DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Decision***
Medical Center of South Arkansas (Provider Number 04-0088)
FYE: 06/30/2012
Case Number: 16-1614

Dear Mr. Summar:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 16-1614 pursuant to a jurisdictional challenge filed by the Medicare Administrative Contractor ("MAC"). The Board's decision is set forth below.

Background

A. Procedural History for Case No. 16-1614

On **November 18, 2015**, the Provider, Medical Center of South Arkansas, was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2012.

On **May 13, 2016**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained two (2) issues:

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

On **May 18, 2016**, the Provider filed its preliminary position paper. On **January 26, 2017**, the Medicare Contractor filed its preliminary position paper.

On **May 9, 2018**, the Medicare Contractor filed a jurisdictional challenge requesting dismissal of Issue 1. On **June 8, 2018,** the Provider timely filed a jurisdictional response.

On **October 31, 2023**, the Provider filed its final position paper. Similarly, on **December 1, 2023**, the Medicare Contractor filed its final position paper.

On **January 4, 2024**, the Provider withdrew Issue 2 from the appeal. As a result, the only remaining issue in this appeal is Issue 1, DSH – SSI Percentage (Provider Specific).

B. Description of Issue 1 in the Appeal Request

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

> The Provider contends that the MAC did not determine DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).[1]

On October 31, 2023, the Board received the Provider's final position paper in Case No. 16-1614. 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

[1] Provider's Appeal Request at 11 (May 13, 2016).

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

MAC's Contentions

Issue 1 – DSH – SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) because the appeal is premature, as the Provider has not requested realignment in accordance with 42 C.F.R. § 412.106(b)(3):

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's right to a hearing derives from an intermediary or Secretary determination, which is defined at 42 C.F.R. § 405.1801(a):
>
> > [A] determination of the amount of total reimbursement due the provider, pursuant to § 405.1803 following the close of the provider's cost reporting period.
>
> The Provider's appeal is premature. The Provider has not formally requested to have the SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). The Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue. The MAC requests that the PRRB dismiss this issue consistent with its prior jurisdictional decisions.[3]

[2] Provider's Final Position Paper at 7-8 (Oct. 31, 2023).
[3] Jurisdictional Challenge at 3 (May 9, 2018).

Provider's Jurisdictional Response

On June 8, 2018, the Provider filed a Jurisdictional Response in which it makes the following arguments:

> The Provider is not addressing a realignment of the SSI percentage, but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category.
>
> Accordingly, this is an appealable item because the MAC specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year end 2012 resulting from its understated SSI percentage.
>
> The Provider is entitled to appeal an item with which it is dissatisfied. Further, [CMS] in *Northeast Hospital Corporation v. Sebelius* (D.C. Cir. September 13, 2011) specifically abandoned the CMS Administrator's December 1, 2008 decision that the SSI ratio cannot be revised based upon updated data after it has been calculated by CMS. Accordingly, the Provider believes that it can specifically identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS. *See Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008). Once these patients are identified, the Provider contends that it will be entitled to a correction of these errors of omission to its SSI percentage 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 DSH/SSI percentage was adjusted on the Provider's cost report. Accordingly, the Provider requests that the Board find that it has jurisdiction over the DSH/SSI issue.[4]

Analysis and Recommendation

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.

---

[4] Provider's Jurisdictional Response at 1-2 (June 8, 2018).

The Board's review of Issue 1 confirms that it has 2 aspects, one pertaining to realignment and another pertaining to the computation of the SSI fraction. Set forth below is the Board's determination to dismiss both aspects.

1. Realignment aspect of Issue 1

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

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

2. SSI Computation aspect of Issue 1

The aspect of Issue No. 1 regarding the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage is dismissed after review of two factors.

In review of the appeal, the Board has also identified that Community Health Systems ("CHS"), the parent organization of the Medical Center of South Arkansas, filed a Common Issue Related Party ("CIRP") group appeal under Case Number 19-1196GC on February 18, 2019 which was entitled "CHS CY 2012 DSH SSI Percentage CIRP Group." This group case does not appear to include the Medical Center of South Arkansas as a participant (whether by transfer or direct add). Review of the group issue statement indicates that the Group issue was presented as follows:

> 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. § 1395 ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentage calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSI 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]

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[6] 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)."[7] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ."[8] and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[9]

The DSH/SSI Percentage (Systemic Errors) issue in the CHS group Case No. 19-1196GC 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). The Board finds that these are the same issue and notes that "Providers that are commonly owned or controlled must bring a group appeal for any issue common to the related Providers"[10] according to the Board Rules in effect as of July 1, 2015. The provider in the current appeal was not included in the CHS CIRP Group.

Further, the Board finds that CHS abandoned this Provider's opportunity to pursue Issue 1 as part of the CIRP group appeal under Case No. 19-1196GC. This CIRP group was formed with one participant. On March 28, 2019, the Board acknowledged the formation of the group and required the group representative, Quality Reimbursement Services ("QRS"), to file comments by February 18, 2020 on the status of group and whether it was fully formed. On March 28, 2019, QRS filed an ***untimely*** response and stated the group was "not completely formed as an NPR has not been issued for Provider Number 01-0131."[11] On September 24, 2020, the Board dismissed the original participant in the CIRP group. On July 7, 2022, the Medicare Contractor requested dismissal of the appeal for abandonment since the Board had dismissed the sole participant 2 years earlier and there had been no activity since:

> There has not been any activity with Case 19-1196GC since the Board denied the transfer [on September 24, 2020]. There are no active participants of the case. WPS – GHA believes the case has been abandoned and respectfully requests the Board to dismiss the case.

[5] Group Issue Statement in Case No. 19-1196GC (February 18, 2019).
[6] Issue Statement at 1.
[7] *Id.*
[8] *Id.*
[9] *Id.*
[10] PRRB Rule 12.5.B (July 1, 2015).
[11] Status Response Case No. 19-1196GC (March 16, 2020).

Under Board Rules, QRS had 30 days to respond to the Medicare Contractor's Motion but failed to timely file any response or transfer any other participants into the group. Accordingly, on August 11, 2022, the Board dismissed the appeal due to it being abandoned noting: "To date, there has been no response from QRS regarding the Medicare Contractor's dismissal request. Since the sole participant in the group was previously dismissed and there have been no additional providers added to the group in the last three years, the Board hereby closes Case No. 19-1196GC and removes it from the docket." Board Rule 19.2 indicates that "[m]andatory CIRP group appeals must contain all Providers eligible to join the group which intend to appeal the disputed common issue."[12] As such, it is clear that the Provider had an obligation to transfer the issue and pursue it as part of the CIRP group under Case No. 19-1196GC. As the instant provider failed to transfer Issue 1 and join the CHS CIRP group, and the group has since been dismissed due to abandonment, this provider has abandoned its opportunity to appeal the common issue for CY 2012. In this regard, the Board notes that QRS failed to identify this Provider as having the issue in its March 28, 2019 filing and failed to respond to the Medicare Contractor's request that the Board dismiss Case No. 19-1196GC due to abandonment.

The Provider's jurisdictional response is essentially a restatement of its Issue Statement, and admittedly does not address its failure to request realignment, as originally stated in the initial appeal submitted to the Board on May 13, 2016. This further supports the dismissal of the realignment issue in this case.

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

https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[13]

[12] PRRB Rule 19.2 (July 1, 2015).
[13] Last accessed January 16, 2024.

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[14]

The Provider's Final Position Paper asserts that it "hereby incorporates all of the arguments presented before the Unites States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v. Xavier Becerra"[15], yet, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to. Moreover, the Provider's final position paper fails to recognize that, on September 1, 2023, *more than 60 days prior to filing its position paper*, the D.C. Circuit ruled against the Providers in this case. Regardless, the issues raised in *Advocate Christ* are ones that are subject to the CIRP group rules and were part of the CIRP group under Case No. 19-1196GC that CHS abandoned.

Accordingly, *based on the record before it*, the Board finds that the SSI Provider Specific issue in Case No. 16-1614 is dismissed because there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to meet the Board requirements for position papers. Further, the Provider failed to join the mandatory CIRP group for this issue in the applicable calendar year (2012), and that group is now closed, leaving the Provider unable to pursue the issue.

