standardized Payment Amount issue and that its individual appeal under Case No. 20-0593 remain pending.

[7] In fact, according to Tenet's April 19, 2022 correspondence, Tenet did not divest its minority interest in Lake Pointe until March 2018.

[8] Board Rules. (Aug 29, 2018, revised Nov. 1, 2021)

[9] QRS also requested that the April 19, 2022 filing submitted by Tenet regarding ownership be stricken from the record because it pre-dated the May 24, 2022 email confirmation. The Board has considered this request but finds that Tenet's April 19, 2022 correspondence supports the reasoning behind the Board's previous decision to dismiss and, therefore, remains part of the record. The Board's reconsideration determination provides clarification of the facts.

[10] The merger of Scott & White Health with Baylor Healthcare System occurred in 2013 and the system is now known as Baylor Scott & White.

[11] As noted herein, QRS previously agreed to the proposed expansion of Case No. 14-1211GC in correspondence dated November 5, 2021. QRS certified that there were no relevant regulatory or factual changes between CYs 2008 and 2009 for the SSI Days issue.

4. Consolidate Case No. 20-1969GC into the expanded group, Case No. 14-1211GC;
5. Rename Case No. 14-1211GC the "BS & W CYs 2008 & 2009 SSI Percentage Group;
6. Redesignate Case No. 14-1211GC to be fully formed; and
7. Dismiss Case No. 20-1969GC as there are no remaining participants.

In order to effectuate the consolidation of the two groups in OH CDMS, a confirmation will be issued under separate cover.

Finally, the Board puts QRS on notice that the reinstatement of Case No. 20-1969GC (*and its subsequent consolidation into the reopened/expanded CIRP group*) is being granted as a one-time courtesy.[12] In the future, the Board will not consider changing its treatment of any case simply because QRS finally decides it will provide previously requested evidence, as was the circumstance here.

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

For the Board:

12/10/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Federal Specialized Services
Stephanie Webster, Ropes & Gray, LLP (Rep for Case No. 14-3154GC)

[12] This one-time courtesy extends to the determination in Case No. 20-1974GC which will be addressed under separate cover.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Baltimore, MD 21244 1850
410-786-2671

Via Electronic Delivery

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

RE: ***Board Determination on Disbanding Dignity Health CY 2019 NAHE Elimination of Pharmacy Residency Program CIRP Group, Case Number: 24-1375GC***

As it relates to participants:

Provider Name	***Provider Number***	***FYE***	***Case #***	***Ind. Appeal Status***
Mercy Medical Center Redding	*05-0280*	*6/30/2019*	*24-0448*	*Open*
Mercy San Juan Medical Center	*05-0516*	*6/30/2019*	*24-0482*	*Closed 8/1/2024*
Mercy General Hospital	*05-0017*	*6/30/2019*	*23-1774*	*Open*
St. Joseph's Medical Center of Stockton	*05-0084*	*6/30/2019*	*24-0859*	*Closed 9/22/2024*

Dear Ms. Ellis:

The Provider Reimbursement Review Board ("the Board") has reviewed the subject common issue related party ("CIRP") group appeal pursuant to correspondence from Toyon Associates, Inc. ("Toyon") dated November 19, 2024. Toyon's correspondence was filed in reply to an earlier Board Request for Information ("RFI") regarding the question of the suitability of the NAHE Elimination of Pharmacy Residency Program ("NAHE Elimination") issue for the group appeal format. The pertinent facts for this group and the Board's determination are set forth below.

Pertinent Facts:

On **February 20, 2024**, Toyon filed the "Dignity Health CY 2019 NAHE Elimination of Pharmacy Residency Program CIRP Group" under Case No. 24-1375GC, which was formed in the Office of Hearings Case & Document Management System ("OH CDMS") without any providers.

On the same date, Toyon requested the transfer of three of the following NAHE Elimination issues to the group, with the fourth transfer (St. Joseph's Medical Center) requested on 9/22/2024:

Issue description in Ind. Appeal	**Provider**	**From Case No.**
Nursing and Allied Health Removal of Program Costs (#6)	Mercy Medical Center Redding	24-0448
Adj Remove NAHE cost on provider operated pharmacy residency (#7)	Mercy San Juan Medical Center	24-0482[1]
Adj remove NAHE cost on provider operated pharmacy residency (#9)	Mercy General Hospital	23-1774
Nursing and Allied Health-Removal of Program Costs (#7)	St Joseph's Medical Center	24-0859[2]

On **September 16, 2024**, in Case No. 24-0267G, (an optional Toyon group appealing the same issue) Toyon requested the expansion of the calendar year ("CY") 2018 group to include CY 2017. Toyon argued that the expansion of the group would allow another provider, White Memorial Medical Center (Prov. No. 05-0103), to transfer its "Disallowance of Clinical Pastoral Education (CPE) Costs" issue for FYE 12/31/2017 to the group.

On **September 20, 2024**, the Board denied Toyon's request for expansion of Case No. 24-0267G to include CY 2017 because it found that the issues in the individual appeal and the group case involved two different programs and the facts and circumstances surrounding each program were likely to be different.

In that determination, the Board also posed a question regarding the suitability of the NAHE Elimination issue for the group format. The Board noted that the issue seems to be factually specific to each provider since each program may be operated differently and, therefore, could result in differing determinations being rendered by the Board. Therefore, the Board required Toyon to review its pending appeals for the NAHE Elimination issue and to submit comments in support of why it should remain in the group format or, alternatively, confirm that its groups on this issue should be disbanded.

On **November 19, 2024**, Toyon responded to the Board's request indicating that when the NAHE Elimination groups were formed, it believed that the various group providers were ". . . connected by a common question of law (as required by 42 C.F.R. § 405.1837). . . ".[3] However, Toyon acknowledged that, in the event the Board did not agree with that reasoning, it would concede to the Board's proposal to disband its NAHE groups. In the case of the subject CIRP group's disbandment, Toyon requested that the Board transfer the issue back to the Providers' open individual appeals and create new individual appeals for the Providers with closed cases.[4]

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is

[1] Case No. 24-0482 was closed on 8/1/2024.
[2] Case No. 24-0859 was closed on 9/22/2024.
[3] NAHE Elimination of Pharmacy Residency Group Appeals (Nov. 19, 2024).
[4] *Id.*

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.

With respect to issues suitable for group format, the Board relies on 42 C.F.R. § 405.1837(b), which specifies that two or more providers may file a group for ". . . 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." This is further reflected in Board Rule 12.2, which states, "[t]he matter at issue in the group appeal must involve a single question of fact or interpretation of law, regulation, or CMS Rulings that is common to each provider in the group."

After review of Toyon's response, the Board finds that the NAHE Elimination issue appears to be provider specific as the facts could vary from Provider to Provider, in terms of which schools are participating in the program, the operator of the program and the history of the program, and the handling on the specific cost report.[5] Based on this finding, there does not appear to be a single common issue and therefore, the Board is taking the following actions:

1. Transferring the NAHE Elimination issues from Case No. 24-1375GC back to the pending individual appeals, Case Nos. 24-0448 and 23-1774. Rather than create new individual appeals, the Board is electing to reinstate the earlier appeals for Mercy San Juan Medical Center (Case No. 24-0482) and St. Joseph's Medical Center (Case No. 24-0859).[6]
2. As there are no remaining providers in Case No. 24-1375GC, the case is being closed and removed from the Board's docket.

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

For the Board:

12/10/2024

X Kevin D. Smith, CPA

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

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

[5] Toyon's response to the Board's RFI referenced eleven groups, including the group discussed herein. Due to the varying fact patterns for group participants in each case, the Board will address each group under separate cover.
[6] The Board notes that preliminary position papers were filed in two of the four individual appeals, but they were filed after the transfer of the NAHE Elimination issue. In the other two groups, Case Nos. 24-0482 and 24-0859, preliminary position papers were not filed prior to their closures. Therefore, the Board will issue a request for supplemental preliminary position papers for the NAHE Elimination issue under separate cover in each case.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Lisa Ellis
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1800 Sutter Street, Suite 600
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RE: ***Board Determination on Disbanding Univ of California CY 2006 NAHE Elimination of Pharmacy Residency Program CIRP Group, Case Number: 24-1377GC***

As it relates to the participant:
UCSF Medical Center (Provider Number 05-0454)
FYE: 6/30/2006
Case Number: 16-2159

Dear Ms. Ellis:

The Provider Reimbursement Review Board ("the Board") has reviewed the subject common issue related party ("CIRP") group appeal pursuant to correspondence from Toyon Associates, Inc. ("Toyon") dated November 19, 2024. Toyon's correspondence was filed in reply to an earlier Board Request for Information ("RFI") regarding the question of the suitability of the NAHE Elimination of Pharmacy Residency Program issue for the group appeal format. The pertinent facts for this group and the Board's determination are set forth below.

Pertinent Facts:

On **February 20, 2024**, Toyon filed the "Univ of California CY 2006 NAHE Elimination of Pharmacy Residency Program CIRP Group" under Case No. 24-1377GC, which was formed in the Office of Hearings Case & Document Management System ("OH CDMS") without any providers. On the same date, Toyon requested the transfer of the "Adjustment to Pharmacy Education Expense" ("*NAHE Elimination*") issue for UCSF Medical Center from its individual appeal, Case No. 16-2159.

On **September 16, 2024**, in Case No. 24-0267G, (an optional group appealing the same issue) Toyon requested the expansion of that calendar year ("CY") 2018 group to include CY 2017. Toyon argued that the expansion of the group would allow another provider, White Memorial Medical Center (Prov. No. 05-0103), to transfer its "Disallowance of Clinical Pastoral Education (CPE) Costs" issue for FYE 12/31/2017 to the group.

On **September 20, 2024**, the Board denied Toyon's request for expansion of Case No. 24-0267G to include CY 2017 because it found that the issues in the individual appeal and the group case

involved two different programs and the facts and circumstances surrounding each program were likely to be different.

In that determination, the Board also posed a question regarding the suitability of the NAHE Elimination of Pharmacy Residency Program issue for the group format. The Board noted that the issue seems to be factually specific to each provider since each program may be operated differently and, therefore, could result in differing determinations being rendered by the Board. Therefore, the Board required Toyon to review its pending appeals for the NAHE Elimination of Pharmacy issue and to submit comments in support of why it should remain in the group format or, alternatively, confirm that its groups on this issue should be disbanded.

On **November 19, 2024**, Toyon responded to the Board's request indicating that when the groups were formed, it believed that the various group providers were ". . . connected by a common question of law (as required by 42 C.F.R. § 405.1837). . . ".[1] However, Toyon acknowledged that, in the event the Board did not agree with that reasoning, it would concede to the Board's proposal to disband its NAHE groups. In the case of the subject CIRP group's disbandment, Toyon requested that the Board transfer the issue back to the pending individual appeal.[2]

Board Determination:

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

With respect to issues suitable for group format, the Board relies on 42 C.F.R. § 405.1837(b), which specifies that two or more providers may file a group for ". . . 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." This is further reflected in Board Rule 12.2, which states, "[t]he matter at issue in the group appeal must involve a single question of fact or interpretation of law, regulation, or CMS Rulings that is common to each provider in the group."

After review of Toyon's response, the Board finds that the NAHE Elimination issue appears to be provider specific as the facts could vary from Provider to Provider, in terms of which schools are participating in the program, the operator of the program and the history of the program, and the handling on the specific cost report.[3] Based on this finding, there does not appear to be a single common issue and therefore, the Board is taking the following actions:

1. Transferring the "Adjustment to Pharmacy Education Expense" issue back to UCSF

[1] NAHE Elimination of Pharmacy Residency Group Appeals (Nov. 19, 2024).
[2] *Id.*
[3] Toyon's response to the Board's RFI referenced eleven groups, including the group discussed herein. Due to the varying fact patterns for group participants in each case, the Board will address each group under separate cover.

Medical Center's individual appeal, Case No. 16-2159. This issue must be addressed in the Parties' final position papers which are currently due on April 25, 2025 and May 25, 2025, respectively. The hearing date is set for July 24, 2025.

2. As there are no remaining providers in Case No. 24-1377GC, the case is being closed and removed from the Board's docket.

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

For the Board:

12/10/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Lorraine Frewert, Noridian Healthcare c/o. Cahaba Safeguard Adm. (J-E)
Mridula Bhatnagar, Toyon Associates (Rep of Case 16-2159)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Determination – Failure to Respond to Request for Required Documentation***

CHI St. Alexius Health (Provider Number 35-0002)
FYEs: 06/30/2009 & 06/30/2010
Case Numbers: 25-0573 & 25-0574

Dear Mr. Ravindran:

In a November 22, 2024 determination issued in the subject individual appeals, the Provider Reimbursement Review Board (the "Board"), as a one-time courtesy, agreed to use its discretion and allow Case Nos. 25-0573 and 25-0574 to remain pending after Quality Reimbursement Services ("QRS") cured a critical defect.[1] In that determination, the Board also pointed out that QRS had not included proper Representative letters when it filed the appeals. Specifically, the Board noted that, in addition to the fact that the Provider had been acquired by a new parent organization in 2014, the Representative letters that were uploaded were dated more than ten years ago (prior to that acquisition) and were signed by a representative that was no longer with the company.

Consequently, the Board required that QRS file updated Representative letters within seven days of that notification (***due by December 6, 2024***). The Board advised that failure to submit the updated Representative letter for each case by the deadline would result in dismissal of the respective appeals.

Discussion of Regulations, Rules and Determination:

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

[1] QRS failed to submit the final determinations, the revised Notices of Program Reimbursement, with the appeal request, as required by 42 C.F.R405.1835(f). Instead, QRS filed HRCIS DSH reports that are public information.

Further 42 C.F.R. § 405.1868 states that:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. *The Board's powers include the authority to take appropriate actions in response to the* ***failure of a party*** *to a Board appeal* ***to comply with Board*** rules and ***orders*** or for inappropriate conduct during proceedings in the appeal.
>
> (b) *If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—*
>
> *(1) Dismiss the appeal with prejudice***;**
>
> *(2)* Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
>
> *(3)* Take any other remedial action it considers appropriate.[2]

Board Determination:

When a Representative files an individual appeal for a provider (or directly adds a provider to a group), the Representative is required to certify that it is authorized to make the filing on behalf of the provider by including a copy of the Representation letter evidencing that authorization.[3] Requiring Representation letters to be properly (i.e., timely) executed for the fiscal year at issue protects providers and health chains from potentially coercive or abusive representation situations, whether in the context of an individual or group appeal.

The Board previously acknowledged that the Rules are not specific on how recent the signature on the Representative letter must be. It should, however, be common sense that the authorization letter **cannot have been signed more than ten years ago AND by someone who is no longer with the Provider and would therefore not have the authority to bind a provider in a filing of a new appeal**. This is especially true in this circumstance, where the Provider in these appeals has been subsequently acquired by a new parent organization. That new owner, CHI Health, has filed appeals before the Board and may have no knowledge of QRS filing these appeals on its behalf, since the Representation letter from more than 10 ago was signed by the former parent organization and was signed by a contact who is no longer even with that company.[4]

---

[2] Emphasis added.
[3] See Board Rules 5, 6.1.1, 6.5, 12.8, 12.10, Model Form A, Model Form E.
[4] After a quick internet search, the Board determined that the VP of Accounting & Finance who signed the 2013 Representative letter had left St. Alexius in 2015, and most recently held a position in the North Dakota state

The submission of an outdated authorization letter, in conjunction with the fact that QRS did not have immediate access to the final determinations in these cases, leads the Board to surmise that the Provider may have been unaware of QRS' filings on its behalf. Therefore, because QRS has failed to timely file the perfected Representative letters by the December 6, 2024 deadline as required in the November 22, 2024 determination, the Board finds it appropriate to dismiss Case Nos. 25-0573 and 25-0574 pursuant to its authority under 42 C.F.R. § 405.1868.

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

For the Board:

12/11/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Dean Wolfe, Noridian Healthcare Solutions (J-F)
Pam Cudaback, CHI Health

government. Clearly this person does not have the ability to bind the hospital in 2024, the year in which these appeals were filed.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Determination – Failure to Respond to Request for Required Documentation***

CHI St. Alexius Health (Provider Number 35-0002)
FYEs: 06/30/2009 & 06/30/2010
Case Numbers: 25-0573 & 25-0574

Dear Mr. Ravindran:

In a November 22, 2024 determination issued in the subject individual appeals, the Provider Reimbursement Review Board (the "Board"), as a one-time courtesy, agreed to use its discretion and allow Case Nos. 25-0573 and 25-0574 to remain pending after Quality Reimbursement Services ("QRS") cured a critical defect.[1] In that determination, the Board also pointed out that QRS had not included proper Representative letters when it filed the appeals. Specifically, the Board noted that, in addition to the fact that the Provider had been acquired by a new parent organization in 2014, the Representative letters that were uploaded were dated more than ten years ago (prior to that acquisition) and were signed by a representative that was no longer with the company.