The Provider's Final Position Paper failed to comply with Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits. For example, in its appeal request the provider states it is "seeking 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 but fails to provide any information on the status of that request, what efforts have been made to get that information, or when the information is expected to be available consistent with Board Rule 25.2.2. Similarly, the Provider states in its jurisdictional response that it "believes it can specifically identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS" but fails to include any information or examples, notwithstanding the facts that this case has been pending ***for almost 8*** and the fiscal year at issue has been closed for ***more than 11 years***. In these instances, due to the Provider's failure to properly develop this SSI provider specific issue, we have found the issue to be duplicative of the group issue which in this case was clearly abandoned.[16]

---

[14] Emphasis added.
[15] Provider's Final Position Paper at 7-8.
[16] Examples of CHS cases were the Board has dismissed the SSI provider specific issue include: Case Nos. 18-1103 (letter dated Sept. 28, 2023), 20-0434 (by letter dated Aug. 18, 2023), 18-1422 (Sept. 24, 2020), .*See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

****

As the SSI Provider Specific issue was the sole issue remaining in the appeal, the case is hereby dismissed. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

2/1/2024

X Kevin D. Smith, CPA

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

cc: Wilson Leong, Federal Specialized Services
Michael Redmond, Novitas Solutions (J-H)

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.

Plaintiffs did not follow these rules. In their RFH, Plaintiffs described Issue 4 simply as follows: "The intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment." Ex. 1 at 3. This description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently. Recall, a Disproportionate Share Hospital reimbursement is determined by calculating a provider's Medicare-SSI and Medicaid fractions, which make up the provider's Disproportionate Patient Percentage. The Medicare-SSI Fraction alone has multiple component parts that a provider could challenge. Plaintiffs did not specify which specific portion of the fraction they sought to challenge or what would have constituted correct data for the Disproportionate Share Hospital calculation. This provides sufficient basis to support the Board's dismissal. The Board's procedural rules empower the body to dismiss a provider's appeal when the provider's RFH or Preliminary Position Paper is deficient. *See* 42 C.F.R. § 405.1868(b); Board Rules § 41.2. Because Plaintiffs did not comply with the specificity requirement, the Board acted reasonably in dismissing their Issue 4 claims.

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

Amy Stephens
West Virginia University Health System
P.O. Box 8261
3040 University Avenue
Morgantown, West Virginia 26505

Dana Johnson
National Government Services, Inc.
MP: INA101-AF-42
P.O. Box 6474
Indianapolis, Indiana 46206-6474

RE: ***Board Dismissal of SSI Percentage (Provider Specific)***
Reynolds Memorial Hospital (Provider Number 51-0013)
FYE: 09/30/2016
Case Number: 21-0442

Dear Ms. Stephens and Ms. Johnson,

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

Procedural History for Case No. 21-0442

On July 2, 2020, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2016.

On December 28, 2020, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained three (3) issues:

1. Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) Percentage (Provider Specific)
2. DSH SSI Percentage (Systemic Errors)[1]
3. Standardized Payment Amount[2]

The remaining issue in this appeal is Issue 1.

On January 6, 2021, the Provider submitted its preliminary position paper.

On November 17, 2021, the Medicare Contractor filed a Jurisdictional Challenge.

On December 1, 2021, the Medicare Contractor submitted its preliminary position paper.

[1] On July 28, 2021, this issue was transferred to Case No. 21-1434GC.
[2] On July 28, 2021, this issue was transferred to Case No. 21-1435GC.

A. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 21-1434GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[3]

As the Provider is commonly owned by West Virginia University Health System, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 21-1434GC, WVU Medicine CY 2016 DSH SSI Percentage CIRP Group, on July 28, 2021. The Group Issue Statement in Case No. 21-1434GC reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

[3] Issue Statement at 1 (Dec 28, 2020).

> 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.[4]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $8,000.

On January 6, 2021, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

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

[4] Group Issue Statement, Case No. 21-1434GC.

> *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.[5]

MAC's Contentions

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

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

> Realignment can be performed once per hospital per cost reporting period and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period, regardless of if the result is advantageous to the hospital or not. The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election and not a final MAC determination.
> . . .
>
> The MAC has not made a determination on the realignment of the SSI percent to the hospital fiscal year end, as the Provider's fiscal year end is the same as the federal fiscal year end and it therefore, has not requested realignment, nor is realignment applicable. Since the Provider did not request SSI realignment, as required by 42 C.F.R § 412.106(b)(3), the MAC could not have made a final determination for this issue. The MAC requests that the PRRB dismiss this subsidiary realignment issue consistent with its jurisdictional decisions.[6]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are duplicates.[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 or Motion to Dismiss and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Similarly,

[5] Provider's Preliminary Position Paper at 7-8 (January 6, 2021).
[6] Jurisdictional Challenge at 5-6 (November 17, 2021).
[7] *Id*. at 4.
[8] Board Rule 44.4.3, v. 3.1 (Nov. 2021)

Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Board Analysis and Decision:

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

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 21-1434GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[9] 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 that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[11]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 21-1434GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the

[9] Issue Statement at 1.
[10] *Id.*
[11] *Id.*

DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 21-1434GC. 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.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case 21-1434GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[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 can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 21-1434GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 21-1434GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* 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.

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

> Once the documents become available, promptly forward them to the Board and the opposing party.[14]

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[15]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[16]

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

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 21-1434GC are the same issue.[17] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited

---

[14] (Emphasis added).
[15] Last accessed January 4, 2024.
[16] Emphasis added.
[17] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a West Virginia University Health System CIRP group per 42 C.F.R. § 405.1837(b)(1).

by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal. Further, the Board notes that the Provider's cost reporting period is congruent with the federal fiscal year (both end on 9/30), and thus, any realignment of the SSI percentage would have no effect on reimbursement for this provider.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 21-1434GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. As no issues remain pending, the Board hereby closes Case No. 21-0442 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

2/1/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Corinna Goron
Healthcare Reimbursement Services, Inc.
3900 American Dr., Ste. 202
Plano, TX 75075

RE: ***Notice of Dismissal***
Case No. 24-0310G *et al.* (*see* **Appendix A** listing 50 cases)

Dear Ms. Goron:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the fifty (50) above-referenced common issue related party ("CIRP") and *optional* group cases. Set forth below is the decision of the Board to dismiss these 50 appeals challenging the Treatment of Part C Days from the Final Rule.

Background

Healthcare Reimbursement Services, Inc. ("HRS") represents a number of Providers in CIRP and optional groups which are challenging the Treatment of Part C Days as appealed from the Final Rule. On December 1st, 4th, 5th, and 6 of 2023, HRS filed appeal requests on behalf of 50 different provider groups (both optional and CIRP groups) concerning the final rule that the Secretary of Health and Human Services ("Secretary") published in the June 9, 2023 Federal Register ("June 2023 Final Rule") as it relates to the HRS Groups' yet-to-be-finalized FY 2006-2013 Medicare disproportionate share hospital ("DSH") reimbursement.[1]

In the June 2023 Final Rule, the Secretary adopted and finalized its policy to include Part C days in the SSI fraction as used in the DSH calculation for Part C discharges occurring prior to October 1, 2013 and applied this policy *retroactively* to certain open fiscal years to which this policy would appeal.

The Providers in the group appeals all involve fiscal years ranging from 2006 to 2013. The ***sole*** issue in each of these appeals is "whether Part C days are properly included in the denominator of the Medicare Fraction per a June 9, 2023, retroactive final rule issued by the Centers for Medicare & Medicaid Services ("CMS"), which is binding on the Medicare Administrative Contractor ("MAC"), or whether such final rule is illegal and cannot be enforced."[2] The HRS Groups

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] Issue Statement at 1 in Case No. 24-0310G. Each of the Issue Statements in the 50 HRS appeals referenced in this decision are materially identical.

challenge the procedural and substantive validity of the policy adopted and finalized in the June 2023 Final Rule.[3]

Significantly, the Providers' appeal requests in these cases suggest that they may not have a right to appeal since "this issue [being appealed here] is pending in [another] appeal that was remanded to the MAC." Notwithstanding, they have not provided ***any*** explanation in their appeal requests of why the Board has jurisdiction over their appeal and *none has included* ***any*** *information on the other "pending . . . appeal that was remanded to the MAC"* ***they allege*** *in their group appeal requests*. As explained below, it is the Providers' responsibility under 42 C.F.R. § 405.1837(c) and Board Rules to include the necessary documentation in the appeal request to demonstrate the Board's jurisdiction over the appeals.