Consequently, the Board required that QRS file updated Representative letters within seven days of that notification (***due by December 6, 2024***). The Board advised that failure to submit the updated Representative letter for each case by the deadline would result in dismissal of the respective appeals.

Discussion of Regulations, Rules and Determination:

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

[1] QRS failed to submit the final determinations, the revised Notices of Program Reimbursement, with the appeal request, as required by 42 C.F.R405.1835(f). Instead, QRS filed HRCIS DSH reports that are public information.

Further 42 C.F.R. § 405.1868 states that:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. *The Board's powers include the authority to take appropriate actions in response to the* ***failure of a party*** *to a Board appeal* ***to comply with Board*** rules and ***orders*** or for inappropriate conduct during proceedings in the appeal.
>
> (b) *If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—*
>
> *(1) Dismiss the appeal with prejudice***;**
>
> *(2)* Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
>
> *(3)* Take any other remedial action it considers appropriate.[2]

Board Determination:

When a Representative files an individual appeal for a provider (or directly adds a provider to a group), the Representative is required to certify that it is authorized to make the filing on behalf of the provider by including a copy of the Representation letter evidencing that authorization.[3] Requiring Representation letters to be properly (i.e., timely) executed for the fiscal year at issue protects providers and health chains from potentially coercive or abusive representation situations, whether in the context of an individual or group appeal.

The Board previously acknowledged that the Rules are not specific on how recent the signature on the Representative letter must be. It should, however, be common sense that the authorization letter **cannot have been signed more than ten years ago AND by someone who is no longer with the Provider and would therefore not have the authority to bind a provider in a filing of a new appeal**. This is especially true in this circumstance, where the Provider in these appeals has been subsequently acquired by a new parent organization. That new owner, CHI Health, has filed appeals before the Board and may have no knowledge of QRS filing these appeals on its behalf, since the Representation letter from more than 10 ago was signed by the former parent organization and was signed by a contact who is no longer even with that company.[4]

---

[2] Emphasis added.
[3] See Board Rules 5, 6.1.1, 6.5, 12.8, 12.10, Model Form A, Model Form E.
[4] After a quick internet search, the Board determined that the VP of Accounting & Finance who signed the 2013 Representative letter had left St. Alexius in 2015, and most recently held a position in the North Dakota state

The submission of an outdated authorization letter, in conjunction with the fact that QRS did not have immediate access to the final determinations in these cases, leads the Board to surmise that the Provider may have been unaware of QRS' filings on its behalf. Therefore, because QRS has failed to timely file the perfected Representative letters by the December 6, 2024 deadline as required in the November 22, 2024 determination, the Board finds it appropriate to dismiss Case Nos. 25-0573 and 25-0574 pursuant to its authority under 42 C.F.R. § 405.1868.

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

For the Board:

12/11/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Dean Wolfe, Noridian Healthcare Solutions (J-F)
Pam Cudaback, CHI Health

government. Clearly this person does not have the ability to bind the hospital in 2024, the year in which these appeals were filed.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
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Baltimore, MD 21244 1850
410-786-2671

Via Electronic Delivery

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

Geoff Pike
First Coast Service Options, Inc. c/o
GuideWell Source (J-N)
532 Riverside Avenue
Jacksonville, FL 32202

RE: ***Board Determination on Duplicate Common Issue Related Party ("CIRP") Groups***

Baptist Health System CY 2018 St. Francis Predicated Facts DRG Operating Understatement CIRP Group, Case Number: 25-0688GC and

Baptist Health System CY 2018 St. Francis Predicated Facts DSH Operating Understatement CIRP Group, Case Number: 25-0689GC

Dear Mr. Ravindran and Mr. Pike:

The Provider Reimbursement Review Board (the "Board") has begun a review of the above-captioned common issue related party ("CIRP") group appeals which both involve commonly owned/controlled providers appealing the St. Francis Predicated Facts Operating Understatement issue for calendar year ("CY") 2018. The pertinent facts and the Board's Determination are set forth below.

Pertinent Facts:

On **November 11, 2024**, Quality Reimbursement Services, Inc. ("QRS") filed the "Baptist Health System CY 2018 St. Francis Predicated Facts **DRG** Operating Understatement CIRP Group" under Case No. 25-0688GC. On the same day, QRS filed a second CIRP group for the same hospital chain and CY, titled the "Baptist Health System CY 2018 St. Francis Predicated Facts **DSH** Operating Understatement CIRP Group" under Case No. 25-0689GC. Both groups were formed in the Office of Hearings Case and Document Management System ("OH CDMS") without any participants.

On **November 20, 2024**, Baptist Health System ("Baptist Health") transferred the "St. Francis Predicated Facts **DRG** Operating Understatement" issues from four individual appeals (Case Nos. 23-1221, 23-0741, 23-1007 and 24-0089) to Case No. 25-0688GC. Baptist Health also transferred the "St. Francis Predicated Facts DSH Operating Understatement" issues from the same four individual appeals to Case No. 25-0689GC.[1]

[1] One of the individual appeals, Case No. 24-0089, is for CY 2019. The Board will address these Transfer Requests under separate cover.

On **November 21, 2024**, Baptist Hospital requested transfers of the "St. Francis Predicated Facts **DRG** Operating Understatement" and "St. Francis Predicated Facts DSH Operating Understatement" issues from Case No. 24-0519.[2]

Board Determination:

Pursuant to 42 U.S.C. §1395oo(a) and 42 C.F.R. §§405.1835-405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the contractor's final determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the requires for hearing is filed within 180 days of the date of receipt of the final determination. Further, the Board is bound by the statutes and regulations, including those governing CIRPs, specifically 42 C.F.R. §405.1837(b)(1)(i) which requires that commonly owned or controlled providers file a single group for the same issue occurring in the same year.

Upon review, the Board notes that although Case Nos. 25-0688GC and 25-0689GC have slightly different names (i.e., 25-0688GC is for DRG Operating Understatement and 25-0689GC is for DSH Operating Understatement), the issue statements uploaded in both groups are identical. Both groups, argue that " . . . the 1981 cost reporting data used to calculate the standardized amounts in 1983 erroneously characterized transfers of patients from one hospital to another as "patient discharges," thereby overstating the number of discharges and understating the allowable operating costs per discharge."[3] The groups explain that CMS then applied those determinations when it set the 1983 standardized amounts which impacted all subsequent inpatient prospective payment system ("IPPS") decisions. The IPPS payments were challenged in PRRB appeals which were dismissed in light of a 2013 CMS amendment to reopening regulations. The Board's decision was later challenged in Court and was ultimately rejected by the US District Court of Columbia, which has now reversed the ruling and specifically distinguished reopenings from appeals.[4]

In addition, the issues transferred from the individual appeals included the same description of the issue in both issue statements. Again, although one is titled "DSH Operating Understatement," it is identical to the issue statement uploaded for the "DRG Operating Understatement" issue.

Reviewing the amounts in controversy, the Board has concluded that they are the only thing different between the group issues. The "DSH Operating Understatement" amounts in controversy appears to be a flow through calculation of the DSH payment, if the Providers were to prevail on the underlying "DRG Operating Understatement" issue.

After reviewing the facts in these cases, the Board has determined that the appeal of the CY 2018 "St. Francis Predicated Facts DSH Operating Understatement" issue in Case No. 25-0689GC is

[2] Case No. 24-0519 is also for CY 2019. The Board will address these Transfer Requests under separate cover.
[3] Case Nos. 25-0688GC and 25-0689GC – Issue Statement (Nov. 11, 2024).
[4] *Id.*

duplicative of the issue under the appeal in Case No. 25-0688GC. It is the same legal issue, whether the DRG Operating payment is "understated." The Provider used the EXACT same issue statement for both appeals. The DSH Operating Understatement group is only "different" in that they have a separate DSH calculation. The amounts in controversy can be combined in the DRG Operating Understatement appeal. Consequently, the Board is using its discretion and hereby closes Case No. 25-0689GC as a duplicate of Case No. 25-0688GC. The Provider has 15 days to update the amount in controversy to include both parts of the issue in the surviving appeals for the Providers currently in the group appeal.

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

FOR THE BOARD:

12/11/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Determination on Disbanding Univ of California CY 2007 NAHE Elimination of Pharmacy Residency Program CIRP Group, Case Number: 24-1378GC***

As it relates to the participant:
UCSF Medical Center (Provider Number 05-0454)
FYE: 6/30/2007
Case Number: 18-1300

Dear Ms. Ellis:

The Provider Reimbursement Review Board ("the Board") has reviewed the subject common issue related party ("CIRP") group appeal pursuant to correspondence from Toyon Associates, Inc. ("Toyon") dated November 19, 2024. Toyon's correspondence was filed in reply to an earlier Board Request for Information ("RFI") regarding the question of the suitability of the NAHE Elimination of Pharmacy Residency Program issue for the group appeal format. The pertinent facts for this group and the Board's determination are set forth below.

Pertinent Facts:

On **February 20, 2024**, Toyon filed the "Univ of California CY 2007 NAHE Elimination of Pharmacy Residency Program CIRP Group" under Case No. 24-1378GC, which was formed in the Office of Hearings Case & Document Management System ("OH CDMS") without any providers. On the same date, Toyon requested the transfer of the "Adjustment to Pharmacy Education Expense" ("*NAHE Elimination*") issue for UCSF Medical Center from its individual appeal, Case No. 18-1300.

On **September 16, 2024**, in Case No. 24-0267G, (an optional group appealing the same issue) Toyon requested the expansion of that calendar year ("CY") 2018 group to include CY 2017. Toyon argued that the expansion of the group would allow another provider, White Memorial Medical Center (Prov. No. 05-0103), to transfer its "Disallowance of Clinical Pastoral Education (CPE) Costs" issue for FYE 12/31/2017 to the group.

On **September 20, 2024**, the Board denied Toyon's request for expansion of Case No. 24-0267G to include CY 2017 because it found that the issues in the individual appeal and the group case

involved two different programs and the facts and circumstances surrounding each program were likely to be different.

In that determination, the Board also posed a question regarding the suitability of the NAHE Elimination of Pharmacy Residency Program issue for the group format. The Board noted that the issue seems to be factually specific to each provider since each program may be operated differently and, therefore, could result in differing determinations being rendered by the Board. Therefore, the Board required Toyon to review its pending appeals for the NAHE Elimination of Pharmacy issue and to submit comments in support of why it should remain in the group format or, alternatively, confirm that its groups on this issue should be disbanded.

On **November 19, 2024**, Toyon responded to the Board's request indicating that when the groups were formed, it believed that the various group providers were ". . . connected by a common question of law (as required by 42 C.F.R. § 405.1837). . . ".[1] However, Toyon acknowledged that, in the event the Board did not agree with that reasoning, it would concede to the Board's proposal to disband its NAHE groups. In the case of the subject CIRP group's disbandment, Toyon requested that the Board transfer the issue back to the pending individual appeal.[2]

Board Determination:

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

With respect to issues suitable for group format, the Board relies on 42 C.F.R. § 405.1837(b), which specifies that two or more providers may file a group for ". . . 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." This is further reflected in Board Rule 12.2, which states, "[t]he matter at issue in the group appeal must involve a single question of fact or interpretation of law, regulation, or CMS Rulings that is common to each provider in the group."

After review of Toyon's response, the Board finds that the NAHE Elimination issue appears to be provider specific as the facts could vary from Provider to Provider, in terms of which schools are participating in the program, the operator of the program and the history of the program, and the handling on the specific cost report.[3] Based on this finding, there does not appear to be a single common issue and therefore, the Board is taking the following actions:

1. Transferring the "Adjustment to Pharmacy Education Expense" issue back to UCSF

[1] NAHE Elimination of Pharmacy Residency Group Appeals (Nov. 19, 2024).
[2] *Id.*
[3] Toyon's response to the Board's RFI referenced eleven groups, including the group discussed herein. Due to the varying fact patterns for group participants in each case, the Board will address each group under separate cover.

Medical Center's individual appeal, Case No. 18-1300. This issue was not addressed in the Parties' final position papers which were previously filed in May of 2024. A request for a supplemental final position paper covering the Adjustment to Pharmacy Education Expense issue will be sent under separate cover. The hearing date remains scheduled for July 31, 2025.

2. As there are no remaining providers in Case No. 24-1378GC, the case is being closed and removed from the Board's docket.

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

For the Board:

12/12/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Lorraine Frewert, Noridian Healthcare c/o. Cahaba Safeguard Adm. (J-E)
Mridula Bhatnagar, Toyon Associates (Rep of Case 18-1300)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Baltimore, MD 21244 1850
410-786-2671

Via Electronic Delivery

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

RE: ***Board Determination on Disbanding Univ of California CY 2008 NAHE Elimination of Pharmacy Residency Program CIRP Group, Case Number: 24-1380GC***

As it relates to the participant:
UCSF Medical Center (Provider Number 05-0454)
FYE: 6/30/2008
Case Number: 18-1357

Dear Ms. Ellis:

The Provider Reimbursement Review Board ("the Board") has reviewed the subject common issue related party ("CIRP") group appeal pursuant to correspondence from Toyon Associates, Inc. ("Toyon") dated November 19, 2024. Toyon's correspondence was filed in reply to an earlier Board Request for Information ("RFI") regarding the question of the suitability of the NAHE Elimination of Pharmacy Residency Program issue for the group appeal format. The pertinent facts for this group and the Board's determination are set forth below.

Pertinent Facts:

On **February 20, 2024**, Toyon filed the "Univ of California CY 2008 NAHE Elimination of Pharmacy Residency Program CIRP Group" under Case No. 24-1380GC, which was formed in the Office of Hearings Case & Document Management System ("OH CDMS") without any providers. On the same date, Toyon requested the transfer of the "Adjustment to Pharmacy Education Expense" ("*NAHE Elimination*") issue for UCSF Medical Center from its individual appeal, Case No. 18-1357.

On **September 16, 2024**, in Case No. 24-0267G, (an optional group appealing the same issue) Toyon requested the expansion of that calendar year ("CY") 2018 group to include CY 2017. Toyon argued that the expansion of the group would allow another provider, White Memorial Medical Center (Prov. No. 05-0103), to transfer its "Disallowance of Clinical Pastoral Education (CPE) Costs" issue for FYE 12/31/2017 to the group.

On **September 20, 2024**, the Board denied Toyon's request for expansion of Case No. 24-0267G to include CY 2017 because it found that the issues in the individual appeal and the group case

involved two different programs and the facts and circumstances surrounding each program were likely to be different.

In that determination, the Board also posed a question regarding the suitability of the NAHE Elimination of Pharmacy Residency Program issue for the group format. The Board noted that the issue seems to be factually specific to each provider since each program may be operated differently and, therefore, could result in differing determinations being rendered by the Board. Therefore, the Board required Toyon to review its pending appeals for the NAHE Elimination of Pharmacy issue and to submit comments in support of why it should remain in the group format or, alternatively, confirm that its groups on this issue should be disbanded.

On **November 19, 2024**, Toyon responded to the Board's request indicating that when the groups were formed, it believed that the various group providers were ". . . connected by a common question of law (as required by 42 C.F.R. § 405.1837). . . ".[1] However, Toyon acknowledged that, in the event the Board did not agree with that reasoning, it would concede to the Board's proposal to disband its NAHE groups. In the case of the subject CIRP group's disbandment, Toyon requested that the Board transfer the issue back to the pending individual appeal.[2]

Board Determination:

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

With respect to issues suitable for group format, the Board relies on 42 C.F.R. § 405.1837(b), which specifies that two or more providers may file a group for ". . . 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." This is further reflected in Board Rule 12.2, which states, "[t]he matter at issue in the group appeal must involve a single question of fact or interpretation of law, regulation, or CMS Rulings that is common to each provider in the group."