Issue in Dispute

HRS is the group representative for these 50 cases filed on December 1, 4, 5, and 6 of 2023. Each case has the same issue statement, which reads:

> The issue is whether Part C days are properly included in the denominator of the Medicare Fraction per a June 9, 2023, retroactive final rule issued by the Centers for Medicare & Medicaid Services (CMS), which is binding on the Medicare Administrative Contractor (MAC), or whether such final rule is illegal and cannot be enforced.
>
> The Providers appeal the Secretary's determination, which it calls a "final action," embodied in a June 9, 2023, retroactive final rule, that requires Part C Days to be included in the Medicare Fraction of the disproportionate payment percentage for discharges occurring prior to October 1, 2023 ("the Part C Days Final Rule"). The Part C Days Final Rule became effective on August 8, 2023. The Providers challenge the procedural and substantive validity of the Part C Days Final Rule. Specifically, the Providers assert that the Part C Days Final Rule is procedurally invalid the retroactive nature of the rule violates the rulemaking provisions of the Social Security Act and the Administrative Procedure Act, and is contrary to the D.C. Circuit's opinion in *Northeast Hospital v. Sebelius*, and established precedent regarding the applicability of a pre-existing rule when a later rule is vacated (as was the 2004 final rule on Part C days). The Part C Days Final Rule is substantively invalid because it is arbitrary and capricious. Specifically, the Part C Days Final Rule is arbitrary and capricious because CMS did acknowledge that putting Part C Days in the Medicare Fraction was a departure from its policy or practice prior to the vacated

[3] 88 Fed. Reg. 37772 (June 9, 2023).

> 2004 rule. The Part C Days Final Rule also failed to account for hospitals' reliable interest on the pre-2004 final rule practice or policy, and also failed to recognize the enormous adverse financial impact on hospitals due to the change from the pre-2004 final rule practice or policy.
>
> ***The Providers acknowledge that this issue is pending in an appeal that was remanded to the MAC***. *However, that remand preceded the Part C Days Final Rule and this appeal is limited to challenging the Part C Days Final Rule*. Moreover, it is not clear whether the Providers will have full appeal rights following any decision upon remand. That is, it is not clear whether the Providers will be afforded the opportunity to challenge the legality of the Part C Days Final rule, if, for example,: (a) there is no change in the Provider's Disproportionate Payment Percentage (DPP) in the MAC's determination following remand because Part C days were placed in the Medicare Fraction originally; or (b) there is a positive change in the Providers' DPP for other reasons (such as the addition of Medicaid eligible days) but the DPP would have been even greater had Part C days not been included in the Medicare Fraction. For this reason, out of an abundance of caution the Providers bring this challenge to the Part C Days Final Rule at this time.[4]

Statutory and Regulatory Background:

A. Medicare DSH Payment

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

The IPPS 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 IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[8]

---

[4] Issue Statement at 1 in Case No. 24-0310G (emphasis added). Each of the Issue Statements in the 50 HRS appeals referenced in this decision are identical.
[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.

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 of these fractions consider whether a patient was "entitled to benefits under part A."

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

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

---

[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).
[14] (Emphasis added.)
[15] 42 C.F.R. § 412.106(b)(4).

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

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

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

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

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

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

---

[16] of Health and Human Services.
[17] 55 Fed. Reg. 35990, 39994 (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.

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 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.

---

[20] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).
[21] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[22] 69 Fed. Reg. at 49099.
[23] *Id.* (emphasis added).

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]

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

---

[24] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[25] *Id*. at 47411.
[26] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[27] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[28] 746 F. 3d 1102 (D.C. Cir. 2014).
[29] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[30] *Id.* at 2011.
[31] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).

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]":

> 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

[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).
[38] CMS Ruling 1739-R at 1-2.
[39] 88 Fed. Reg. 37772 (June 9, 2023).

> 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 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]

Decision of the Board:

As set forth below, the Board hereby ***dismisses*** the Providers' appeals because they failed to appeal from a final determination and their appeals are premature and their appeal requests failed to meet the content requirements for a request for Board hearing as a group appeal.

A. ***The Part C Policy finalized in the June 2023 Final Rule Is Not an Appealable "Final Determination" under 42 U.S.C. § 1395oo(a)(1)(A)(ii).***

In their appeal requests, the Providers allege (without providing any proof) "that this issue is pending in an appeal that was remanded to the MAC." The Providers state out of an abundance of caution they have brought this appeal as they are unsure about their appeal rights these cases *allegedly* pending on remand:

> [I]t is not clear whether the Providers will be afforded the opportunity to challenge the legality of the Part C Days Final [R]ule if, for example: (a) there is no change in the Providers' Disproportionate Payment Percentage (DPP) in the MAC's determination following remand because Part C days were placed in the Medicare Fraction originally; or (b) there is a positive

[40] *Id.* at 37775 (emphasis added).
[41] 88 Fed. Reg. at 37788 (emphasis in original).

> change in the Providers' DPP for other reasons (such as the addition of Medicaid eligible days)[,] but the DPP would have been even greater had Part C days not been included in the Medicare Fraction. For this reason, out of an abundance of caution the Providers bring this challenge to the Part C Days Final Rule at this time.[42]

Notwithstanding the fact that these *other* alleged appeals are still *pending* and involve the *same* issue and fiscal years, the Providers filed appeal requests to establish the instant 50 group appeals set forth in **Appendix A** based on their appeal of the finalization of the policy at issue in the June 2023 Final Rule. In filing these group appeals, the Providers identified the June 2023 Final Rule as the "final determination" being appealed. As this is a final rule (as opposed an NPR or revised NPR), they appear to be asserting that their right to appeal is based on 42 U.S.C. § 1395oo(a)(1)(A)(ii). In this regard, § 1395oo(a) the following in pertinent part:

> **(a) Establishment**
>
> . . . *[A]ny hospital* which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title *and which has submitted such [cost] reports within such time as the Secretary may require in order to make payment under such section* may obtain a hearing with respect to such payment by the Board, if—
>
> (1) such provider—
>
> (A) . . .
>
> (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, ...[43]

However, the Board finds that the adoption/finalization of this policy in the June 2023 Final Rule is not a "final determination" directly appealable to the Board *for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii)*. Rather, the providers' appeals are premature as described below.

Unlike DRG rates and other adjustments such as the wage index, 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*.[44] To this end, DSH eligibility ***and*** payment, if any, is determined, calculated,

---

[42] Providers' Group Issue Statements.

[43] (Bold emphasis in original and italics and underline emphasis added.)

[44] 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

and finalized *annually* through the cost report audit/settlement process as made clear in 42 C.F.R. § 412.106(i) which sets forth the following instructions regarding the determination of a hospital's eligibility for a DSH payment for each fiscal year and, if so, how much:

> (i) *Manner and timing of [DSH] payments*. (1) **Interim** [DSH] **payments** are made **during the payment year to each hospital that is estimated to be eligible** for payments under this section at the time of the annual final rule for the hospital inpatient prospective payment system, **subject to the final determination of eligibility at the time of cost report settlement for each hospital**.
>
> (2) **Final payment determinations are made at the time of cost report settlement**, based on the **final** determination of each hospital's eligibility for payment under this section.[45]

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***."[46] Examples of other adjustments to IPPS payment rates that are based, in whole

---

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.

[45] (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)).