After review of Toyon's response, the Board finds that the NAHE Elimination issue appears to be provider specific as the facts could vary from Provider to Provider, in terms of which schools are participating in the program, the operator of the program and the history of the program, and the handling on the specific cost report.[3] Based on this finding, there does not appear to be a single common issue and therefore, the Board is taking the following actions:

1. Transferring the "Adjustment to Pharmacy Education Expense" issue back to UCSF

[1] NAHE Elimination of Pharmacy Residency Group Appeals (Nov. 19, 2024).
[2] *Id.*
[3] Toyon's response to the Board's RFI referenced eleven groups, including the group discussed herein. Due to the varying fact patterns for group participants in each case, the Board will address each group under separate cover.

Medical Center's individual appeal, Case No. 18-1357. This issue was not addressed in the Parties' final position papers which were previously filed in May of 2024. A request for a supplemental final position paper covering the Adjustment to Pharmacy Education Expense issue will be sent under separate cover. The hearing date remains scheduled for July 31, 2025.

2. As there are no remaining providers in Case No. 24-1380GC, the case is being closed and removed from the Board's docket.

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

For the Board:

12/12/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Lorraine Frewert, Noridian Healthcare c/o. Cahaba Safeguard Adm. (J-E)
Mridula Bhatnagar, Toyon Associates (Rep of Case 18-1357)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Determination on Disbanding Univ of California CY 2009 NAHE Elimination of Pharmacy Residency Program CIRP Group, Case Number: 24-1381GC***

As it relates to the participant:
UCSF Medical Center (Provider Number 05-0454)
FYE: 6/30/2009
Case Number: 18-1360

Dear Ms. Ellis:

The Provider Reimbursement Review Board ("the Board") has reviewed the subject common issue related party ("CIRP") group appeal pursuant to correspondence from Toyon Associates, Inc. ("Toyon") dated November 19, 2024. Toyon's correspondence was filed in reply to an earlier Board Request for Information ("RFI") regarding the question of the suitability of the NAHE Elimination of Pharmacy Residency Program issue for the group appeal format. The pertinent facts for this group and the Board's determination are set forth below.

Pertinent Facts:

On **February 20, 2024**, Toyon filed the "Univ of California CY 2009 NAHE Elimination of Pharmacy Residency Program CIRP Group" under Case No. 24-1381GC, which was formed in the Office of Hearings Case & Document Management System ("OH CDMS") without any providers. On the same date, Toyon requested the transfer of the "Adjustments to Pharmacy Education Expense" ("*NAHE Elimination*") issue for UCSF Medical Center from its individual appeal, Case No. 18-1360.

On **September 16, 2024**, in Case No. 24-0267G, (an optional group appealing the same issue) Toyon requested the expansion of that calendar year ("CY") 2018 group to include CY 2017. Toyon argued that the expansion of the group would allow another provider, White Memorial Medical Center (Prov. No. 05-0103), to transfer its "Disallowance of Clinical Pastoral Education (CPE) Costs" issue for FYE 12/31/2017 to the group.

On **September 20, 2024**, the Board denied Toyon's request for expansion of Case No. 24-0267G to include CY 2017 because it found that the issues in the individual appeal and the group case

involved two different programs and the facts and circumstances surrounding each program were likely to be different.

In that determination, the Board also posed a question regarding the suitability of the NAHE Elimination of Pharmacy Residency Program issue for the group format. The Board noted that the issue seems to be factually specific to each provider since each program may be operated differently and, therefore, could result in differing determinations being rendered by the Board. Therefore, the Board required Toyon to review its pending appeals for the NAHE Elimination of Pharmacy issue and to submit comments in support of why it should remain in the group format or, alternatively, confirm that its groups on this issue should be disbanded.

On **November 19, 2024**, Toyon responded to the Board's request indicating that when the groups were formed, it believed that the various group providers were ". . . connected by a common question of law (as required by 42 C.F.R. § 405.1837). . . ".[1] However, Toyon acknowledged that, in the event the Board did not agree with that reasoning, it would concede to the Board's proposal to disband its NAHE groups. In the case of the subject CIRP group's disbandment, Toyon requested that the Board transfer the issue back to the pending individual appeal.[2]

Board Determination:

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

With respect to issues suitable for group format, the Board relies on 42 C.F.R. § 405.1837(b), which specifies that two or more providers may file a group for ". . . 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." This is further reflected in Board Rule 12.2, which states, "[t]he matter at issue in the group appeal must involve a single question of fact or interpretation of law, regulation, or CMS Rulings that is common to each provider in the group."

After review of Toyon's response, the Board finds that the NAHE Elimination issue appears to be provider specific as the facts could vary from Provider to Provider, in terms of which schools are participating in the program, the operator of the program and the history of the program, and the handling on the specific cost report.[3] Based on this finding, there does not appear to be a single common issue and therefore, the Board is taking the following actions:

1. Transferring the "Adjustments to Pharmacy Education Expense" issue back to UCSF

[1] NAHE Elimination of Pharmacy Residency Group Appeals (Nov. 19, 2024).
[2] *Id.*
[3] Toyon's response to the Board's RFI referenced eleven groups, including the group discussed herein. Due to the varying fact patterns for group participants in each case, the Board will address each group under separate cover.

Medical Center's individual appeal, Case No. 18-1360. This issue was not addressed in the Parties' final position papers which were previously filed in May of 2024. A request for a supplemental final position paper covering the Adjustments to Pharmacy Education Expense issue will be sent under separate cover. The hearing date remains scheduled for July 31, 2025.

2. As there are no remaining providers in Case No. 24-1381GC, the case is being closed and removed from the Board's docket.

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

For the Board:

12/12/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Lorraine Frewert, Noridian Healthcare c/o. Cahaba Safeguard Adm. (J-E)
Mridula Bhatnagar, Toyon Associates (Rep of Case 18-1360)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Decision – Untimely Direct Add***
25-0966G QRS CY 2006 Part C Days Retroactive Final Rule Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the "Board") has reviewed the above-captioned optional group and finds an impediment to jurisdiction. The pertinent facts and the Board's determination are set forth below.

Background:

On **December 3, 2024**, Quality Reimbursement Services, Inc. ("QRS"/"Representative") filed the "QRS CY 2006 Part C Days Retroactive Final Rule Group" under Case No. 25-0966G. The group, which is not yet fully formed, was established in the Office of Hearings Case and Document Management System ("OH CDMS") without any participants.

On **December 4, 2024**, QRS added a provider to the group: John Dempsey Hospital ("JDH"/Prov. No. 07-0036). JDH was directly added to the group from a Revised Notice of Program Reimbursement ("RNPR") issued on **May 14, 2024.**

The "Direct Add" request for JDH was received ***204 days after*** issuance of the RNPR.

Board Determination:

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

JDH Untimely Direct Add:

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

case of JDH as a participant in this group, the Medicare Contractor issued the RNPR on May 14, 2024. The 185th day to file an appeal fell on Friday, November 15, 2024. The Direct Add for JDH was not filed in OH CDMS until Wednesday, December 4, 2024, which was 204 days after the issuance of the final determination.[1]

Therefore, the Board finds that the direct add of JDH to Case No. 25-0966G does not meet the regulatory filing requirements and hereby dismisses JDH from the group.

Optional Group Requirements:

Pursuant to 42 C.F.R. § 405.1837(b):

> (2) Optional group appeals. (i) Two or more providers not under common ownership or control may bring a group appeal before the Board under this section, if the providers 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. Alternatively, any provider may appeal to the Board any issues in a single provider appeal brought under §405.1835 of this subpart.

With regard to establishing a group in the Office of Hearings Case & Document Management System ("OH CDMS"), the commentary under Board Rule 12.1 (Dec. 2023) indicates:

> [I]f a group is to be formed solely through transfers, it may initially be established in OH CDMS with no participating providers. In such cases, the providers must be transferred i***mmediately*** following the establishment of the group case in order to fulfill the regulatory requirement for the minimum number of providers per Rule 12.6. The Board will close all group cases that do not meet the minimum participant requirements.[2]

Board Rule 12.6.2, goes on to state that, "[o]ptional group appeals must have a minimum of two different providers, both at inception and at full formation of the group."

The Board finds that the subject group appeal, Case No. 25-0966G, is an optional group that was formed with only a single provider (*and that provider was, in fact, untimely filed*). Therefore, the group was not filed in compliance with Board Rules or the regulations. Accordingly, the Board hereby dismisses Case No. 25-0966G and removes it from the docket.

[1] There was no allegation of good cause filed with JDH's direct add filing.
[2] Board Rules v, 3.1 (Nov. 1, 2021)

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

For the Board:

12/13/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Danelle Decker, National Government Services (J-K)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Affinity Medical Center, Prov. No 36-0151, FYE 06/30/2010
Case No. 19-2282

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-2282. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") payment for SSI Percentage (Provider Specific).

Background

A. *Procedural History for Case No. 19-2282*

On **January 16, 2019,** the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2010. The Provider is commonly owned by Quorum Health ("Quorum").

On **January 23, 2019,** Quorum filed the Provider's individual appeal request. The initial Individual Appeal Request contained three (3) issues:

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

As the Provider is commonly owned/controlled by Quorum, 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 **February 25, 2020**, the Provider transferred Issue 2 to PRRB Case No. 20-1002GC.

[1] On February 25, 2020, this issue was transferred to Case No. 20-1002GC. Case No. 20-1002GC was closed on July 16, 2021, as the sole participant in the group, Affinity Medical Center, was transferred to Case No. 19-1503GC, Quorum CY 2010 & CY 2016 DSH SSI Percentage CIRP Group.
[2] On November 7, 2024, this issue was withdrawn by the Provider.

On **July 24, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

On **March 16, 2020**, the Provider timely filed its preliminary position paper.

On **June 10, 2020,** the Medicare Contractor filed a Jurisdictional Challenge, requesting dismissal of Issue 1.

On **June 19, 2020,** the Medicare Contractor timely filed its preliminary position paper.

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

On **September 18, 2024**, the Provider timely filed its final position paper.

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

On **October 22, 2024,** the Medicare Contractor filed a Jurisdictional Challenge, requesting dismissal of Issues 1 and 3. Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Jurisdictional Challenge. However, the Provider ***failed*** to timely respond to the Jurisdictional Challenge.

On **November 7, 2024**, the Provider withdrew Issue 3 – DSH – Medicaid Eligible Days from the appeal.

As a result of the case transfer and withdrawn issue, there is one remaining issue in this appeal: Issue 1 - DSH Payment/SSI Percentage (Provider Specific).

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-1503GC - Quorum CY 2010 & CY 2016 DSH SSI Percentage CIRP Group

[3] (Emphasis added.)

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).[4]

The Provider initially transferred the SSI Systemic Errors issue to Case No. 20-1002GC, and then was subsequently transferred to Case No. 19-1503GC, as it was the only participant in Case No. 20-1002GC. The Group issue Statement in Case No. 19-1503GC, in which the Provider is now a participant, 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

[4] Issue Statement at 1 (July 18, 2019).

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 September 18, 2024, the Board received the Provider's final position paper in 19-2282. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

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

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $25,000.

---

[5] Group Appeal Issue Statement in Case No. 19-1503GC.
[6] Provider's Preliminary Position Paper at 11-12 (May 4, 2020).

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2. The portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[7]

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

Decision of the Board

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

As set forth below, the Board hereby ***dismisses*** the Provider's (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*

[7] Medicare Contractor's Jurisdictional Challenge at 2 (Dec. 8, 2023)
[8] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

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. 19-1503GC.

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."[9] 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)."[10] 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."[11]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 19-1503GC 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. 19-2282 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-1002GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[12], 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.[13] 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 Final Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 19-1503GC, 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 Board Rule 25 (Dec. 2024) governing the content

[9] Issue Statement at 1.
[10] *Id.*
[11] *Id.*
[12] PRRB Rules v. 3.2 (Dec. 2023).
[13] 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).

of position papers. As explained in the Commentary to Rule 23.3 (Dec. 2024), 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 (Dec. 2024)**
>
> If documents necessary to support your position are still unavailable, the provider the following information in the position papers:
>
> 1. *Identify* the missing documents;
> 2. *Explain why* the documents remain unavailable;
> 3. S*tate 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.[14]

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

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

[14] (Italics and underline emphasis added.)
[15] Last accessed Dec. 11, 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."[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. 20-1002GC.

Accordingly, *based on the record before it*,[17] the Board finds that the SSI Provider Specific issue in Case No. 19-2282 and the group issue from the CHS CIRP group under Case No. 20-1002GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

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

* * * * *

Based on the foregoing, the Board has dismissed the remaining issue in this case Issue 1: DSH SSI Percentage (Provider Specific). As no issues remain, the Board hereby closes Case No. 19-2282 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.

[16] (Emphasis added).
[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.

Board Members Participating:

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

For the Board:

12/13/2024

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

cc: Judith Cummings, CGS Administrators (J-15)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
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410-786-2671

Via Electronic Delivery

Ms. Patricia Ruffier, CEO
Hillside Home Management, LLC d/b/a
1st Choice Home Health
10662 Vista Del Sol Dr.
El Paso, TX 79935-4520

Ms. Dana Johnson
Lead Auditor
National Government Services, Inc.
P.O. Box 6474
Mailpoint INA101-AF-42
Indianapolis, IN 46206-6474

RE: **Board Determination re: Controversy Amount Threshold**
Hillside Home Management, LLC d/b/a 1st Choice Home Health (74-1606)
Appealed Period: FFY 2023
PRRB Case No.: 25-0955

Dear Ms. Ruffier and Ms. Johnson:

The above-captioned appeal was filed with the Provider Reimbursement Review Board ("Board") via the Office of Hearings Case and Document Management System ("OH CDMS"). After review of the facts outlined below, the Board has determined that the subject appeal was not filed in accordance with the Board Rules. The Board's review and determination is set forth below.

BACKGROUND:

On **December 2, 2024**, the Provider filed an appeal for the Federal Fiscal Year ("FFY") 2023 based on the Notice of Effect of Inpatient Day Limitation Hospice Cap Amount dated October 31, 2024. The Provider stated that the amount in controversy for the subject appeal was $7,134.

BOARD DECISION:

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

More specifically, 42 C.F.R. § 405.1839 **Amount in Controversy** provides:

> **(a)** ***Single provider appeals.***
> **(1)** In order to satisfy the amount in controversy requirement under § 405.1811(a)(2) or § 405.1811(c)(3) for a contractor

> hearing or the amount in controversy requirement under § 405.1835(a)(2) or § 405.1835(c)(3) for a Board hearing for a single provider, the provider must demonstrate that if its appeal were successful, the provider's total program reimbursement for each cost reporting period under appeal would increase by at least $1,000 but by less than $10,000 for a contractor hearing, or by at least $10,000 for a Board hearing, as applicable

Similarly, Board Rule 6.4 (Dec. 2023), Amount in Controversy, states:

> *An individual appeal request must have a total amount in controversy of at least $10,000 at the time of filing*. See 42 C.F.R. §§ 405.1835 and 405.1839. A calculation of the amount in controversy with supporting documentation must be provided for ***each*** issue.[1]

The Board notes this appeal has only one issue, and that the Provider has stated that the amount in controversy for that one issue as $7,134, as supported by the Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount, which identified the total amount due to the Medicare program as $7,134. As a result, the Board finds that subject appeal does not meet the controversy amount threshold of $10,000 at the time of the initial filing. Therefore, the Board hereby dismisses case number 25-0955 and removes it from its docket.

However, please note that pursuant to 42 C.F.R. § 405.1839(a)(1), the Provider may have rights to a Medicare contractor hearing provided it meets the applicable filing requirements for that hearing.

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

Board Members:

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

FOR THE BOARD:

12/17/2024

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

cc: Wilson C. Leong, Federal Specialized Services

[1] Italics and underlined emphasis added; bold emphasis in original.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Mail Stop: B1-01-31
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410-786-2671

Via Electronic Delivery

Nicholas Putnam
Strategic Reimbursement Group, LLC
360 W Butterfield Rd. Suite 310
Elmhurst, IL 60126

RE: ***Notice of Dismissal***
Covenant Health System, Prov. No. 45-0040, FYE 06/30/2012
Case No. 18-1654

Dear Mr. Putnam:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 18-1654. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for Unmatched Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 18-1654*

On **February 28, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2012.

On **August 27, 2018**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained two (2) issues:

1. Entitlement of Full DRG Payment for Transfer Cases[1]
2. Federal DRG Prospective Payment Understatement[2]

On **September 13, 2018**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim,

[1] On April 19, 2019, the Provider transferred this issue to PRRB Case No. 19-1745GC
[2] On April 19, 2019, the Provider transferred this issue to PRRB Case No. 19-1744GC. On August 1, 2023, the Provider withdrew this issue.