[46] 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.
>
> *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.
>
> ****
>
> **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**

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,[47] direct graduate medical education ("GME"),[48] and indirect GME.[49]

Here, none of the Providers' appeal requests included a copy of the NPR or revised NPR (with associated audit adjustment pages) for the year at issue that would underlie the alleged pending remand to the MACs. As a result, it is unclear whether that those NPRs/revised NPRs addressed consistent with 42 C.F.R. § 412.106(i) both: (1) whether each of these Providers is eligible for a DSH payment *for the relevant year at issue*; and (2) if so, how much.[50] Further, as discussed *infra*, each of these Providers have alleged that it has pending before the MAC another appeal of the same Part C days issue; however, it is unclear why the Providers were remanded as alleged (*e.g.*, remanded pursuant to a Court Order vs. remanded pursuant to CMS Ruling 1498-R) and what the parameters of those remands is.

Regardless, the four corners of the June 2023 Final Rule confirms that the Providers appeals are premature because the June 2023 Final Rule confirms both that: (1) it is ***not*** a final determination

---

> **settlement.** As we discuss in greater detail in section V.E.3.f. of the preamble to this final rule, we will make interim eligibility determinations based on data from the most recently available SSI ratios and Medicaid fractions prior to the beginning of the payment year. We will then make final determinations of eligibility at the time of settlement of each hospital's cost report. Therefore, we proposed that, at cost report settlement, the fiscal intermediary/MAC will issue a notice of program reimbursement that includes a determination concerning whether each hospital is eligible for empirically justified Medicare DSH payments and, therefore, eligible for uncompensated care payments in FY 2014 and each subsequent year. In the case where a hospital received interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year on the basis of estimates prior to the payment year, but is determined to be ineligible for the empirically justified Medicare DSH payment at cost report settlement, the hospital would no longer be eligible for either payment and CMS would recoup those monies. For a hospital that did not receive interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year, but at cost report settlement is determined to be eligible for DSH payments, the uncompensated care payment for such a hospital is calculated based on the Factor 3 value determined prospectively for that fiscal year.

Id. at 50626-27 (emphasis added).

[47] 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.).

[48] 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.").

[49] 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)).

[50] In this regard, a provider that did not qualify for a DSH payment adjustment for a particular fiscal year may appeal that finding by challenging multiple components of the DSH adjustment calculation which, if successful, could result in the provider qualifying for a DSH adjustment for that year. Further, the fact that a hospital has received a DSH payment in a ***prior*** fiscal year, does not mean or guarantee that the hospital will (or continue to) be eligible for and receive a DSH payment in a subsequent fiscal year. For each fiscal year, the Medicare contractor determines whether a hospital is eligible for a DSH payment and, if so, how much based on multiple variables associated with that fiscal year (*e.g.*, the number of Medicaid eligible days in the relevant fiscal year).

appealable to the Board; *and* (2) the Secretary did ***not*** otherwise intend for it to be a final determination appealable to the Board. The June 2023 Final Rule simply finalizes the adoption of the Part C days policy at issue for open and prospective cost reporting periods relating to discharges occurring prior to October 1, 2013. It does not make any determination on *any* hospital's DSH eligibility (much less these Providers') and, if so, how much. Moreover, it does not publish *any* hospital's SSI percentage (much less these Providers for the relevant years at issue) that would be used in DSH calculations for those hospitals whose eligibility would later be determined as part of their cost report settlement process for the relevant fiscal years. Further, the following excerpts from the June 2023 Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule to be an appealable "final determination":

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports****. In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[51]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[52]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised***

[51] 88 Fed. Reg. at 37774-75 (emphasis added).
[52] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).

> ***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."[53]

4. "*When the Secretary's treatment of Part C days in this final action is reflected **in NPRs and revised NPRs**, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation **by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[54]

The above discussion in the preamble to the June 2023 Final Rule makes clear that hospitals would be *not* able to ***directly*** appeal from Final Rule since the finalized policy is not applied in the Final Rule to any specific hospitals and the preamble's discussion of a hospital's right to challenge that finalized policy is only in the context of the yet-to-be issued NPRs (original or revised) that: (1) would be issued *following publication of the new SSI percentages*; and (20 would both apply the finalized policy and would be sued to determine DSH eligibility for a hospital's prior pre-October 1, 2013 cost reporting period that is still open for resolution (whether through issuance of an original or revised NPR[55]) and, if so, the amount of the DSH payment. Here, if the June 2023 Final Rule will be applied to them for the fiscal years at issue, then it is clear that Providers' appeals are premature as they will have an opportunity to later file an appeal to challenge the policy at issue once their respective fiscal year NPRs/revised NPRs are issued *consistent with the above excerpts from the preamble to the June 2023 Final Rule and 42 C.F.R. § 412.106(i)*.

The Board recognizes that the Part C issue has a long litigation history and the most recent is referred to as the *Allina II* litigation.[56] However, the *Allina II* litigation has no relevance to the ***jurisdictional*** issue that the Board is addressing in the instant case because that litigation did *not* address the Board's *jurisdiction* over the underlying appeals of the nine (9) Plaintiff hospitals in

---

[53] *Id.* at 37788 (emphasis added).
[54] *Id.* (emphasis added).
[55] Just because a hospital was eligible for a DSH payment in the original NPR, does not mean that the hospital would *continue* to be eligible for a DSH payment following the issuance of a revised NPR pursuant to the June 9, 2023 Final Rule. Similarly, the converse may be true. As such, a hospital eligibility status may change following the issuance of a revised NPR pursuant to the June 9, 2023 Final Rule. Moreover, there could be other DSH variables at play in the NPR/revised NPR such as consideration of Medicaid eligible days (removal or addition of such days) depending on what other issues may remain open in the relevant fiscal year.
[56] *Allina II* began as *Allina Health Servs. v. Burwell*, No. 14-01415, (D.D.C. Aug. 19, 2014) resulting in *Allina Health Servs. v. Burwell*, 201 F. Supp. 3d 94 (D.D.C. 2016), *reversed Allina Health Servs. v. Price*, 863 F.3d 937 (D.C. Cir. 2017), *aff'd sub nom. Azar v. Allina Health Servs.*, 139 S. Ct. 1804 (2019) ("*Allina II*").

Allina II (*i.e.*, it does not address whether the publication of the SSI ratios was a "final determination" *for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii)*).[57]

Similarly, the Board declines to follow D.C. District Court's decision in *Battle Creek*[58] and instead continues to find the D.C. District Court's 2022 decision in *Memorial Hospital* to be instructive. *Memorial Hospital* concerns another variable used in the DSH adjustment calculation. Specifically, the providers in that case appealed ***the publication of their DSH SSI ratios*** (which is one step *after* the cases at hand where Providers are appealing the final rule adopting/finalizing a policy ***prior to*** the publication of the DSH SSI ratios reflecting that Final Rule[59]). 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 this case because "the secretarial determination at issue was either the only determination on which payment depended or clearly promulgated as a final rule."[60] 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

---

[57] Rather, *Allina II* addresses the Board's "no-authority determination" when it granted EJR for the *Alliana II* providers. This is not a *jurisdictional* issue under 42 U.S.C. § 1395oo(a)(1), but rather an issue relating to whether the Board appropriately granted EJR pursuant to 42 U.S.C. § 1395oo(f)(1). Further, 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)).

[58] 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 cases at hand. *Battle Creek* addressed whether the publication of SSI fractions is a final determination. In contrast, the Providers did not appeal the publication of SSI fractions but rather a final rule adopting and finalizing the policy at issue ***prior to*** the issuance of new SSI fractions to be used in the yet-to-be issued NPRs/revised NPRs for the hospital covered by the terms of that final rule. To this end, in finalizing that policy adoption in the June 2023 Final Rule, the Secretary announced that "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*** . . . ." 88 Fed. Reg. at 37774 (emphasis added).

[59] The Providers' appeal requests are clear that they were filed to appeal from the June 2023 Final Rule, as opposed to appeal from any publication of SSI fractions. Indeed, it is not clear from the record before the Board whether any new SSI percentages for these Providers *for the specific fiscal years appealed* have been in fact issued *pursuant to the implementation of the June 2023 Final Rule as set forth therein*. To this end, the Board notes that 42 C.F.R. § 405.1837(c)(3) requires an appeal request to include a copy of the final determination being appealed, but none of the appeal request include a copy of the publication of any SSI fractions.

[60] 2022 WL 888190 at *8.

ratios, *even if the publication of the SSI fractions had been issued as "final,"* it 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*."[61] 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).").[62]

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.[63]

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 . . . .";[64] and (b) "The amount is the per-patient amount calculated under § 1395ww(d) and is final once the Secretary has published the DRG amounts (as 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."[65]

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 June 2023 Final Rule, it is ***not*** a "final determination" as to the amount of payment received by Providers for their various fiscal years at issue. Rather, the June 2023 Final Rule reflects "just one of the variables that determines

---

[61] *Id.* at *9 (emphasis added).
[62] *Id.* at *8.
[63] *Id.* at *9.
[64] 795 F.2d at 143 (emphasis added).
[65] *Id.* at 147 (footnote omitted).

whether hospitals receive a DSH payment [for the relevant fiscal year] ***and***, ***if so***, *for how much*"; and any "***final*** *payment* determination"[66] 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)*.[67] In this regard, the Board again notes that the June 2023 Final Rule did not make a determination on any specific hospital's DSH eligibility and, if so, the amount of DSH payment. Rather, as it relates to this appeal, the Final Rule adopts a policy that is to be applied *retroactively* but only to certain hospitals and makes clear that, *following the publication of new SSI percentages*, those affected hospitals who had open cost reporting periods for this issue would be issued an NPR (original or revised) that both would apply the finalized policy and would determine: (a) DSH eligibility for a hospital's prior period that is still open for resolution (whether through issuance of an original or revised NPR); and (b) if so, the amount of the DSH payment.[68]

In summary, the Board finds that the June 2023 Final Rule appealed in the instant case is not an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835(a) and the appeal (as alleged) appears premature.[69] Accordingly, the Board finds it is appropriate dismiss the instant appeal and remove it from the Board's docket, since satisfying the criteria set out in 42 C.F.R. § 405.1835(a) is required (as explained in 42 C.F.R. §§ 405.1837(a)(1) and 405.1837(c)(1)) before the Board can exercise jurisdiction over an appeal,[70] and since the Providers have failed to demonstrate in its hearing request that those criteria have been met for the fiscal years under appeal.[71]

B. ***Even if the June 9, 2023 Final Rule Could Be Appealed as a "Final Determination" Under 42 U.S.C. § 1395oo(a)(1)(A)(ii), the Providers' Appeal Requests Failed to Meet the Minimum Content Requirements For an Appeal Request to Demonstrate that the Final Rule Was Applicable to Them For the Fiscal Years at Issue.***

42 C.F.R. § 405.1835(c) specifies the content requirements for a request for a Board hearing as a group appeal. The Providers allege that the issue in these appeals "is pending in an appeal that was remanded to the MAC." Notwithstanding, they have not provided any explanation in their appeal requests of why the Board has jurisdiction over their appeal and *none has included* ***any*** *information on the other "pending . . . appeal that was remanded to the MAC"* ***they allege*** *in their group appeal requests*. In this regard, the Board notes that it is the Providers' responsibility under 42 C.F.R. § 405.1837(c) and Board Rules to include the necessary documentation in the appeal request to demonstrate the Board's jurisdiction over the appeals.

---

[66] 42 C.F.R. § 412.106(i)(2) (emphasis added).
[67] 2022 WL 888190 at *9 (emphasis added).
[68] *See supra* note 59 (confirming that none of the Providers appealed from the publication of SSI fractions).
[69] The Board's dismissal does not mean that the Secretary's policy finalized in the June 2023 Final Rule cannot be appealed. As noted *supra* in the preamble to the June 2023 Final Rule, providers may appeal NPRs or revised NPRs that are subsequently issued and reflect this policy *as it relates to prior periods held open for this issue*. This may encompass the Providers depending on the nature and status of the alleged remand(s) referenced by the Providers and the issuance of revised NPRs as appropriate and consistent with the terms of that remand.
[70] 42 C.F.R. § 405.1840(a), (b).
[71] 42 C.F.R. § 405.1837(c).

42 C.F.R. § 405.1837(a)(1) makes clear that a provider's right to a Board hearing as part of group appeal is dependent on "[t]he provider satisfy[ng] individually the requirements for a Board hearing under § 405.1835(a) or § 405.1835(c), except for the $10,000 amount in controversy requirement." One of the requirements in § 405.1835(a) is that the provider is appealing "a final contractor or Secretary determination."

The content requirements for a group appeal request are located at 42 C.F.R. § 405.1837(c) and specify that the appeal request must "demonstrate[e] that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section" and that, in addition to the "final contractor or Secretary determination under appeal", must include "any other documentary evidence the providers consider to satisfy the hearing request requirements of paragraphs (c)(1) . . . of this section."

Here, none of the Providers include as part of their appeal requests any documentation relating to the implied *prior* appeals and related remand, notwithstanding: (1) their responsibilities under 42 C.F.R. § 405.1837(c) as quoted above, and (2) the fact that Board Rule 35.3 specifies that evidence must be submitted into the record by a party including evidence from another Board case:

> The Board will ***not*** be responsible for supplementing any record with evidence *from a previous hearing*. All evidence submitted into the record, ***must*** be done by the parties.[72]

Without having the NPR or any additional documentation on the Providers' alleged remand as it relates to the fiscal years at issue, the Board cannot confirm that the June 2023 Final Rule is, in fact, applicable to the Provider's for the fiscal years at issue (*i.e.*, that the fiscal years appealed by the Providers remain open and are eligible for resolution of the Part C days issue raised in the this appeal through the operation of the June 2023 Final Rule). Indeed, if the Providers' alleged remand(s) for the fiscal years at issue is still pending before MAC, then the Remand Order itself (whether from a Court, the Administrator, or the Board) is relevant since it might otherwise preclude Board consideration of these appeals.[73] In this regard, the Board is unable determine whether each of the Providers even qualified for a DSH payment during the fiscal years at issue since the record does not include a copy of the relevant NPR/revised NPR with the relevant audit adjustment pages alleged to have been issued to the Providers for the relevant fiscal years. Accordingly, the Board finds that the Providers' group appeal requests are *fatally* flawed because, even if the June 2023 Final Rule were an appealable "final determination" under 42 U.S.C. § 1395oo(a)(1)(A)(ii), it is unclear whether that Final Rule is, in fact, applicable *to the fiscal years appealed by the Provider* given their failure to comply with the content requirements of 42 C.F.R. § 405.1837(c) requiring its appeal request demonstrate that each of the Providers

---

[72] (Emphasis added.)

[73] *See also* CMS Ruling 1739-R; Board Rule 4.6 (entitled "No Duplicate Filings" and specifying in Board Rule 4.6.2 that "Appeals of the same issue from distinct determinations covering the same time period must be pursued in a single appeal").

satisfies the requirements for Board hearing and that the "final determination" being appealed, *in fact*, involves a payment determination ***retroactively*** *applicable to them* under the terms of the Final Rule. This finding serves as an alternative and *independent* basis for the Board's dismissal of these appeals.

C. Conclusion

The Board finds that: (1) the Part C policy issued in the June 2023 Final Rule that the Providers appealed for the fiscal years at issue is not an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835(a); and (2) even if the June 2023 Final Rule could be appealable as a "final determination" under 42 U.S.C. § 1395oo(a)(1)(A)(ii), the Providers' appeal request failed to meet the content requirements under 42 C.F.R. § 405.1837(c) based on its failure to demonstrate that the June 2023 Final Rule was, in fact, a payment determination *retroactively* applicable to them for the fiscal years at issue consistent with the terms of that Final Rule. Based on the foregoing, the Board hereby dismisses the 50 group appeals listed in **Appendix A** in their entirety 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 Participating:

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

For the Board:

2/1/2024

X Clayton J. Nix

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

Enclosure: Appendix A – Listing of 50 CIRP and Optional Groups

cc: Michael Redmond, Novitas Solutions, Inc. (J-H)
Judith Cummings, CGS Administrators (J-15)
Lorraine Frewert, Noridian Healthcare Solutions, c/o CGS Administrators (J-E)
Wilson Leong, FSS