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

On **October 25, 2018**, the Provider added five issues including the Unmatched Medicaid Eligible Days issue.[4]

On **June 12, 2019**, the Board closed the case as no issues remained pending. On **September 24, 2020**, the case was reopened due to improper transfers of 3 issues, including the Unmatched Medicaid Eligible days issue. Shortly thereafter, the other two issues were withdrawn, and Unmatched Eligible Days was the sole issue remaining in the appeal.

On **August 1, 2023**, the Provider filed its Preliminary Position Paper, and the Medicare Contractor filed its Preliminary Position Paper on **November 30, 2023**.

On **September 24, 2024**, the Provider submitted its Final Position Paper, and the Medicare Contractor filed its Final Position Paper on **October 22, 2024**.

On **October 17, 2024**, the Medicare Contractor filed a Jurisdictional Challenge over the remaining issue, DSH- Unmatched Medicaid Eligible Days. The Provider had until November 18, 2024, to file a Jurisdictional Response. To date, the Provider has failed to file a Jurisdictional Response.

MAC's Contentions

Issue 7- DSH- Unmatched Medicaid Eligible Days

The MAC contends the Provider failed to file a complete preliminary and final position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rules 25 and 27. The Provider 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. Accordingly, the Provider has essentially abandoned the DSH- Medicaid Eligible Days Issue.

The Provider filed its preliminary position paper on August 1, 2023. The Provider's position states, "while the providers implement diligent and adequate efforts to identify their population of Medicaid recipients, a portion of the providers' eligible Medicaid recipients often go unverified or unmatched prior to the conclusion of audit. The unverified population at the

[3] (Emphasis added.)
[4] On April 19, 2019, the Provider transferred this issue to PRRB Case No. 19-1740GC. Reopened on September 24, 2020.

conclusion of audit is at dispute in this appeal."[5] However, the Provider failed to submit a list of additional Medicaid days and all supporting documentation or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable within their preliminary or final position paper, in accordance with Board Rule 25.2.2 and 27. The final paper excludes any list of additional eligible days under dispute, or any explanation as to why they were not submitted. Additionally, the Provider's "Exhibit P-4 does not include a list of eligible days nor does the paper indicate that the information will be forthcoming."[6]

Therefore, the MAC respectfully requests that the Board dismiss this issue for the reasons stated above.

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.[7] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. As previously noted, Board Rule 44.4.3 which 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, the Provider's response to the Motion to Dismiss was due within 30 days but the Provider failed to timely file a response. In this regard, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Decision of the Board

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

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

A. DSH Payment – Unmatched Medicaid Eligible Days

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

[5] Medicare Contractor's Jurisdictional Challenge at 2.
[6] Id at 3

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:

> **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.[8]

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

Board Rule 25 pertains to position papers requiring the content to be fully developed on the party's position and to provide all available supporting exhibits:

[8] (Bold emphasis added.)

Rule 25 Preliminary Position Papers[9]

> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will issue a notice setting deadlines for the first position paper generally at eight months after filing the appeal request for the provider, and twelve months for the Medicare contractor. Even though it will not be addressed in the Board's notice, the provider may file an optional response no later than ninety days following the due date for the Medicare contractor's preliminary position paper. Therefore, the Board requires preliminary position papers to present the ***fully*** developed positions of the parties and expects that parties will be diligent in planning and conducting any required investigation, discovery, and analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the 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

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

> 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 Board's September 13, 2018 Notice of Critical Due Dates issued in this case gave instruction on the content of the group's preliminary position paper (as quoted above) consistent with the 42 C.F.R. § 405.1853(b)(2) and Board Rule 25 and referenced Board Rule 25.

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)(iv) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[10]

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,
- 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.

Similarly, the regulations at 42 C.F.R. § 405.1868 state the following:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.
>
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may-
>
> (1) Dismiss the appeal with prejudice;
>
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or

[10] (Emphasis added.)

(3) Take any other remedial action it considers appropriate.

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. As the Provider failed to timely include a list of additional Medicaid eligible days with its preliminary and final position paper. 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.[11]

Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Jurisdictional Challenge. However, the Provider ***failed to*** timely respond to that Motion by the November 18, 2024, filing deadline (*i.e.*, 30 days after October 17, 2024).

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 Unmatched 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).

Finally, pursuant to 42 C.F.R. § 412.106(b)(iv), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[12] 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.[13] As the Provider failed to identify even a single Unmatched Medicaid eligible day as being in dispute as part of the position paper filing, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0. For these reasons, the Board finds the group issue abandoned and dismisses the group appeal.

Conclusion:

The Board dismisses Issue 7, the DSH Unmatched Medicaid Eligible Days issue, in its entirety from this appeal. As there are no remaining issues on appeal, the case is closed and removed from the Board's docket.

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[11] *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.

[12] (Emphasis added.)

[13] The Board's finding that the position paper failed to meet the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in Evangelical Community Hospital v. Becerra, No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

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

Board Members Participating:

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

For the Board:

12/18/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Micheal Redmond, Novitas Solutions, Inc (J-H)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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

RE: ***Board Determination on Disbanding Dignity Health CY 2018 NAHE Elimination of Pharmacy Residency Program CIRP Group, Case Number: 24-1373GC***

As it relates to participants:

Provider Name	***Provider Number***	***FYE***	***Case #***	***Indiv. Appeal Status***
Mercy Medical Center Redding	*05-0280*	*6/30/2018*	*22-0433*	*Closed 2/21/2024*
Mercy San Juan Medical Center	*05-0516*	*6/30/2018*	*23-0298*	*Open*
Mercy General Hospital	*05-0017*	*6/30/2018*	*22-1194*	*Open*
St. Joseph's Medical Center of Stockton	*05-0084*	*6/30/2018*	*22-0606*	*Closed 8/5/2024*
St. Joseph's Hospital & Medical Center	*03-0024*	*6/30/2018*	*23-0061*	*Closed 2/21/2024*

Dear Ms. Ellis:

The Provider Reimbursement Review Board ("the Board") has reviewed the subject common issue related party ("CIRP") group appeal pursuant to correspondence from Toyon Associates, Inc. ("Toyon") dated November 19, 2024. Toyon's correspondence was filed in reply to an earlier Board Request for Information ("RFI") regarding the question of the suitability of the NAHE Elimination of Pharmacy Residency Program ("NAHE Elimination") issue for the group appeal format. The pertinent facts for this group and the Board's determination are set forth below.

Pertinent Facts:

On **February 20, 2024**, Toyon filed the "Dignity Health CY 2018 NAHE Elimination of Pharmacy Residency Program CIRP Group" under Case No. 24-1373GC, which was formed in the Office of Hearings Case & Document Management System ("OH CDMS") without any providers.

On the same date, Toyon requested the transfer of the following NAHE Elimination issues to the group:

Issue description in Ind. Appeal	Provider	From Case No.
Nursing and Allied Health Removal of Program Costs (#7)	Mercy Medical Center Redding	22-0433[1]
Adj Remove NAHE cost on provider operated pharmacy residency (#8)	Mercy San Juan Medical Center	23-0298
Adj remove NAHE cost on provider operated pharmacy residency (#8)	Mercy General Hospital	22-1194
Nursing and Allied Health-Removal of Program Costs (#9)	St Joseph's Medical Center	22-0606[2]
Nursing and Allied Health- Removal of Program Costs (#6)	St. Joseph's Hospital & Medical Center	23-0061[3]

On **September 16, 2024**, in Case No. 24-0267G, (an optional Toyon group appealing the same issue) Toyon requested the expansion of the calendar year ("CY") 2018 group to include CY 2017. Toyon argued that the expansion of the group would allow another provider, White Memorial Medical Center (Prov. No. 05-0103), to transfer its "Disallowance of Clinical Pastoral Education (CPE) Costs" issue for FYE 12/31/2017 to the group.

On **September 20, 2024**, the Board denied Toyon's request for expansion of Case No. 24-0267G to include CY 2017 because it found that the issues in the individual appeal and the group case involved two different programs and the facts and circumstances surrounding each program were likely to be different.

In that determination, the Board also posed a question regarding the suitability of the NAHE Elimination issue for the group format. The Board noted that the issue seems to be factually specific to each provider since each program may be operated differently and, therefore, could result in differing determinations being rendered by the Board. Therefore, the Board required Toyon to review its pending appeals for the NAHE Elimination issue and to submit comments in support of why it should remain in the group format or, alternatively, confirm that its groups on this issue should be disbanded.

On **November 19, 2024**, Toyon responded to the Board's request indicating that when the NAHE Elimination groups were formed, it believed that the various group providers were ". . . connected by a common question of law (as required by 42 C.F.R. § 405.1837). . . ".[4] However, Toyon acknowledged that, in the event the Board did not agree with that reasoning, it would concede to the Board's proposal to disband its NAHE groups. In the case of the subject CIRP group's disbandment, Toyon requested that the Board transfer the issue back to the Providers' open individual appeals and create new individual appeals for the Providers with closed cases.[5]

[1] After the transfer of the last issue, Case No. 22-0433 was closed on 2/21/2024.
[2] After the transfer of the NAHE Elimination issue, the only other issues in Case No. 22-0606 were withdrawn. The case was closed on August 5, 2024.
[3] After the transfer of the last issue, Case No. 23-0061 was closed on 2/21/2024.
[4] NAHE Elimination of Pharmacy Residency Group Appeals (Nov. 19, 2024).
[5] *Id.*

Board Determination:

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

With respect to issues suitable for group format, the Board relies on 42 C.F.R. § 405.1837(b), which specifies that two or more providers may file a group for ". . . 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." This is further reflected in Board Rule 12.2, which states, "[t]he matter at issue in the group appeal must involve a single question of fact or interpretation of law, regulation, or CMS Rulings that is common to each provider in the group."

After review of Toyon's response, the Board finds that the NAHE Elimination issue appears to be provider specific as the facts could vary from Provider to Provider, in terms of which schools are participating in the program, the operator of the program and the history of the program, and the handling on the specific cost report.[6] Based on this finding, there does not appear to be a single common issue and therefore, the Board is taking the following actions:

1. Transferring the NAHE Elimination issues from Case No. 24-1373GC back to the pending individual appeals, Case Nos. 22-1194 and 23-0298. Rather than create new individual appeals, the Board is electing to reinstate the earlier appeals for Mercy Medical Center Redding (Case No. 22-0433), St. Joseph's Hospital & Medical Center (Case No. 23-0061) and St. Joseph's Medical Center of Stockton (Case No. 22-0606).[7]
2. As there are no remaining providers in Case No. 24-1373GC, the case is being closed and removed from the Board's docket.

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

For the Board:

12/18/2024

X Kevin D. Smith, CPA

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

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

[6] Toyon's response to the Board's RFI referenced eleven groups, including the group discussed herein. Due to the varying fact patterns for group participants in each case, the Board will address each group under separate cover.
[7] The Board notes that the preliminary position papers filed in all five individual appeals briefed the NAHE Elimination issue. Therefore, there is no need to request supplemental briefs. Case No. 22-1194 remains scheduled for a hearing on August 6, 2025; the remaining individual cases are not yet scheduled for hearings.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Daniel Hettich
King & Spalding, LLP
1700 Pennsylvania Ave NW, Suite 900
Washington, DC 20006

RE: ***Request for Hearing on the Record***
GHS Greenville Memorial Hospital (Provider Number: 42-0078)
FYE: 9/30/2012
Case Number: 19-0743

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") is in receipt of your letter dated December 9, 2024 requesting a hearing on the record for the above-captioned appeal to Board Rule 32.4.

The issue in the case is as follows:

> whether the [Medicare Contractor] acted outside its authority when it disallowed $867,448 in bad debt associated with patients who were determined to be indigent under the Provider's financial assistance policy, consisting of $498,883 in inpatient bad debt and $368,565 in outpatient bad debt.[1]

The parties have filed stipulations and agreed that a record hearing would be appropriate as "the objects of controversy in this appeal [are limited] to questions of law and very limited (if any) fact disputes."[2]

The Board looks to Board Rule 32.4 Record Hearing which states the following in part:

> In cases involving only legal interpretation or very limited fact disputes, and where both parties agree that the case is appropriate for a record hearing, the Board may approve the parties' request to submit their case only on the existing written record. Generally, record hearings are inappropriate when material facts are in dispute and/or the credibility of witnesses may be at issue. After approving the request, if the Board concludes that a case is not

[1] Unopposed Request for Hearing on Record at 1 (Dec. 9, 2024).
[2] *Id*.

> suitable for record hearing, the Board will reset the case for an in-person, video, or telephonic hearing.
>
> To be approved for a record hearing, the record must be substantially complete and well organized. Position papers must be filed by both parties and clearly reference specific evidence on which the parties rely, including the exhibit number and page. The Board will generally deny the parties' request for a record hearing if stipulations regarding all undisputed facts and principles of law are not submitted with the parties' request.

After review, the Board ***denies*** the Provider's request for a hearing on the record, as the request does not comply with Board Rule 32.4. The Board finds that the request is deficient in two aspects. First, the submitted joint stipulations are not fully descriptive. Second, after reviewing the parties' submissions, the Board has determined that issues remain that could elicit Board questions or need clarification. For instance, the stipulations do not readily show how many bad debts were reviewed/are under dispute, if those bad debts reviewed were all disallowed for only one reason (the use of the Transunion review), if other discrepancies were resolved, etc. Further review of the record indicates that there seem to be differences in data that may or may not have been verified. The Board finds it likely that it would have questions which it would not be able to have answered in a record hearing.

The Board will proceed with preparations for a live, in-person hearing currently scheduled for January 15, 2025 at 9 A.M. Should the parties require additional time for preparation or wish to request a Zoom hearing, please confer and file a joint request through the OH CDMS system as soon as possible. If the parties require a pre-hearing conference or have additional questions, please contact the Board Advisor, Derek R. Moscati, at derek.moscati1@cms.hhs.gov.

Board Members Participating:

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

FOR THE BOARD

12/18/2024

X Kevin D. Smith, CPA

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

cc: Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

David Cohan & James Ravindran
Quality Reimbursement Services, Inc.
150 North Santa Anita Avenue
Suite 570A
Arcadia, CA 91006

RE: ***EJR Decision***
Case Nos. 11-0626GC *et al.*, QRS CHW and Dignity Health Crossover Bad Debt CIRP Groups (13 cases, *see* Appendix A)

Dear Messrs. Cohan & Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the pending requests for expedited judicial review ("EJR") and the Providers' responses to the Board's October 15, 2024 Request for Information and Show Cause Order in the above-referenced common interest related party ("CIRP") group appeals. The decision to ***deny*** the requests for EJR and ***dismiss*** the cases is set forth below.

Background:

The issue statements for each group are materially similar and state:

> **Description of the Issue**
>
> Whether First Coast Service Options, Inc. ("Medicare Audit Contractor") properly determined the Provider's Medicare Reimbursement for all allowable Inpatient and Outpatient crossover bad debts.
>
> **Statement of the Legal Basis**
>
> The Providers contend that the MAC did not determine Medicare reimbursement for allowable bad debts in accordance with the Statutory instruction at 42 U.S.C. §1395x(v). Specifically, the Providers disagree with the MAC's instruction that it could not claim bad debts for all indigent/crossover Inpatients and Outpatients unless those crossover patients were billed to the Medicaid program.
>
> The Providers contend that the MAC advised that the Providers could only claim these crossover bad debts if they could show proof in the form of a denial on a remittance advice. The Providers contend that this is

> inconsistent with the Regulations and Instructions per 42 C.F.R. § 413.80 and the Provider Reimbursement Manual ("PRM"), Part 1, § 308.[1]

The Providers in each group filed a Request for EJR on **September 16 or 20, 2024**. The Providers' Request for EJR notes that the regulations governing bad debts at 42 C.F.R. § 413.89 were amended in the FY 2021 IPPS Final Rule to codify CMS' policy related to crossover bad debts involving dual eligible beneficiaries, and that the regulations apply retroactively.[2] They seek to challenge §§ 413.89(e)(2)(iii)(A)(2) and (3) as "arbitrary and capricious and otherwise contrary to law." They note that section (e)(2)(iii)(A)(2) requires a remittance advice, and that while (e)(2)(iii)(A)(3) provides an exception to submit alternative documentation, it does not obviate the requirement to bill the state. The Providers also claim that the amended bad debt regulations cannot be applied retroactively pursuant to the requirements found in 42 U.S.C. § 1395hh(e)(1)(A), which only permits retroactive rulemaking when required by statute or when it is in the public interest.[3] The Providers concede that none of them billed the state for any bad debts at issue, have not received a remittance advice, and do not qualify for the exception found at 42 C.F.R. § 413.89(e)(2)(iii)(A)(3).[4] Since the Board is bound to apply the regulation and cannot declare it invalid, the Providers believe EJR is appropriate.