APPENDIX A
Listing of 50 CIRP and Optional Groups

24-0310G	HRS CY 2010 Treatment of Part C Days Final Rule Group
24-0312G	HRS CY 2011 Treatment of Part C Days Final Rule Group
24-0314GC	Willis-Knighton CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-0329GC	Willis-Knighton CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-0330GC	Willis-Knighton CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0331GC	Willis-Knighton CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0333GC	Willis-Knighton CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0334GC	Willis-Knighton CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0335GC	Willis-Knighton CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0337GC	ProMedica Health CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-0338G	HRS CY 2007 Treatment of Part C Days Final Rule Group
24-0340G	HRS CY 2008 Treatment of Part C Days Final Rule Group
24-0357G	HRS CY 2009 Treatment of Part C Days Final Rule Group
24-0358G	HRS CY 2012 Treatment of Part C Days Final Rule Group
24-0359G	HRS CY 2013 Treatment of Part C Days Final Rule Group
24-0360GC	Texas Health Resources CY 2008 Treatment of Part C Days Final Rule CIRP Grp
24-0362GC	Texas Health Resources CY 2010 Treatment of Part C Days Final Rule CIRP Grp
24-0363GC	Texas Health Resources CY 2011 Treatment of Part C Days Final Rule CIRP Grp
24-0368GC	Texas Health Resources CY 2012 Treatment of Part C Days Final Rule CIRP Grp
24-0369GC	Texas Health Resources CY 2013 Treatment of Part C Days Final Rule CIRP Grp
24-0370GC	Prime Healthcare CY 2006 Treatment of Part C Days Final Rule CIRP Group
24-0371GC	Prime Healthcare CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-0372GC	Prime Healthcare CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0374GC	Prime Healthcare CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0378GC	Prime Healthcare CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0379GC	Prime Healthcare CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0380GC	Prime Healthcare CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0381GC	UHHS CY 2006 Treatment of Part C Days Final Rule CIRP Group
24-0382GC	UHHS CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-0383GC	UHHS CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0384GC	UHHS CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0385GC	UHHS CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0386GC	UHHS CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0387GC	UHHS CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0388GC	UHHS CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-0389GC	Prime Healthcare CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-0392GC	Cleveland Clinic Fdn. CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-0393GC	Cleveland Clinic Fdn. CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0395GC	Cleveland Clinic Fdn. CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0397GC	Cleveland Clinic Fdn. CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0398GC	Cleveland Clinic Fdn. CY 2011 Treatment of Part C Days Final Rule CIRP Group

24-0400GC	Cleveland Clinic Fdn. CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0401GC	Franciscan Missionaries CY 2007 Treatment of Part C Days Final Rule CIRP Grp
24-0402GC	Franciscan Missionaries CY 2008 Treatment of Part C Days Final Rule CIRP Grp
24-0403GC	Franciscan Missionaries CY 2009 Treatment of Part C Days Final Rule CIRP Grp
24-0404GC	Franciscan Missionaries CY 2010 Treatment of Part C Days Final Rule CIRP Grp
24-0408GC	Franciscan Missionaries CY 2011 Treatment of Part C Days Final Rule CIRP Grp
24-0409GC	Franciscan Missionaries CY 2012 Treatment of Part C Days Final Rule CIRP Grp
24-0410GC	Franciscan Missionaries CY 2013 Treatment of Part C Days Final Rule CIRP Grp
24-0411G	HRS CY 2006 Treatment of Part C Days Final Rule Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

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

RE: ***Board Dismissal of SSI Percentage (Provider Specific) & Medicaid Eligible Days***
Martin General Hospital (Provider Number 34-0133)
FYE: 04/30/2015
Case Number: 18-1229

Dear Mr. Ravindran and Mr. Lamprecht,

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

A. *Procedural History for Case No. 18-1229*

On October 30, 2017, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end April 30, 2015.

On May 1, 2018, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

As the Provider is owned by Quorum Health and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2, 4, and 5 to Quorum Health groups on December 19, 2018. The remaining issues in this appeal are Issues 1 and 3.

On May 21, 2018, the Medicare Contractor filed a Jurisdictional Challenge which included Issues 1, 3, and 4.

On December 26, 2018, the Provider submitted its preliminary position paper.

[1] On December 19, 2018, this issue was transferred to Case No. 18-1333GC.
[2] On December 19, 2018, this issue was transferred to Case No. 18-0594GC.
[3] On December 19, 2018, this issue was transferred to Case No. 18-0595GC.

On April 26, 2019, the Medicare Contractor submitted its preliminary position paper.

On March 2, 2023, the Medicare Contractor filed a second Jurisdictional Challenge addressing the DSH Medicaid Eligible Days issue stating the Provider has effectively abandoned the issue by failing to furnish documentation in support of its claim for additional Medicaid Eligible Days.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-1333GC

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

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

The Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 18-1333GC, QRS Quorum 2015 DSH SSI Percentage CIRP Group, on December 19, 2018. The Group Issue Statement in Case No. 18-1333GC reads, in part:

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

[4] Issue Statement at 1 (May 1, 2018).

Statement of the Legal Basis

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

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

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

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $8,000.

On December 26, 2018, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (April 30).

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

Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received

[5] Group Issue Statement, Case No. 18-1333GC.

> the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believe to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[6]

C. Filings Concerning the Jurisdictional Challenge

1. MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Provider Specific issue in its first jurisdictional challenge. The MAC also asserts that the DSH SSI Provider Specific issue is duplicative of the DSH - SSI Systemic Errors issue.

> In Issue 1 the Provider contends that the MAC used the incorrect SSI percentage in processing its DSH payment. In Issue 2 the Provider contends that the secretary improperly calculated its SSI percentage. The Provider is making the same argument, as the MAC is required to use the SSI ratio provided by CMS. Essentially, the Provider contends that the SSI ratio applied to its cost report was incorrect; the SSI ratio is the underlying dispute in both Issue 1 and Issue 2. Under Board Rules, the Provider is barred from filing a duplicate SSI percentage issue. Therefore, the PRRB should find that the SSI percentage is one issue for appeal purposes and that Issue 1 should be dismissed consistent with recent jurisdictional decisions.[7]

Issue 3 – DSH Payment – Medicaid Eligible Days

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

---

[6] Provider's Preliminary Position Paper at 8-9 (December 26, 2018).
[7] Jurisdictional Challenge at 2 (May 21, 2018).

> …failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of their claim in the preliminary position papers.
>
> . . .
>
> …neglected to include all supporting documentation, or alternatively state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.
>
> . . .
>
> …failed to respond to the MAC's various requests to submit the required documentation
>
> . . .
>
> …failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats its appeal request.
>
> . . .
>
> …essentially abandoned the issue by failing to properly develop their arguments and to provide supporting documents or to explain why they cannot produce those documents, as required by the regulations and the Board Rules.[8]

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

2. <u>Provider's Jurisdictional Response</u>

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[9] The Provider has not filed a response to the Jurisdictional Challenge or Motion to Dismiss and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Similarly, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different

[8] 2nd Jurisdictional Challenge at 4 & 8 (March 2, 2023).
[9] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

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

Board Analysis and Decision:

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

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 18-1333GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[10] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[11] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[12]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 18-1333GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the

[10] Issue Statement at 1.
[11] *Id.*
[12] *Id.*

DSH/SSI Percentage (Systemic Errors) issue in Case No. 18-1333GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[13], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case 18-1333GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[14] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 18-1333GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 18-1333GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* 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.

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

> Once the documents become available, promptly forward them to the Board and the opposing party.[15]

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[16]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[17]

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

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 18-1333GC are the same issue.[18] 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.

---

[15] (Emphasis added).
[16] Last accessed January 4, 2024.
[17] Emphasis added.
[18] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Quorum Health CIRP group per 42 C.F.R. § 405.1837(b)(1).

2. Second Aspect of Issue 1

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

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

B. DSH Payment – Medicaid Eligible Days

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

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends 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.[19]

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

[19] Individual Appeal Request, Issue 3.

Board Rule 7.3.1.2 states:

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

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

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[20]

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*.[21]

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

---

[20] *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.

[21] (Emphasis added).

> 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.