On **October 15, 2024**, the Board issued a Scheduling Order, noting that it could only grant EJR if it determined that it has jurisdiction over these cases and providers (including an amount in controversy exceeding $50,000 in each case)[5] and that there are no factual issues in dispute.[6] The Board noted that it had reviewed the records in these cases but had not identified exhibits or documentary evidence to establish an actual amount in controversy ("AIC") for the specific bad debts being appealed in these group cases (*e.g.*, evidence of what, if any, bad debts were claimed and/or disallowed; evidence to demonstrate there were bad debts that concerned patients that were, in fact, Medicaid eligible; and evidence that the bad debts were for the correct time period being appealed).

Pursuant to 42 C.F.R. § 405.1842(e)(3), the Board ordered the Group Representative to supplement the Request for EJR to clarify what evidence, documentary or otherwise, had been submitted in the records for each provider in each case to substantiate the amount in controversy over the specific bad debts in question. It also held that consideration of the Providers' evidence filed in these cases will generally be ***limited*** to that which was submitted with their Position Papers. The Providers' response was due no later than November 15, 2024, and any reply from the Medicare Contractor was due no later than thirty days after the Providers' response was filed.

The Provider filed its response on **November 13, 2024**, and the Medicare Contractor filed its response on **November 27, 2024**.

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[1] *E.g.*, Case 09-1702GC Group Appeal Request, Tab 2 (May 19, 2009).
[2] Request for EJR, 1 (Sept. 16, 2024).
[3] *Id.* at 2.
[4] *Id.* at 3.
[5] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R.§ 405.1842(f)(1).
[6] Board Rue 42.3 (2023).

Amount in Controversy:

A. Relevant Law

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.

Pursuant to 42 C.F.R. § 405.1840(b), the Board has jurisdiction over specific matters at issue from final determinations for a group of providers if the requirements of 42 C.F.R. § 405.1837 have been met. The criteria set forth at 42 C.F.R. § 405.1837 for a group of Providers to have a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports are:

- The Providers must be dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider must be filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [7]
- The matter at issue must involve a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- ***The amount in controversy must be, in the aggregate, $50,000 or more***.[8]

Pursuant to Board Rule 4.1 (2023), the Board may review jurisdiction on its own motion at any time, regardless of whether a challenge has been made or filed by the Medicare Contractor or its representative. Rule 4.1 also specifies that the parties cannot waive jurisdictional requirements. Additionally, pursuant to 42 C.F.R. §§ 405.1842(b)(1), (e)(2)(ii), and (e)(3)(ii), the Board specifically finding jurisdiction over a provider's appeal is also a ***mandatory*** prerequisite to consideration of an EJR request.

The regulation governing the amount in controversy requirement ***specifically divests*** the Board of jurisdiction if the amount in controversy changes to an amount less than the requisite amount due to a more accurate assessment of the amount in controversy.[9] The Providers in a group appeal have an affirmative, ***mandatory***[10] obligation to ***demonstrate*** that the amount in controversy has been met. Demonstrating that this requirement has been met requires a good

[7] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[8] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[9] 42 C.F.R. §405.1839(c)(5)(B).
[10] "In order to satisfy the amount in controversy requirement . . . the group ***must demonstrate*** that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal would increase, in the aggregate, by at least $50,000." 42 C.F.R. § 405.1839(b)(1) (emphasis added).

faith pleading of the amount in controversy.[11] If a Request for EJR is filed and the Board determines that the amount in controversy has not been satisfied, the Board lacks jurisdiction and is ***required*** to deny the request.[12]

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must set forth*** the relevant facts and *arguments regarding the Board's* ***jurisdiction*** *over* ***each*** *remaining matter* at issue in the appeal (as described in § 405.1840 of this subpart), and the merits of the provider's Medicare payment claims for each remaining issue.
> (3) In the absence of a Board order or general instructions to the contrary, ***any supporting exhibits regarding Board jurisdiction must accompany the position paper.*** Exhibits regarding the merits of the Provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions.[13]

Similarly, with regard to position papers,[14] Board Rule 25.2.1 (2021) requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[15] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Consistent with that regulation, Board Rule 25.2.2 (2021) 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,* identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents; and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[16]

Board Rule 42.3 (2023) states that a provider or group of providers must file a written request for EJR with a ***fully developed***[17] narrative that ***must*** demonstrate the Board has jurisdiction and also demonstrate that there are no factual issues in dispute.

Failure to comply with the Board's rules can be found at 42 C.F.R. § 405.1868:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations,

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[11] *See, e.g. Infinity Care of Tulsa v. Sebelius*, 2011 WL 778111 at *3 (N.D. OK 2011).
[12] 42 C.F.R. § 405.1842(f)(2)(i); *see also Affinity Healthcare Svcs. v. Sebelius*, 746 F.Supp.2d 106, 116 (D.D.C. 2010).
[13] (Emphasis added.)
[14] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2 (2021).
[15] (Emphasis added.)
[16] (Emphasis added.)
[17] (Emphasis added).

> and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. ***The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules*** and orders or for inappropriate conduct during proceedings in the appeal.
> (b) ***If a provider fails to meet*** a filing deadline or ***other requirement*** established by the Board ***in a rule*** or order, the Board may—
>
> (1) Dismiss the appeal with prejudice;
> (2) *Issue an order requiring the provider to show cause why the Board should not dismiss the appeal*; or
> (3) *Take any other remedial action it considers appropriate*.[18]

B. Positions of the Parties:

Each of the Providers in each CIRP group case claims it had bad debts for indigent, crossover dual-eligible patients. They briefly state that they "had sufficient documentation of the amounts owed by Medicare for the bad debts[.]"[19] They "request the MAC to sample the listings as soon as practicable"[20] and also claim they "have not submitted alternative documentation (documentation other than a remittance advice from the Medicaid State Agency) with this Final Position Paper because they are unsure whether the MAC will accept such alternative documentation."[21] But the exhibits submitted with each Preliminary and/or Final Position Paper are limited to one provision of the Provider Reimbursement Manual and, in some cases, a copy of the Schedule of Providers.

The Board's Request for Information and Show Cause Order noted that, pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1), it can only grant EJR if it determines that it has jurisdiction. Board Rule 42.3 (2023) states that an EJR Request ***must*** demonstrate the Board has jurisdiction and also demonstrate that there are no factual issues in dispute. The Board's jurisdiction is dependent on a finding that there is an actual amount in controversy exceeding $50,000 in damages. The records in these cases contain no listings to illustrate what, if any, bad debts were claimed and/or disallowed; if those bad debts concerned patients that were, in fact, Medicaid eligible; and if they were for the correct time period. The Board ordered the Group Representative to supplement the Requests for EJR to clarify what evidence, documentary or otherwise, had been submitted in the records for each provider in each case to substantiate the amount in controversy for the specific bad debts in question.

1. Providers' Response to the Board's Show Cause Order

The Providers filed a Response to the Board's October 15, 2024 Show Cause Order on **November 13, 2024**. The Providers claim "it is simply inconceivable that the amount in

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[18] (Emphasis added).
[19] Providers' Preliminary Position Paper at 11 (Apr. 7, 2023) ("Providers' PPP")
[20] *Id.* at 13.
[21] Providers' Final Position Paper at 5.

controversy (AIC) for any of the 13 group appeals is not met" because "the documentation already submitted demonstrates[] the AIC for each group is well over the minimum requirement."[22] They also point out that the Medicare Contractor has not questioned the amount in controversy in any of the groups in the Request for EJR.

The Providers argue that the "documentation already submitted" which demonstrates the amount in controversy has been met is the Schedule of Providers, which lists an AIC for each provider. They claim that Board Rule 25 (concerning position papers), or any other Board Rule, does not require a "group of providers [to] allege or prove in a position paper that the AIC is met, let alone patient by patient."[23] They insist that position papers only need to address the *merits* of a provider's position, and that providers are only instructed to address the AIC in the schedule of providers under Board Rule 21. They specifically state their position papers were not required to contain exhibits to satisfy the AIC requirement. They point to Board Rule 25.1.1 and note that the requirements of a position paper there do not mention jurisdiction or the AIC. They argue that the Board's citation of 42 C.F.R. § 405.1853(b)(3) is not on point, that while it requires position papers to contain any supporting exhibits regarding Board jurisdiction, this is only "in the absence of a Board order or general instruction to the contrary[.]" The Providers' allege that Board Rule 21 directs the AIC be cited in the SOP, which is a general instruction to the contrary.[24] They insist that citing the AIC estimate via the Schedule of Providers is sufficient to meet the AIC requirements for the Board's jurisdiction.

Finally, the Providers argue that whether or not the position papers are defective is irrelevant. The Board is required to rule on a Request for EJR whether or not a position paper has been filed, and they insist this is further evidence that the Board Rules do not require position papers to contain exhibits concerning the AIC. "Why place the AIC requirement in position papers (rather than in the SOP) when no position paper may ever be filed?"[25]

2. Medicare Contractor's Response to the Board's Show Cause Order

The Medicare Contractor's Representative, Federal Specialized Services ("FSS") filed a response to the Board's Show Cause Order or November 27, 2024. It notes that the Board ordered the Providers to clarify what evidence in the record substantiated the amount in controversy over the specific bad debts in question, but that the Providers response "fails to detail this information."[26] FSS states that the position papers and appeal requests related to these group cases do list an amount sought but "fail to support the claim with any documentation."[27]

FSS argues that there is no actual documentation to support the "bald, unsupported number" which is listed for any particular amount in controversy. In response to the Providers' argument that Board Rule 25.1.1 does not mention jurisdiction or the AIC, FSS argues that it does require a

[22] Response to October 15, 2024 Show Cause Letter at 2 (Nov. 13, 2024).
[23] *Id.*
[24] *Id.* at 3.
[25] *Id.* at 3-4.
[26] FSS' Response to Board's Show Cause Order at 1 (Nov. 27, 2024).
[27] *Id.*

fully developed narrative and compliance with Board Rule 25.2, which, in turn, requires the exchange of "***all*** available documentation as exhibits to fully support your position."[28]

Next, FSS addresses the Providers' contention that the regulation at 42 C.F.R. § 405.1853 (requiring exhibits supporting jurisdiction accompany position papers unless there is a contrary Board order or instruction) is contravened by Board Rule 21 (requiring the AIC be stated in the SOP). It notes that Board Rule 20 specifically states that, prior to certifying that a group is fully formed, a "group representative should review each participating provider's supporting jurisdictional documentation to ensure it is complete and, if not, file any additional documentation in OH CDMS."

C. Decision of the Board

The Providers have pointed out that 42 C.F.R. § 405.1853(b)(3) requires position papers to contain any supporting exhibits regarding Board jurisdiction only "in the absence of a Board order or general instruction to the contrary[.]" They argue that Board Rule 21 contradicts the general mandate to include supporting jurisdictional exhibits. Board Rule 21 governs the contents of a group schedule of providers and supporting documentation, and the Providers are correct that it has historically required a provider to identify the amount in controversy.[29] But this rule and requirement is *supplementary* to those found at 42 C.F.R. § 405.1853(b)(3), not contradictory. There is nothing in this Rule that obviates the mandate set forth at 42 C.F.R. § 405.1853(b)(3) to include supporting exhibits regarding Board jurisdiction in a provider's position paper.

The Providers have also suggested that, even if the Board's Rules and Regulations required jurisdictional documentation in position papers, this is irrelevant since a request for EJR is independent of that position paper and could be filed before any position papers are ever due. But this ignores the fact that pursuant to 42 C.F.R. §§ 405.1842(b)(1), (e)(2)(ii), and (e)(3)(ii), the Board finding jurisdiction is a ***prerequisite*** to consideration of an EJR request. The regulation governing the amount in controversy requirement also ***specifically divests*** the Board of jurisdiction if the amount in controversy changes to an amount less than the requisite amount due to a more accurate assessment of the amount in controversy.[30] This indicates that the AIC is not necessarily a stagnant, one-time reporting of data, with little or no importance, as the Providers would have it, but instead, may be taken into account by the Board as changes occur.

Demonstrating that the amount in controversy requirement has been met requires a good faith pleading of the amount in controversy, and not merely a bald allegation or the listing of a dollar amount in an appeal request.[31] As noted in its October 15, 2024 Request for Information and Show Cause Order, the Board reviewed the records in these cases and could not identify any listings to illustrate what, if any bad debts were claimed and/or disallowed; if those bad debts concerned patents that were, in fact, Medicaid eligible, and if they were for the correct time period. The Board requested the Providers identify what evidence, documentary or otherwise, exists in the records for each case which substantiates the amounts in controversy for the specific

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[28] *Id.* at 1-2.
[29] The Board Rules in effect when Preliminary Position Papers were filed in these cases have changed versions over the years, but the requirements have not materially changed.
[30] 42 C.F.R. §405.1839(c)(5)(B).
[31] *See, e.g. Infinity Care of Tulsa v. Sebelius*, 2011 WL 778111 at *3 (N.D. OK 2011).

bad debts in question. The Board's review of the amounts in controversy claimed by each provider and listed in the Schedules of Providers found that the amounts appear to be arbitrary percentages applied to **total** Medicare deductibles and coinsurance amounts for the year in question. The Board requested clarity from the Providers as to what evidence would substantiate these claims, but the Providers have declined to expand on how these figures were determined or are applicable **to the specific issue being appealed in these cases**. Not all disallowed bad debts for coinsurance and deductible amounts would be relevant to this appeal. The Medicare Contractor could have made adjustments to disallow bad debts for a myriad of reasons: many would not have been related to Medicare Crossover patients; perhaps they were applicable to a different cost reporting period; perhaps the amounts claimed contained inaccuracies due to errors in accounting. The Board finds that assuming a general, blanket percentage (which appears to be identical to each provider) of ***all*** Medicare coinsurance and deductible amounts for the entire year, without any justification as to how or why that percentage was applied, does not constitute a good faith estimate of a real amount in controversy that is specific to the issue under appeal. The Providers fail to identify a single, specific bad debt claim that was written off in the applicable cost reporting period which can clearly be identified in the audit adjustments as having been written off. The calculations appear to have been made in a manner that was convenient, but arbitrary. Alleging a convenient, but arbitrary, amount in controversy does not satisfy the Providers' obligation to demonstrate that it has pled this jurisdictional requirement in good faith.

Since the Board finds that the amounts in controversy were not made in good faith, but rather calculated in an arbitrary manner, the Board finds that the Providers have failed to affirmatively **demonstrate** that the amount in controversy requirement has been met in each of these cases as required by 42 C.F.R. § 405.1839(b)(1). Since demonstrating the amount in controversy has been met is a requirement for the Board's jurisdiction, and since a finding of jurisdiction is a prerequisite to granting a request for EJR, the Board hereby ***denies*** the requests for EJR in the thirteen (13) cases listed in **Appendix A**. Additionally, since the Board is unable to establish it has jurisdiction over these appeals, the Board also hereby ***dismisses*** the cases and will remove them from the Board's docket.

As an additional basis for denying EJR, the Board notes there are a number of factual disputes remaining in these cases. Board Rule 42.3 (2023) requires that an EJR Request demonstrate that there are no factual issues in dispute. The Providers claim they "had sufficient documentation of the amounts owed by Medicare for the bad debts[.]"[32] They also state "the Providers request the MAC to sample the listings as soon as practicable."[33] They also claim they "have not submitted alternative documentation (documentation other than a remittance advice from the Medicaid State Agency) with this Final Position Paper because they are unsure whether the MAC will accept such alternative documentation."[34] The records in these cases, however, do not contain any listings of bad debts or documentation whatsoever, despite the fact the Preliminary Position Paper indicated it wanted the listings sampled, let alone any evidence of which patients were in question or whether those patients dually eligible for Medicare and Medicaid or if the bad debts were written off during the cost reporting periods under appeal.