With regard to position papers,[22] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[23] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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

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

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

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

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

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

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

> • if it has a reasonable basis to believe that the issues have been fully settled or abandoned,

---

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

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

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled, consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[25] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing, unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. Indeed, without any days identified in the position paper filing, the Board must assume that there are no days and that the actual amount in dispute is $0 for this issue. Indeed, based on these facts, plus the Provider's failure to respond to either the Medicare Contractor's request for the listing or the Medicare Contractor's Motion to Dismiss on this issue, the Board assumes that the Provider has abandoned this issue.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 18-1333GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 18-1229 and removes it from the Board's docket.

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

---

[25] (Emphasis added).

Board Members Participating:

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

For the Board:

2/2/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

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

RE: ***Board Dismissal of SSI Percentage (Provider Specific)***
Pottstown Hospital (Provider Number 39-0123)
FYE: 09/30/2017
Case Number: 21-1134

Dear Mr. Ravindran and Mr. Lamprecht,

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

Procedural History for Case No. 21-1134

On September 14, 2020, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2017.

On March 8, 2021, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained three (3) issues:

1. Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) Percentage (Provider Specific)
2. DSH SSI Percentage[1]
3. DSH – Medicaid Eligible Days[2]

The remaining issue in this appeal is Issue 1, the DSH SSI Provider Specific Issue.

The Provider is subject to the mandatory rules governing common issue related party ("CIRP") groups at 42 C.F.R. § 405.1837(b)(1) since the Provider is owed by Community Health Systems ("CHS"). Accordingly, on October 13, 2021, the DSH SSI Percentage issue was transferred to CIRP Group Case Number 20-0997GC, *CHS CY 2017 DSH SSI Percentage CIRP Group.*

On June 12, 2023, the Provider submitted its preliminary position paper.

[1] On October 13, 2021, this issue was transferred to Case No. 20-0997GC.
[2] On July 10, 2023, this issue was withdrawn by the Provider.

On August 18, 2023, the Medicare Contractor filed a Jurisdictional Challenge.

On October 4, 2023, the Medicare Contractor submitted its preliminary position paper.

To date, the Provider has not responded to the jurisdictional challenge.

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

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation
>
> . . .
>
> 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.[3]

As the Provider is commonly owned by Community Health Systems, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 20-0997GC, CHS CY 2017 HMA DSH SSI Percentage CIRP Group, on October 13, 2021. The Group Issue Statement in Case No. 20-0997GC reads, in part:

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

[3] Issue Statement at 1 (March 8, 2021).

Statement of the Legal Basis

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

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

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

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $12,000.

On June 12, 2023, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Provider Specific

The Provider contends that its SSI percentage published by 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

[4] Group Issue Statement, Case No. 20-0997GC.

> 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).[5]

MAC's Contentions

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

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

> The MAC asserts that the Board does not have jurisdiction over realignment. There was no final determination over the SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.
>
> . . .
>
> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.[6]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are duplicates.[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 or Motion to Dismiss and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge. Failure to respond will result in the Board

[5] Provider's Preliminary Position Paper at 7-8 (June 12, 2023).
[6] Jurisdictional Challenge at 2 & 6 (August 18, 2023).
[7] *Id*. at 4-6.
[8] Board Rule 44.4.3, v. 3.1 (Nov. 2021)

making a jurisdictional determination with the information contained in the record." Similarly, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Board Analysis and Decision:

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

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

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

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[9] 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 that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[11]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-0997GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment

[9] Issue Statement at 1.
[10] *Id.*
[11] *Id.*

determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-0997GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[12], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations, and to that end, the Provider is pursuing that issue as part of the group under Case 20-0997GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[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 can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-0997GC.

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

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* 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.

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

> Once the documents become available, promptly forward them to the Board and the opposing party.[14]

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[15]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[16]

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

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 20-0997GC are the same issue.[17] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited

---

[14] (Emphasis added).
[15] Last accessed January 4, 2024.
[16] Emphasis added.
[17] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Community Health Systems CIRP group per 42 C.F.R. § 405.1837(b)(1).

by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

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

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 20-0997GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. As no issues remain pending, the Board hereby closes Case No. 21-1134 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

2/2/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal of Untimely Appeals***
Case Nos. 24-0968GC, *et al.* (*see* attached listing of 109 cases)

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("PRRB") is in receipt of the above-captioned 75 individual and 34 common issue related party ("CIRP") group appeals that were filed on January 30, and 31, 2024 and February 1, 2024, by the Providers' designated representative, James Ravindran of Quality Reimbursement Services, Inc. ("QRS") based on an appeal of the final rule published in the Federal Register on June 9, 2023 ("June 9, 2023 Final Rule") involving Part C days as used in the disproportionate share calculation ("DSH") by the Centers for Medicare and Medicaid Services ("CMS").[1] Set forth below is the Board's decision dismissing the above-captioned 109 individual and CIRP group cases for failure of the Providers' to *timely* file their appeals of the June 9, 2023 Final Rule by the Wednesday, December 6, 2023 filing deadline consistent with 42 U.S.C. § 1395oo(a)(1)(3), 42 C.F.R. §§ 405.1835(a)(3) and 405.1837(a)(1) and Board Rules 4.3.2 and 7.1.1.

Background

On January 30, and 31, 2024 and February 1, 2024, QRS filed appeal requests in the Office of Hearings Case and Document Management System ("OH CDMS") to establish the above-captioned 75 individual and 34 CIRP group cases. The appeal request filed for each case identifies the final determination being appealed as the June 9, 2023, Final Rule and describe the statement of issue as follows:

> **ISSUE TITLE**
>
> [DSH] – Inclusion of Part C Days in Denominator of the Medicare Fraction- Challenge to Part C Days retroactive final rule.
>
> **STATEMENT OF ISSUE**
>
> The issue is whether Part C days are properly included in the denominator of the Medicare Fraction per a July 8, 2023, retroactive final rule issued by [CMS], which is binding on the [Medicare contractor], or whether such final rule is illegal and cannot be enforced.

[1] 88 Fed. Reg. 37772 (June 9, 2023).

> The Provider appeals [Providers appeal] the Secretary's determination, which it calls a "final action," embodied in a July 8, 2023, retroactive final rule, that requires Part C Days to be included in the Medicare Fraction of the disproportionate payment percentage for discharges occurring prior to October 1, 2013 ("the Part C Days Final Rule"). The Part C Days Final Rule ***became effective on August 8, 2023***. The Providers challenge the procedural and substantive validity of the Part C Days Final Rule. Specifically, the Providers assert that the Part C Days Final Rule is procedurally invalid the retroactive nature of the rule violates the rulemaking provisions of the Social Security Act and the Administrative Procedure Act, and is contrary to the D.C. Circuit's opinion in *Northeast Hospital v. Sebelius*, and established precedent regarding the applicability of a pre-existing rule when a later rule is vacated (as was the 2004 final rule on Part C days). The Part C Days Final Rule is substantively invalid because it is arbitrary and capricious. Specifically, the Part C Days Final Rule is arbitrary and capricious because CMS did acknowledge that putting Part C Days in the Medicare Fraction was a departure from its policy or practice prior to the vacated 2004 rule. The Part C Days Final Rule also failed to account for hospitals' reliable interest on the pre-2004 final rule practice or policy, and also failed to recognize the enormous adverse financial impact on hospitals due to the change from the pre-2004 final rule practice or policy.[2]

However, each of these 109 individual and group appeals were filed more than ***180 days*** after the publication of the June 9, 2023 Final Rule provision that implemented the Final Rule for "Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage."[3] Notwithstanding, each of these appeal requests identified, *in error*, that the "final determination date" from which they are appealing is August 8, 2023 – the ***effective date*** of the provision, rather than the date of ***notice***, *i.e.*, the publication date, of June 9, 2023.

Decision of the Board

The Board finds that the above-captioned 109 appeals were ***not*** timely filed as required by the Board's enabling statute at 42 U.S.C. § 1395oo(a)(3), which specifies that appeals of Federal Register Notices (i.e., appeals under 42 U.S.C. § 1395(a)(1)(ii)) must be filed "*within . . . 180 days after* ***notice*** *of the Secretary's final determination.*"[4] These appeals were filed in OH CDMS ***almost 2 months after*** the filing deadline of 180 days after the issuance of the June 9, 2023 Federal

[2] Providers' Appeals Issue Statement.
[3] 88 Fed. Reg. 37772 (June 9, 2023). *See also Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ("[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") and *Dist. of Columbia Hosp. Ass'n Wage Index Group Appeal*, HCFA Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993) (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).
[4] (Emphasis added.)