The Providers also note in their PPP that the participants in these CIRP groups are all acute care

[32] *E.g.*, Case 11-0626GC Providers' Preliminary Position Paper ("PPP") at 11.
[33] *Id.* at 13.
[34] *E.g.*, Case 11-0626GC Providers' Final Position Paper at 5.

hospitals located in Arizona, California, and Nevada.[35] They claim that the state Medicaid plans in Arizona, California, and Nevada "do not pay for certain inpatient and outpatient deductible and coinsurance amounts incurred by Medicare beneficiaries when the beneficiary is also eligible for Medicaid"[36] but do not specify what "certain" amounts these states will not pay, or if the bad debts in question fall into those categories. (Again, there is no listing to identify any specific bad debts in question.) They also claim that California *does* issue remittance advices, "but only when the provider bills the state within one year of the hospital stay,'[37] but do not specify describe what Arizona or Nevada will pay for, or whether they issue remittance advices. They also do not indicate why the applicable Providers did not bill California within the required time period if it knew that the state would have issued remittance advices.

Even assuming the Board had jurisdiction in these cases, it would require a resolution to these factual disputes before granting EJR pursuant to Board Rule 42.3.

Additional Jurisdictional Challenges and Issues:

Even if the Board were to find that it has jurisdiction over these cases and providers *with regard to the AIC*, it must still "find that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question."[38] There are jurisdictional challenges in seven (7) of the thirteen (13) cases in the EJR Request, many of which have common challenges.

A. Untimely Appeals

1. Case 09-1702GC

The Medicare Contractor argues that St. Johns-Pleasant Valley (05-0616) did not timely add the group issue to its individual appeal request (and thus could not transfer that issue to the group) in accordance with 42 C.F.R. § 405.1835(c).[39] The Provider filed a response to the challenge on December 15, 2016. It disagrees, noting the appeal issue discussed the exclusion of unbilled crossover bad debts and their objection to the need for a remittance advice. The Board has reviewed the record for St. Johns-Pleasant Valley (05-0616) and concurs with the Provider. Based on the foregoing, the Board denies this jurisdictional challenge.

2. Case 11-0626GC

The Medicare Contractor argues that three (3) Providers that appealed from an untimely contractor determination did not meet the requirements of 42 C.F.R. § 405.1835(a)(3).[40] Specifically, this regulation allows an appeal to the Board if the Medicare Contractor does not issue an NPR within twelve (12) months of receipt of the perfected or amended cost report. 42 C.F.R. § 405.1835(a)(3) requires an appeal be filed within 180 days following the expiration of

[35] *E.g.*, Case 11-0626GC Providers' PPP at 2.
[36] *Id.* at 11.
[37] Request for EJR at 2.
[38] 42 C.F.R. § 405.1842(b)(1).
[39] MAC's Jurisdictional Challenge, 3-4 (Nov. 16, 2016).
[40] Medicare Administrative Contractor's Jurisdictional Challenge, 3-4 (June 24, 2024).

this twelve-month period. Three (3) Providers, however, filed their appeals more than 180 days from the expiration of the twelve-month allotted timeframe for the issuance of the contractor's determination. All of the Providers in this appeal have a fiscal year ending June 30, 2009, and the untimely determination appeals were all filed May 27, 2011, which was more than 180 days from that expiration date for the following three (3) Providers:

Provider	**Receipt of Last Cost Report**	**End of 12-Month Period for NPR**	**End of 180 Day Appeal Period**
Marian Regional Medical Center, Arroyo Grande (05-0016)	11/26/2009	11/26/2010	5/25/2011
St. John's Regional Medical Center (05-0082)	11/24/2009	11/24/2011	5/23/2011
Marian Regional Medical Center (05-0107)	11/24/2009	11/24/2011	5/23/2011

The Board finds that this is an alternative basis to deny EJR and dismiss these specific providers from the appeal taken from untimely determinations.

B. Premature Appeals

Medicare Contractors must issue an NPR within twelve months of receiving a Provider's perfected or amended 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) . . .

In some instances, Providers file amended cost reports before twelve months has elapsed from the filing of their original cost reports. When that happens, the Medicare Contractor is afforded twelve months to issue an NPR following acceptance of that amended cost report. The right to appeal an untimely NPR, however, is only afforded when the failure to issue an NPR is through no fault of the provider. Filing an amended cost report, which resets the timeline to issue an NPR, is a provider action; therefore, the failure to issue an NPR on the original cost report is the provider's "fault." Filing an appeal before twelve months has elapsed from the acceptance of the

amended cost report is premature. Based on the jurisdictional challenges filed and the records before the Board, the following cases and providers have filed premature appeals in this context:

1. Case 10-0773GC

The Medicare Contractor argues that nine (9) Providers that appealed from an untimely contractor determination did not meet the requirements of 42 C.F.R. § 405.1835(a)(3) because they filed their appeals before the twelve (12) month period for the issuance of an NPR had elapsed.[41] The Board agrees. The untimely determination appeals were all submitted on March 16, 2010. For some of the challenged Providers, the cost report was filed less than one year before the appeal request, meaning the Medicare Contractor had more time to issue an NPR and these appeals were premature.

For the remaining challenged providers, the amended cost reports were accepted well after the original appeal was filed. Thus, the late issuance of their NPR from the first cost report was "through no fault of Provider." When their appeal was filed, the Medicare Contractor had been in possession of the cost report for more than twelve months, had not issued an NPR, and had not received or accepted an amended cost report. The acceptance of an amended cost report, however, has made the appeal of an untimely NPR moot, since the Medicare Contractor then had a renewed twelve month period to issue an NPR. The following providers were challenged by the Medicare Contractor:

Provider	**Receipt of Last Cost Report**	**End of 12-Month Period for NPR**
Merch General Hospital (05-0017)	3/9/2012	3/9/2013
Bakersfield Memorial Hospital (05-0036)	10/7/2009	10/7/2010
Glendale Memorial Hospital & Health Center (05-0058)	4/28/2011	4/28/2012
Comm Hosp of San Bernardino (05-0089)	1/27/2010	1/27/2011
California Hospital Medical Center (05-0149)	4/21/2011	4/21/2012
Saint Francis Memorial Hospital (05-0152)	7/5/2011	7/5/2012
Mark Twain St. Joseph's Hospital (05-0366)	6/30/2009	6/30/2010
Mercy Medical Center -Merced (05-0444)	9/28/2009	9/29/2010
St. Mary's Medical Center (05-0457)	6/1/2009	6/1/2010

The Board finds that this is an alternative basis to deny EJR and dismiss these Providers' appeals taken from untimely determinations.

2. Case 11-0626GC

The Medicare Contractor argues that seven (7) Providers that appealed from an untimely contractor determination did not meet the requirements of 42 C.F.R. § 405.1835(a)(3) because they filed their appeals before the twelve (12) month period for the issuance of an NPR had elapsed.[42] The Board agrees for these providers and has identified one other premature appeal.

[41] MAC's Jurisdictional Challenge, unnumbered page 8 (Dec. 27, 2016).
[42] Medicare Administrative Contractor's Jurisdictional Challenge, 3-4 (June 24, 2024).

The untimely determination appeals were all submitted on May 27, 2011. For some of the challenged Providers, the cost report was filed less than one year before the appeal request, meaning the Medicare Contractor had more time to issue an NPR and these appeals were premature.

For the remaining challenged providers, the amended cost reports were accepted well after the original appeal was filed. Thus, the late issuance of their NPR from the first cost report was "through no fault of Provider." When their appeal was filed, the Medicare Contractor had been in possession of the cost report for more than twelve months, had not issued an NPR, and had not received or accepted an amended cost report. The acceptance of an amended cost report, however, has made the appeal of an untimely NPR moot, since the Medicare Contractor then had a renewed twelve month period to issue an NPR. The following providers were challenged by the Medicare Contractor:

Provider	**Receipt of Last Cost Report**	**End of 12-Month Period for NPR Issuance**
St. Joseph's Hospital & Medical Center (03-0024)	2/4/2011	2/4/2012
Bakersfield Memorial Hospital (05-0036)	10/22/2010	10/22/2011
St. Mary Medical Center (05-0191)	12/2/2010	12/2/2011
Mercy Medical Center (05-0444)	9/27/2010	9/27/2011
Mercy General Hospital (05-0017)	7/23/2013	7/23/2014
Glendale Memorial Hospital & Health Center (05-0058)	8/15/2011	8/14/2012
California Hospital Medical Center (05-0149)	5/1/2012	5/1/2013

The Board also identified the following Provider with a premature appeal:

Provider	**Receipt of Last Cost Report**	**End of 12-Month Period for NPR Issuance**
Sequoia Hospital (05-0197)	12/10/2010	12/10/2011

The Board finds that this is an alternative basis to deny EJR and dismiss these Providers' appeals taken from untimely determinations.

3. Case 12-0339GC

The Medicare Contractor argues that fourteen (14) Providers that appealed from an untimely contractor determination did not meet the requirements of 42 C.F.R. § 405.1835(a)(3) because they filed their appeals before the twelve (12) month period for the issuance of an NPR had elapsed.[43] The Board agrees. The untimely determination appeals were all submitted on May 15, 2012. For some of the challenged Providers, the cost report was filed less than one year

[43] MAC's Jurisdictional Challenge, 3 (May 24, 2019).

before the appeal request, meaning the Medicare Contractor had more time to issue an NPR and these appeals were premature.

For the remaining challenged providers, the amended cost reports were accepted well after the original appeal was filed. Thus, the late issuance of their NPR from the first cost report was "through no fault of Provider." When their appeal was filed, the Medicare Contractor had been in possession of the cost report for more than twelve months, had not issued an NPR, and had not received or accepted an amended cost report. The acceptance of an amended cost report, however, has made the appeal of an untimely NPR moot, since the Medicare Contractor then had a renewed twelve month period to issue an NPR. The following providers were challenged by the Medicare Contractor:

		Last Amended MCR received by MAC	12-month period after receipt of Amended MCR
05-0017	Mercy General Hospital	7/16/2013	7/16/2014
05-0036	Bakersfield Memorial Hospital	8/18/2011	8/17/2012
05-0042	St. Elizabeth Community Hospital	6/21/2011	6/20/2012
05-0058	Glendale Memorial Hospital	3/12/2012	3/12/2013
05-0084	St. Joseph's Medical Center	9/13/2011	9/12/2012
05-0129	St. Bernardine Medical Center	9/20/2011	9/19/2012
05-0149	California Medical Center	5/1/2012	5/1/2013
05-0152	St. Francis Memorial Hospital	10/24/2011	10/23/2012
05-0242	Dominican Hospital	3/29/2011	3/28/2012
05-0280	Mercy Medical Center-Redding	6/21/2011	6/20/2012
05-0295	Mercy Hospital of Bakersfield	9/15/2011	9/14/2012
05-0444	Mercy Medical Center Merced	8/15/2011	8/14/2012
29-0045	St. Rose Dominican Hospital-Siena	6/27/2011	6/26/2012
29-0053	St. Rose Dominican Hospital-St Martin	6/27/2011	6/26/2012

The Providers filed a response to the jurisdictional challenge. They disagree that the acceptance of an amended cost report has made the appeal of an untimely NPR moot or that the Medicare Contractor then had a renewed twelve-month period to issue an NPR. They claim that the statute affords the right to an appeal if the Medicare Contractor had been in possession of the cost report for more than twelve months, had not issued an NPR, and had not received or accepted an amended cost report; there is no language stating that an amended cost report supersedes this right.[44] The Board disagrees, noting that 42 C.F.R. § 405.1835(c)(1) specifically references the receipt of amended cost reports triggering the twelve-month clock beginning to run.

The Board finds that this is an alternative basis to deny EJR and dismiss these Providers' appeals taken from untimely determinations.

4. Case 17-1470GC

[44] Providers' Response to MAC's Jurisdictional Challenge (June 21, 2019).

The Medicare Contractor argues that three (3) Providers that appealed from an untimely contractor determination did not meet the requirements of 42 C.F.R. § 405.1835(a)(3) because they filed their appeals before the twelve (12) month period for the issuance of an NPR had elapsed.[45] The Board agrees. The untimely determination appeals were all submitted in May, 2017. For these challenged providers, the amended cost reports were accepted well after the original appeal was filed. Thus, the late issuance of their NPR from the first cost report was "through no fault of Provider." When their appeal was filed, the Medicare Contractor had been in possession of the cost report for more than twelve months, had not issued an NPR, and had not received or accepted an amended cost report. The acceptance of an amended cost report, however, has made the appeal of an untimely NPR moot, since the Medicare Contractor then had a renewed twelve month period to issue an NPR. The following providers were challenged by the Medicare Contractor:

Provider	**Receipt of Last Cost Report**	**End of 12-Month Period for NPR Issuance**	**Date of Appeal Request**
Methodist Hospital of Sacramento St. Rose (05-0590)	12/21/2017	12/21/2018	5/18/2017
Dominican – Siena Campus St. Rose (29-0045)	12/22/2017	12/22/2018	5/24/2017
Dominican – San Martin Campus (29-0053)	12/23/2017	12/23/2018	5/10/2017

The Board finds that this is an alternative basis to deny EJR and dismiss these Providers' appeals taken from untimely determinations.

5. Case 18-1329GC and 18-1330GC

The Medicare Contractor argues that thirty-two (32) Providers that appealed from an untimely contractor determination did not meet the requirements of 42 C.F.R. § 405.1835(a)(3) because they filed their appeals before the twelve (12) month period for the issuance of an NPR had elapsed.[46] The Board agrees. The untimely determination appeals were all submitted on May 25, 2018. For these challenged providers, the amended cost reports were accepted well after the original appeal was filed. Thus, the late issuance of their NPR from the first cost report was "through no fault of Provider." When their appeal was filed, the Medicare Contractor had been in possession of the cost report for more than twelve months, had not issued an NPR, and had not received or accepted an amended cost report. The acceptance of an amended cost report, however, has made the appeal of an untimely NPR moot, since the Medicare Contractor then had a renewed twelve month period to issue an NPR. The following providers were challenged by the Medicare Contractor:

[45] MAC's Jurisdictional Challenge, 3-4 (Apr. 29, 2024).
[46] Medicare Administrative Contractor's Jurisdictional Challenge, 2-5 (Jan. 23, 2023). Identical challenges were filed over the same providers in both cases 18-1329GC and 18-1330GC.

Prov#	Provider Name	*Amended* CR Received	End of 12-month period
03-0024	St. Joseph's Hospital & Medical Center	12/22/17	12/22/18
03-0036	Chandler Regional Medical Center	12/22/17	12/22/18
03-0119	Mercy Gilbert Medical Center	12/22/17	12/22/18
05-0017	Mercy General Hospital	12/21/17	12/21/18
05-0036	Bakersfield Memorial Hospital	12/22/17	12/22/18
05-0042	St. Elizabeth Community Hospital	12/21/17	12/21/18
05-0058	Glendale Memorial Hospital & Health Center	12/21/17	12/21/18
05-0082	St. John's Regional Medical Center	12/21/17	12/21/18
05-0084	St Joseph's Medical Center	1/31/18	1/31/19
05-0089	Community Hospital of San Bernardino	12/22/17	12/22/18
05-0107	Marian Regional Medical Center	12/21/17	12/21/18
05-0116	Northridge Hospital Medical Center Taylor	12/21/17	12/21/18
05-0127	Woodland Memorial Hospital	12/21/17	12/21/18
05-0129	St. Bernardine Medical Center	12/22/17	12/22/18
05-0149	California Hospital Medical Center	12/26/17	12/26/18
05-0150	Sierra Nevada Memorial Hospital	12/21/17	12/21/18
05-0152	Saint Francis Memorial Hospital	12/22/17	12/22/18
05-0191	St. Mary Medical Center	12/21/17	12/21/18
05-0197	Sequoia Hospital	12/22/17	12/22/18
05-0232	French Hospital Medical Center	12/21/17	12/21/18
05-0242	Dominican Hospital	12/22/17	12/22/18
05-0280	Mercy Medical Center Redding	12/21/17	12/21/18
05-0295	Mercy Hospital	12/22/17	12/22/18
05-0414	Mercy Hospital of Folsom	12/21/17	12/21/18
05-0444	Mercy Medical Center	12/28/17	12/28/18
05-0457	St. Mary's Medical Center	12/22/17	12/22/18
05-0516	Mercy San Juan Medical Center	12/21/17	12/21/18
05-0590	Methodist Hospital of Sacramento	12/21/17	12/21/18
05-0616	St. John's Pleasant Valley Hospital	12/21/17	12/21/18
29-0012	St. Rose Dominican Hospital-DeLima Campus	12/22/17	12/22/18
29-0045	St. Rose Dominican Hospital-Siena Campus	12/22/17	12/22/18
29-0053	St. Rose Dominican Hospitals-San Martin Campus	12/22/17	12/22/18

The Board finds that this is an alternative basis to deny EJR and dismiss these Providers' appeals taken from untimely determinations.

C. No Protest

In five cases,[47] the Medicare Contractor has alleged that several providers made no claim on their cost reports for the crossover bad debt amounts sought and therefore, adjustments were not made to these contested crossover bad debt amounts. Nor have these providers shown there was any practical impediment which prevented them from billing the disputed crossover bad debts.[48] There is no dispute that these Providers failed to claim or protest the bad debts sought in these appeals, so the Board looks to whether the Providers were required to claim or protest these bad debts for the Board to have jurisdiction pursuant to CMS Ruling 1727-R.[49]

[47] 09-1702GC, 10-0773GC, 17-1470GC, 18-1329GC, and 18-1330GC. See **Appendix B** for a listing of all Providers challenged with regard to the protest requirement.
[48] *E.g.*, PRRB Case 09-1702 Jurisdictional Challenge at 3.
[49] *Available at* https://www.cms.gov/regulations-and-guidance/guidance/rulings/downloads/cms-1727-r.pdf.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending on or after December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming it as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[50] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[51]

On August 21, 2008, new regulations governing the Board were effective.[52] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required, for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[53] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[54]

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

The first step of analysis under 1727-R involves the appeal's filing date and cost reporting period. The appeal must have been pending or filed after the Ruling was issued on April 23, 2018. All of the instant group cases satisfy the appeal pending date requirement. Additionally, the Ruling applies to appeals of cost reporting periods that ended on or after December 31, 2008 and began before January 1, 2016. All of the appealed cost reporting periods fall within the required time frame.

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[50] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[51] *Bethesda*, 108 S. Ct. at 1258-59.
[52] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[53] 201 F. Supp. 3d 131 (D.D.C. 2016).
[54] *Id.* at 142.

Second, the Board must determine whether the appealed item "was subject to a regulation or other payment policy that bound the [Medicare] contractor and left it with no authority or discretion to make payment in the manner sought by the provider."[55] The Providers in these cases were not prevented from billing Medicaid (and receiving a remittance advice) or claiming disputed additional crossover bad debts on the filed cost reports. The Board does not find that Providers' crossover bad debt issue "was subject to a regulation or other payment policy that bound the [Medicare] contractor and left it with no authority or discretion to make payment in the manner sought by the provider." The Providers were entitled to claim (and the Medicare Contractors could allow) the crossover bad debts if they were valid and had supporting documentation.

The third, fourth and fifth steps of analysis under Ruling 1727 involve the Board's assessment of whether a provider's appeal has met the jurisdictional requirements set out in 42 C.F.R. § 405.1835. Except as otherwise noted in this decision, the Providers' appeals were timely filed and they were timely added to the groups, and the estimated amount in controversy is over $50,000 in each case,[56] so the first two Board jurisdictional requirements have been met. With respect to the "dissatisfaction" requirement, Ruling 1727 sets out three different scenarios—in steps three, four and five—for the Board to consider.

The Board looks to step three if it is reviewing an appealed item which was, in fact, within the payment authority or discretion of the Medicare contractor, i.e., an "allowable" item. In the instant appeal, the crossover bad debts were within the payment authority or discretion of the Medicare Contractor because they are allowable costs with sufficient documentation.

Under step four of Ruling 1727, the Board does not apply the self-disallowance jurisdiction regulation (in § 405.1835(a)(1)(ii) or § 405.1811(a)(1)(ii), as applicable) if a determination has been made that the item under appeal was subject to a regulation or other policy that bound the Medicare Contractor and left it with no authority or discretion to make payment as sought. As discussed in step two above, crossover bad debts are allowable costs that could be claimed on a cost report, and therefore the Board should not apply the self-disallowance jurisdiction regulation in this jurisdictional decision.

Under step five of Ruling 1727, the Board is directed to consider the circumstances surrounding a provider's self-disallowance claim. If a Provider self-disallows a specific item by filing the pertinent parts of its cost report under protest, but the Board determines that the Medicare Contractor actually had the authority or discretion to make payment for that specific item, then the Board must apply step three of 1727-R. The issue with these challenged providers is that no protest was made. As a result, this step is inapplicable to the instant group appeals.

For the providers listed in **Appendix B** which did not claim or protest crossover bad debts, the

[55] CMS 1727-R at unnumbered page 6.
[56] However, the Board notes its original dismissal of these cases as a result of the failure to calculate the AIC in good faith. For the instant discussion, the Board notes the amount exceeds $50,000 but does not, in any way, validate the amount.

Board finds this is an alternative basis deny EJR and dismiss them for lack of jurisdiction.

D. Improper Transfers (Group Issue Not Appealed in Individual Appeals)

In Case 11-0626GC, all ten (10) Providers which have added an NPR appeal were transferred from individual appeals. The Medicare Contractor argues that the issue from these individual appeals differs from the issue being appealed in this CIRP group.[57]

The same argument was raised for following ten (10) Providers which have added an NPR appeal in Case 17-1470GC:[58]

- Glendale Memorial Hospital & MC (Prov. No. 05-0058, FYE 6/30/2015)
- St. Joseph's Medical Center (Prov. No. 05-0084, FYE 6/30/2015)
- Community Hospital of San Bernardino (Prov. No. 05-0089 6/30/2015)
- St. Bernardine Medical Center (Prov. No. 05-0129, FYE 6/30/2015)
- St. Mary Medical Center (Prov. No. 05-0191, FYE 6/30/2015)
- Mercy Hospital of Bakersfield (Prov. No. 05-0295, FYE 6/30/2015)
- Methodist Hospital of Sacramento (Prov. No. 05-0590, FYE 6/30/2015)
- St. Rose Dominican Hospital-DeLima Campus (Prov. No. 29-0012, FYE 6/30/2015)
- St. Rose Dominican Hospital-Siena Campus (Prov. No. 29-0045, FYE 6/30/2015)
- St. Rose Dominican Hospital-San Martin (Prov. No. 29-0053, FYE 6/30/2015)

The same argument was also made for two (2) Providers which have added an NPR appeal in Cases 18-1329GC and 18-1330GC:[59]

- Mercy Hospital (Provider 05-0295, FYE 6/30/2016)
- St. Rose Dominican Hospital – San Martin Campus (Provider 29-0053, FYE 6/30/2016)

The group appeal issue relates to bad debts being disallowed for failing to bill the Medicaid program and receive a remittance advice. The issue from the individual appeals from Case 11-0626GC, however, is as follows:

> The Intermediary made adjustments to the Provider's reported Medicare crossover bad debt reimbursement which included an amount related to the issue of inpatient and outpatient Medicare unbilled bad debts. The Provider contends that their bad debt reimbursement is understated by co-payments related to Medicare crossover claims **not completely billed because some of the payment information was cut-off due to the restriction in the number of crossover bad debt claim lines that can be processed by the State of California or for other reasons**. The applicable Medicare Regulation is 42 C.F.R. §413.89. The estimated amount of Medicare reimbursement is unknown at this time.[60]

[57] Case No. 11-0626GC MAC's Jurisdictional Challenge at 3.
[58] Case No. 17-1470GC MAC's Jurisdictional Challenge at 5.
[59] Case No. 18-1329GC MAC's Jurisdictional Challenge at 8-9.
[60] Case No. 11-0626GC MAC's Jurisdictional Challenge at 6 (Emphasis added.)

Similarly, the issue from the individual appeals for the Providers noted above from Case 17-1470GC is as follows:

> The MAC eliminate [*sic*] the Provider's protested amounts reported on the as-filed cost report, which included an amount related to the issue of inpatient and outpatient Medicare unbilled crossover bad debts. The Provider contends that their bad debts reimbursement is understated by co-payments related to Medicare crossover claims not completely billed because some of the payment information was cut-off due to the restriction in the number of crossover bad debt claim lines that can be processed by the State of California or for other reasons.[61]

The issue from the individual appeals for the Providers noted above from Case 18-1329GC and 18-1330GC are materially similar, as well.

The Medicare Contractor argues that the difference between these two issue statements illustrates that the facts are not common to all group members, and that more than one question of fact or interpretation of law, regulation or CMS policy or ruling is being appealed in violation of 42 C.F.R. § 405.1837(a)(2) and Board Rule 13 (2009).[62]

The Medicare Contractor also argues that a second issue is raised in the Provider's PPP: bad debts that were incurred, but for some reason they "were not originally aware of."[63] The Medicare Contractor argues that the group should be dismissed in its entirety for failure to appeal and brief a single common question of fact or interpretation of a legal authority.[64]

The CIRP group issue in Case No. 11-0626GC challenges the Medicare Contractor's position that bad debts can only be claimed if they were billed and they submit proof of billing via a remittance advice.

The NPR issue statements for several of the individual appeals that were transferred into the CIRP group describe additional bad debt claims not included on the cost report due to provider error or negligence in failing to bill all of the bad debts it had. More specifically, it suggests that they attempted to bill for and collect these bad debts but had technical difficulties with payment information being cut off in its submission to the state of California.[65] As noted by the Medicare Contractor, "[t]here is no mention of a disagreement to a regulation or other policy, which is the basis of this Group appeal."[66]

As noted above, the Board has found that the records do not demonstrate the amount in

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[61] Case No. 17-1470GC MAC's Jurisdictional Challenge at 5.
[62] The group appeal was filed when the Board's Rules (2009) were in effect, but the requirement of a single question of fact or interpretation of a legal authority is mandated by regulation and has persisted in the Board's Rules to the present day.
[63] *E.g.*, Case 11-0626GC, Medicare Administrative Contractor's Jurisdictional Challenge at 6-7 (June 24, 2024); Case 17-1470GC, Medicare Administrative Contractor's Jurisdictional Challenge at 5 (Apr. 4, 2024)
[64] Case 11-0626GC Jurisdictional Challenge at 6-7.
[65] *Id.* at 7-9.
[66] *Id.* at 7.

controversy requirement has been satisfied for all providers in this case. Since this is a different issue than the group appeal's issue, and group appeals can only contain one question of fact or interpretation of law, regulation or CMS policy or ruling, the Board finds this disparity is an alternative basis to deny the Request for EJR for the providers listed above appealing from their NPRs. If the Board had not already found it lacks jurisdiction over these providers, it would deny the transfer requests and transfer the issues back to the providers' respective individual appeals.

E. Bifurcation

The Board notes that, if it had found it has jurisdiction over the providers in these cases, it would bifurcate Cases 09-1702GC, 10-0773GC, 11-0626GC, and 12-0339GC. Each of these CIRP groups concern inpatient **and** outpatient bad debts. The later FY cases all concern *either* inpatient *or* outpatient bad debts. Indeed, the Board issued a decision noting these are two separate and distinct issues in Case 17-1470GC,[67] which is also encompassed in the instant EJR Requests.

Conclusion:

In summary, the Board finds that it lacks jurisdiction over the thirteen (13) cases listed in **Appendix A** because the Providers have failed to demonstrate they meet the amount in controversy requirement set forth in the applicable statute, regulations, and Board Rules. The Board finds that the alleged amounts in controversy were not made in good faith, but rather in an arbitrary manner, and the Board is unable to determine how much (if any) of the alleged amount in controversy actually concerns Medicare Crossover bad debts for the time periods at issue. Since the Board lacks jurisdiction, it is obligated to deny the Requests for EJR and dismiss the appeals.

The Board also finds, as outlined above, that there are several alternative bases to deny EJR and/or dismiss certain providers from their respective cases, including untimely and premature appeal requests, failure to claim or protest the item sought on appeal, and improper transfers (*i.e.*, the issue appealed in the individual appeals was not the same as the issue in these group appeals).[68]

Based on the foregoing, the Board hereby denies the Requests for EJR filed in the thirteen (13) cases listed in **Appendix A**, and also dismisses them for lack of jurisdiction and will remove them from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

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[67] Board Decision (Dec. 18, 2023).
[68] The Board also notes that there are Substantive Claim Challenges in three (3) cases but declines to address them based on its finding that it lacks jurisdiction over all of the providers in those cases.

FOR THE BOARD:

12/18/2024

X Kevin D. Smith, CPA

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

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Wilson Leong, FSS

Appendix A
(List of Thirteen Cases Subject to this EJR Determination)

21-1130GC	*Dignity Health FFY 2021 Medicare Unbilled Outpatient Crossover Bad Debts CIRP Group*
21-1128GC	*Dignity Health FFY 2021 Medicare Unbilled Inpatient Crossover Bad Debts CIRP Group*
18-1329GC	*QRS Dignity Health 2016 Medicare Unbilled Outpatient Crossover Bad Debts Group*
18-1330GC	*QRS Dignity Health 2016 Medicare Unbilled Inpatient Crossover Bad Debts CIRP Group*
17-1470GC	*QRS Dignity Health 2015 Medicare Unbilled Inpatient Crossover Bad Debts CIRP Group*
16-1726GC	*QRS Dignity Health 2014 Medicare Unbilled Outpatient Crossover Bad Debts CIRP Group*
16-1728GC	*QRS Dignity Health 2014 Medicare Unbilled Inpatient Crossover Bad Debts CIRP Group*
14-3536GC	*QRS Dignity Health 2012 Medicare Unbilled Outpatient Crossover Bad Debts CIRP Group*
14-3543GC	*QRS Dignity Health 2012 Medicare Unbilled Inpatient Crossover Bad Debts CIRP Group*
12-0339GC	*QRS CHW 2010 Medicare Unbilled Inpatient & Outpatient Crossover Bad Debts CIRP Group*
10-0773GC	*QRS CHW 2008 Medicare Unbilled Inpatient & Outpatient Crossover Bad Debts CIRP Group*
09-1702GC	*QRS CHW 2007 Medicare Unbilled Inpatient & Outpatient Crossover Bad Debts Grp*
11-0626GC	*QRS CHW 2009 Medicare Unbilled Inpatient & Outpatient Crossover Bad Debts CIRP Grp*

Appendix B
(Cases and Providers Challenged Based on Lack of Claim or Protest)

1. Case 09-1702GC
    a. Chandler Regional MC (Prov. No. 03-0036, FYE 6/30/2007)
    b. Arroyo Grande Comm Hosp. (Prov. No. 05-0016, FYE 6/30/2007)
    c. Bakersfield Memorial Hosp. (Prov. No. 05-0036, FYE 6/30/2007)
    d. Marian Medical Ctr (Prov. No. 05-0107, FYE 6/30/2007)
    e. Woodland Memorial Hosp. (Prov. No. 05-0127, FYE 6/30/2007)
    f. St. Mary Medical Ctr. (Prov. No. 05-0191, FYE 6/30/2007)
    g. Sequoia Hospital (Prov. No. 05-0197, FYE 6/30/2007)
    h. French Hospital Med Ctr (Prov. No. 05-0232, FYE 6/30/2007)
    i. Mercy - Redding (Prov. No. 05-0280, FYE 6/30/2007)
    j. Mark Twain St. Joseph's Hospital (Prov. No. 05-0366/05-1332, FYE 6/30/2007)
    k. St. Mary's Medical Ctr. (Prov. No. 05-0457, FYE 6/30/2007)
    l. St. John's Pleasant Valley Hospital (Prov. No. 05-0616, FYE 6/30/2007)
2. Case 10-0773GC
    a. Mercy Hospital of Bakersfield (Prov. No. 05-0295, FYE 6/30/2008)
    b. St. Rose Dominican Hospital (Prov. No. 29-0045, FYE 6/30/2008)
    c. Mercy General Hospital (Prov. No. 05-0017, FYE 6/30/2008)
    d. Bakersfield Memorial Hosp. (Prov. No. 05-0036, FYE 6/30/2008)
    e. Glendale Memorial Hospital (Prov. No. 05-0058, FYE 6/30/2008)
    f. Community Hospital of San Bernardino(Prov. No. 05-0089, FYE 6/30/2008)
    g. California Hospital Medical Center (Prov. No. 05-0149, FYE 6/30/2008)
    h. Saint Francis Memorial Hospital (Prov. No. 05-0152, FYE 6/30/2008)
    i. Mark Twain St. Joseph's Hospital (Prov. No. 05-0366, FYE 6/30/2008)
    j. Mercy Medical Center-Merced (Prov. No. 05-0444, FYE 6/30/2008)
    k. St. Mary's Medical Ctr. (Prov. No. 05-0457, FYE 6/30/2008)
3. Case 17-1470GC
    a. Glendale Memorial Hospital & MC (Prov. No. 05-0058, FYE 6/30/2015)
    b. St. Joseph's Medical Center (Prov. No. 05-0084, FYE 6/30/2015)
    c. Community Hospital of San Bernardino (Prov. No. 05-0089 6/30/2015)
    d. St. Bernardine Medical Center (Prov. No. 05-0129, FYE 6/30/2015)
    e. St. Mary Medical Center (Prov. No. 05-0191, FYE 6/30/2015)
    f. Mercy Hospital of Bakersfield (Prov. No. 05-0295, FYE 6/30/2015)
    g. Methodist Hospital of Sacramento (Prov. No. 05-0590, FYE 6/30/2015)
    h. St. Rose Dominican Hospital-DeLima Campus (Prov. No. 29-0012, FYE 6/30/2015)
    i. St. Rose Dominican Hospital-Siena Campus (Prov. No. 29-0045, FYE 6/30/2015)
    j. St. Rose Dominican Hospital-San Martin (Prov. No. 29-0053, FYE 6/30/2015)
4. Case 18-1329GC
    a. Mercy Hospital (Provider 05-0295, FYE 6/30/2016)
    b. St. Rose Dominican Hospital – San Martin Campus (Provider 29-0053, FYE 6/30/2016)

5. Case 18-1330GC
    a. Mercy Hospital (Provider 05-0295, FYE 6/30/2016)
    b. St. Rose Dominican Hospital – San Martin Campus (Provider 29-0053, FYE 6/30/2016)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Michael Newell
Southwest Consulting Associates
2805 North Dallas Parkway
Suite 620
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RE: ***Expedited Judicial Review Decision***
Case Number: 25-0552GC - Carilion Clinic CY 2008 Medicare Part C CIRP Group

Dear Mr. Newell:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petition for Expedited Judicial Review ("EJR") filed on December 5, 2024, in the above-referenced group appeal. The Board's decision on jurisdiction and EJR for the above-referenced group appeal is set forth below.

Background and Issue:

On November 1, 2024, the Board received a request to establish a Common Issue Related Party ("CIRP") group for Carilion Clinic, CY 2008. The CIRP group is appealing from Revised Notices of Program Reimbursement ("RNPRs") which were issued to implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to CY 2008.

The issue in this appeal is the DSH "calculation of days for patients who were enrolled in Medicare Advantage plans under Part C of the Medicare statute ("part C days") in the aftermath of the *Allina II* litigation . . . . [and] contends that part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction for patients eligible for Medicaid."[2] The Providers are seeking to challenge the CMS policy adopted in the June 2023 Final Rule to be applied *retroactively* for periods prior to October 1, 2013.

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] Appeal Request, Statement of Issue at 1 (Nov. 1, 2024).

Statutory and Regulatory Background:

A. RNPR Appeals

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

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

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

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

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

[3] *See also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).
[4] 42 C.F.R. § 405.1889(b)(1).

B. Medicare DSH Payment

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

The PPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[7] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[8]

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

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

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

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

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

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[5] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[6] *Id.*
[7] *See* 42 U.S.C. § 1395ww(d)(5).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[11] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[12] (Emphasis added.)
[13] 42 C.F.R. § 412.106(b)(2)-(3).

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[14]

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

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

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

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

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

[14] (Emphasis added.)
[15] 42 C.F.R. § 412.106(b)(4).
[16] of Health and Human Services.

> including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[17]

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

With the creation of Medicare Part C in 1997,[19] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C and, following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[20] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[21] The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[22]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated that her intention to address the comments received on that proposal in the FFY 2005 IPPS final rule.[23] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[24] In response to a comment regarding this change, the Secretary explained that:

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these*

[17] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[18] *Id.*
[19] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[20] 68 Fed. Reg. 27154,27208 (May 19, 2003).
[21] *Id.*
[22] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[23] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[24] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).

> *days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[25]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[26] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[27] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[28]

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

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[29]

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[25] *Id.* (emphasis added).
[26] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[27] *Id*. at 47411.
[28] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[29] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).

In 2014, the D.C. Circuit in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[30] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS final rule.[31] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[32] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[33] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.[34] A number of hospitals appealed this action.[35] In *Azar v. Allina Health Services* ("*Allina II*"),[36] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[37] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[38] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[39]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[40] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in *Allina [II]*":

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[30] 746 F. 3d 1102 (D.C. Cir. 2014).
[31] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[32] *Id.* at 2011.
[33] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[34] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[35] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo**(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board, **pursuant to 42 U.S.C. § 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[36] 139 S. Ct. 1804 (2019).
[37] *Id.* at 1817.
[38] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[39] 139 S. Ct. at 1814.
[40] 85 Fed. Reg. 47723 (Aug. 6, 2020).

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[41]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[42] Relevant to the instant EJR Request, the June 2023 Final Rule provides the following guidance on the extent to which it is to be applied *retroactively*:

> [T]he Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals whose DSH payments ***for those periods are still open or have not yet been finally settled***, encompassing thousands of cost reports.[43]

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

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP

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

> fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[44]

Providers' Appeal Request:

The "Statement of Issue" included with the appeal request states that the issue concerns the proper treatment in the Medicare DSH calculation of days for Medicare Part C patients in the aftermath of the *Allina* litigation. The Providers contend that the Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.[45]

The Providers characterized the relevant background facts as follows:

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

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

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that "the Secretary's continued application of the same [Part C days] standard from the FY 2004 rule in 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to engage in notice-and-comment rulemaking to adopt the 2004 standard . . . . The Supreme Court's decision "did not address the D.C. Circuit's alternate ruling that the readopted policy was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the policy could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[46]

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

Based on the above, the Providers maintain that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule "is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[47]

The Provider also claims that the vacatur of the 2004 rule in *Allina I* effectively restored the pre-2004 DSH Part C standard embodied in the 1986 regulation. Since that policy was established

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[44] 88 Fed. Reg. at 37788 (emphasis in original).
[45] Appeal Request, Statement of Issue at 1.
[46] *Id.* (citing to 139 S. Ct. at 1816).
[47] *Id.* (citing 4 U.S.C. § 706(2)).

through notice-and-comment rulemaking, the Provider argues that the Secretary is incorrect in alleging it needed to engage in further notice-and-comment rulemaking to establish such a standard.[48] The Provider further argues that the retroactive nature of the new Part C regulation violates 42 U.S.C. § 1395hh(e) "because neither of the narrow exceptions for retroactive rulemaking apply." First, "the DSH statute does not require any specific treatment of Part C days" and, second, the new regulation "cannot be said to be in the public interest." It also notes there is a well-established presumption in law against retroactivity.[49] The Provider claims that the new Part C regulation violates *Allina II* and is procedurally invalid and arbitrary and capricious based on the lack of explanation for changing from the pre-2004 standard and the lack of consideration or recognition of the severe impact it will have on hospitals.[50]

Providers' Request for EJR

The Providers have requested EJR over the "post-*Allina* retroactive Part C policy issue" because they believe they have met the requirements for a hearing before the Board, but the Board lacks "the authority to decide the substantive and procedural validity of CMS' final rule published in the Federal Register on June 9, 2023."[51] They seek a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.[52] "The Providers contend that the new, post-*Allina* retroactive part C days rule, applied in the [revised] notices of program reimbursement ("RNPR") appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[53] Since the Board is bound by this regulation,[54] it lacks the authority to provide the relief requested, and thus, the Providers believe EJR is appropriate.

The Providers' EJR request asserts that the Providers have met the applicable statutory conditions for appeal because they are dissatisfied with their RNPRs which apply the June 9, 2023 retroactive final rule related to Part C days. They cite language from that final rule which outlined Providers' ability to challenge this final rule once they were issued RNPRs implementing the rule.[55]

On December 9, 2024, the Medicare Contractor's representative, Federal Specialized Services, filed a timely response to the Request for EJR in this case. They simply advised that, in each

[48] *Id.* (citing 88 Fed. Reg. at 37776).
[49] *Id.* (citing *Bowen v. Georgetown Univ. Hospital*, 488 U.S. 204, 208 (1988); *Landgraf v. USI Film Prods*., 511 U.S. 244, 245 (1994)).
[50] *Id.*
[51] Provider's Petition for Expedited Judicial Review, 12 (Dec. 5, 2024).
[52] *Id.* at 15.
[53] *Id.* at 1-2.
[54] 42 C.F.R. § 405.1867.
[55] Provider's Petition for Expedited Judicial Review, 12-13 (Dec. 5, 2024) (citations omitted).

case, "a jurisdictional challenge will not be filed. A substantive claim challenge will not be filed. The MAC will not challenge Provider's request for expedited judicial review."[56]

Decision of the Board:

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

A. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [57]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[58]

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

42 C.F.R. § 405.1889 governs the scope of appeals once a contractor determination is "reopened as provided in § 405.1885[.]" In this circumstance, Providers have *limited* appeal rights, and are only able to appeal issues or matters that were "specifically revised" in the RNPR. In the June 9, 2023 Final Rule, however, the Secretary made clear that the Part C Days rule could be appealed following the issuance of a new NPR or RNPR "***even if the Medicare fraction or DSH payment does not change numerically.***"[59] Thus, the new rule could be appealed even if the treatment of Part C Days was not "specifically revised."

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[56] Response to Provider's Request for Expedited Judicial Review (Case No. 25-0552GC, Dec. 9, 2024).
[57] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[58] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[59] 88 Fed. Reg. 37788 (emphasis added).

Following the issuance of a RNPR, the Secretary stated that Providers "***will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions contained in the NPRs or revised NPRs***[,]" "**will be able to challenge the agency's interpretation** [of the treatment of Part C days in this final action] by appealing those NPRs and revised NPRs[,]" and further stated that they "**can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[60]

The Board finds that the Providers in Case 25-0552GC have all filed timely appeals from their RNPRs concerning the same common issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these RNPRs, even if there was no change in payment. The Board also finds that the amount in controversy in each case exceeds $50,000 as required by 42 C.F.R. § 405.1837(a)(3). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

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

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

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

4) It is without the authority to decide the legal question of whether the DSH Part C Days policy, as adopted on a retroactive basis in the June 9, 2023 Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of the DSH Part C Days policy, as adopted in the June 9, 2023 Final Rule, properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request 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 this group case, the Board hereby closes the case and removes it from the Board's docket.

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[60] 88 Fed. Reg. at 37787-88 (emphasis added).

Board Members Participating:

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

FOR THE BOARD:

12/18/2024

X Kevin D. Smith, CPA

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

Enclosures: Schedule of Providers

cc: Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
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RE: ***Board Dismissal – Failure to File Supplemental Preliminary Position Paper***
Heart Hospital of Bakersfield, Provider No. 05-0724, FYE 9/30/2011
PRRB Case No. 15-3206

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the "Board") has reviewed the subject individual appeal in response to the Medicare Contractor's December 16, 2024 Final Position Paper in which it advises the Provider failed to submit the required supplemental preliminary position paper in this case by the May 17, 2022 deadline set by the Board. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

The Provider submitted a request for hearing on **August 13, 2015**, from a Notice of Program Reimbursement ("NPR") **February 10, 2015**. The Initial Appeal contained eight (8) issues:

1. DSH – SSI Percentage (Provider Specific)
2. DSH – SSI (Systemic Errors)
3. DSH – SSI Fraction/Part C Days
4. DSH – SSI Fraction/Dual Eligible Days (Exhausted)
5. DSH – Medicaid Eligible Days
6. DSH – Medicaid Fraction/Part C Days
7. DSH – Medicaid Fraction/Dual Eligible Days (Exhausted)
8. Outlier Payments – Fixed Loss Threshold

On **April 20, 2016**, Issue Nos. 2, 3, 4, 6, 7 and 8 were transferred to various group appeals.[1]

On **April 28, 2016**, the Provider submitted a Preliminary Position Paper briefing Issue Nos. 1 and 5. On **August 15, 2016**, the Medicare Contractor filed its Preliminary Position Paper.

[1] Issue 2 was transferred to CN 15-1642GC, Issue 3 was transferred to CN 15-1645GC, Issue 4 was transferred to CN 15-1643GC, Issue 6 was transferred to CN 15-1647GC, Issue 7 was transferred to CN 15-1644GC, and Issue 8 was transferred to CN 15-1648GC.

The Provider submitted a request to withdraw the appeal on **March 8, 2021**. The Board closed the case on **March 9, 2021**.

In a determination dated **January 13, 2022**, the Board closed Case Nos. 15-1642GC, 15-1643GC, 15-1644GC, and 15-1648GC as the groups failed to meet the minimum number of participants requirement for a CIRP group, reinstated Case No. 15-3206, and transferred Issues 2, 4, 7, and 8 back to the reinstated individual appeal. The determination stated that the Parties would receive a Critical Due Dates Notice for the reinstated individual appeal under separate cover.

On **January 18, 2022**, the Board issued a Request for Information setting forth **May 17, 2022** and **September 19, 2022** due dates for the Provider and the Medicare Contractor to submit supplemental preliminary position papers briefing issues 2, 4, 7, and 8. The Request for Information stated "*if the necessary documentation is not submitted by the deadline, the Board will take action in accordance with 42 C.F.R. § 405.1868."* The Provider did not submit a preliminary position paper. On **September 21, 2022**, the Medicare Contractor submitted a letter stating that as the Provider had not submitted any supplemental preliminary position paper, the Medicare Contractor had no additional supplemental appeal issues to brief.

The Board issued a Notice of Hearing and Critical Due Dates on **April 22, 2024**, establishing a **November 20, 2024** due date for the Provider's final position paper and a **December 20, 2024** due date for the Medicare Contractor's final position paper. The Provider submitted its final position paper on **November 20, 2024** and the Medicare Contractor submitted its final position paper on **December 16, 2024**.

Medicare Contractor's Final Position Paper

In its final position paper, the Medicare Contractor made the following statement:

> On March 9, 2021, the PRRB closed Case Number 15-3206 in response to the Provider's withdrawal. On January 13, 2022, the Board reinstated the subject individual appeal, reinstating Issues 2, 4, 7, and 8 after transferring them back to this individual case from group cases.
>
> On January 18, 2022, the Board also established new Preliminary Position Papers due dates with the Provider's PPP due May 17, 2022. The Provider did not submit a Supplemental Preliminary Position Paper in 2022. Note that the Provider's original Preliminary Position Paper filed in 2016 did not address Issues 2, 4, 7, and 8, as those issues were transferred to groups at that point in time. Therefore, these four issues were never briefed by the Provider until the submission of its Position Paper in 2024. As the Provider failed to file the required Preliminary Position Paper, the MAC filed a letter explaining that the MAC PPP would not be filed as the Provider had failed to file. The MAC asserts that the Provider essentially abandoned the reinstated Issues 2, 4, 7, and 8 when the Provider failed to file its Preliminary Position Paper briefing these issues by the due date of May

17, 2022. Therefore, the MAC requests that the Board dismiss these four issues and this case.[2]

Pertinent Regulations

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

Further 42 C.F.R. § 405.1868 states that:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. *The Board's powers include the authority to take appropriate actions in response to the* ***failure of a party*** *to a Board appeal* ***to comply with Board*** rules and ***orders*** or for inappropriate conduct during proceedings in the appeal.
>
> (b) *If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—*
>
> *(1) Dismiss the appeal with prejudice***;**
>
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
>
> (3) Take any other remedial action it considers appropriate.[3]

Board Determination

The Critical Due Dates issued shortly after an appeal is filed, notifies providers "You are responsible for pursuing your appeal in accordance with the Board's Rules. You must mee the above due dates . . . If you miss any of your due dates, the Board will dismiss your appeal."[4] The Provider missed the deadline to file the supplemental position paper for the issues transferred back to this individual appeal (after the initial preliminary paper was filed), as th group appeals to which the issues had been transferred did not meet regulatory requirements. There was a mandate to file the preliminary paper with legal arguments for those issues. The

[2] Medicare Contractor's Final Position Paper at 1-2.
[3] Emphasis added.
[4] Acknowledgement and Critical Due dates letter issued August 19, 2015.

Board finds that the Provider failed to file a supplemental preliminary position paper briefing the reinstated Issues 2, 4, 7 and 8 by the May 17, 2022 deadline set in the Board's January 18, 2022 Request for Information. Therefore, the Board hereby dismisses those issues from this appeal pursuant to its authority under 42 C.F.R. § 405.1868. As there are no issues remaining in the appeal, Case No. 15-3206 is now 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:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

12/20/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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