Register provision that implemented the Final Rule for "Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage."

Consistent with 42 U.S.C. § 1395oo(a)(3), 42 C.F.R. § 405.1835(a)(3) specifies that a provider's appeal request must be filed no later than 180 days after the "date of receipt" of the final determination being appealed:

> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.

The regulation at 42 C.F.R. § 405.1837(a)(1) makes clear that this requirement applies to provider's participating in a group appeal whether by transfer or direct add.[5] To this end, Board Rule 7.1.1 specifies that the appeal request must "[i]dentify the date the final determination ***was issued***"[6] and Board Rule 4.3.2 specifies in connection with appeals based on a Federal Register Notice that: (1) "[t]he date of receipt of a Federal Register Notice is the date the Federal Register is published"; and (2) "[t]he appeal period begins on the date of publication and ends 180 days from that date."

The Board is bound by all of the provisions of Title XVIII of the Act (the Social Security Act, as amended) and the regulations issued thereunder.[7] The Board cannot apply a regulation or instruction which is contrary to a statute and other regulations that deal specifically with the matter at hand: the date a provider is deemed to have notice of the contents of the Federal Register. In this case, the laws and regulations governing the publication of Federal Register notices specifically define the time of notice as that of publication. These laws and regulations have been incorporated into Title XVIII.

The Secretary[8] has enacted Part 401 of Title 42 of the Code of Federal Regulations which is entitled "General Administrative Requirements." Subpart B, §§ 401.101(a)(1) and (2) of this Part states that "[t]he regulations in this subpart: (1) Implement section 1106(a)[9] of the Social Security Act [relating to disclosure of information] as it applies to [CMS] . . . [and] (2) Relate to the availability to the public, under 5 U.S.C. § 552,[10] of records of CMS." These laws and regulations set out which records are available and how they may be obtained, and they supplement the regulations of

---

[5] 42 C.F.R. § 405.1837(a)(1) specifies that a provider's right to participate in a group is dependent, in part, on the "[t]he provider satisfy[ying] 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)." NOTE – none of the providers in these 109 appeals have alleged that they are appealing from the nonissuance of an NPR or revised NPR consistent with § 405.1835(c) and, to that end, there is no information in the records for these cases to support such an allegation consistent with Board Rule 7.5.

[6] (Emphasis added.)

[7] *See* 42 C.F.R. § 405.1867.

[8] of the Department of Health and Human Services.

[9] 42 U.S.C. § 1306(a).

[10] 5 U.S.C. § 550 *et seq.* contains the Administrative Procedures Act; 5 U.S.C. § 552 deals with the availability of government information and is known as the Freedom of Information Act ("FOIA").

CMS relating to the availability of information. Section 401.106 of this subpart, which deals with publication of materials under 5 U.S.C. § 552, requires publication to serve as notice and identifies the Federal Register as the vehicle to be used to give notice. Section 552(a) states in part that:

> (1) Each agency shall separately state and currently publish in the Federal Register for the guidance of the public-
>
> * * * *
>
> (D) substantive rules of general applicability adopted as authorized by law, and statements of general policy or interpretations of general applicability formulated and adopted by the agency; and
> (E) each amendment, revision, or repeal of the foregoing.

In order to comply with the statutes and regulations requiring that public notice be given, the Secretary annually publishes the schedules of the Inpatient Prospective Payment System ("IPPS") rates as well as other IPPS policies in the Federal Register pursuant to the requirements of 42 C.F.R. § 412.8(b)(2). The Secretary may issue other changes as Federal Register Notices outside of this annual ratesetting process as was done here with the issuance of the Part C days policy published in the June 9, 2023 Final Rule. These processes were created to comply with 5 U.S.C. § 552 of the Freedom of Information Act which requires that agencies publish regulations and notices in the Federal Register.[11]

With regard to the Notices published in the Federal Register, 44 U.S.C. § 1507 states in part that:

> A document required. . .to be published in the Federal Register is not valid as against a person who has not had actual knowledge of it until the duplicate originals or certified copies of the document have been filed with the Office of the Federal Register and a copy made available for public inspection as provided by section 1503. . . . *[F]iling of a document, required or authorized to be published [in the Federal Register] by section 1505. . .is sufficient to give notice* of the contents of the document to a person subject to or affected by it.[12]

Reflecting new technology and the ability to transmit information immediately upon publication, the Government Printing Office ("GPO") promulgated 1 C.F.R. § 5.10 which authorizes publication of the Federal Register on the internet at the GPO website.[13] The GPO website containing the Federal Register is updated daily at 6 a.m. Monday through Friday, except holidays.[14] Consequently, the Provider is deemed to have notice of the Part C days policy at issue on the date the Federal Register was published and made available online. Indeed, the Board notes that Notices are often available for public inspection several days ***prior to*** the official

[11] *See also* 42 C.F.R. Part 401, Subpart B.
[12] (Emphasis added).
[13] *See also* 44 U.S.C. § 4101 (the Superintendent of Documents is to maintain an electronic director and system of online access to the Federal Register).
[14] *See* http://www.gpo.gov/help/index.html#about_federal_register.htm.

publication date and, here, the June 9, 2023 Final Rule was posted to the public at 4:15 pm on June 7, 2023, 2 days in advance of the June, 9, 2023 publication date.[15]

With respect to statutes and regulations dealing with the Federal Register, the Supreme Court has found that:

> Congress has provided that the appearance of rules and regulations in the Federal Register give legal notice of their contents . . . .
>
> . . . Regulations [are] binding on all who sought to come within the [Act], regardless of actual knowledge of what is in the Regulations or of the hardship resulting from innocent ignorance.[16]

The statutes governing the Board (44 U.S.C. § 1507 as applied through the requirements of 42 C.F.R. § 401.101 and the Administrative Procedures Act ("APA")) are clear on their face: ***the date of publication*** of the Federal Register is the date the Providers are deemed to have notice of the June 9, 2023 Final Rule. The Board is bound by all of the provisions of Title XVIII which includes, by reference, the provisions of the Administrative Procedures Act and the Public Printing and Documents law which require that CMS publish its notices and regulations in the Federal Register. In publishing materials in the Federal Register, CMS must comply with the statutes and regulations governing the Superintendent of Documents and the Governing Printing Office.

Pursuant 42 U.S.C. § 1395oo(a)(3), the Board's enabling statute, providers have 180 days "after *notice* of the Secretary's final determination" to file an appeal. To this end, Board Rule 4.3.2 confirms that the appeal period for a final rule published in the Federal Register appeal ends 180 days from the date of ***publication***, not the effective date that may be listed in a provision:

> The date of receipt of a Federal Register Notice is the date the Federal Register is ***published***. The appeal period begins on the date of publication and ends 180 days from that date.[17]

In this case, the notice of the Secretary's determination is, by law, the date the Federal Register is issued by the Superintendent of Documents, or June 9, 2023. Here, the 180th day for appealing was ***Wednesday, December 6, 2023***. The above-captioned appeals were not filed with the Board until ***almost 2 months after this deadline*** (specifically between January 30, 2024 and February 1, 2024) and, thus, were not timely filed.[18]

Based on the above findings, the Board concludes that it does not have jurisdiction over the above-captioned 109 appeals for failure of the Providers' to *timely* file these appeals of the June 9, 2023 Final Rule by the Wednesday, December 6, 2023 filing deadline consistent with 42

---

[15] https://www.federalregister.gov/public-inspection/2023/06/07 (last accessed Jan. 19, 2024).
[16] *Fed. Crop Ins. Corp. v. Merrill*, 332 U.S. 380, 385 (1947).
[17] Emphasis added.
[18] The Providers in these 109 appeals have not requested good cause exception under 42 C.F.R. § 405.1836 and have not presented any evidence suggesting that they would qualify under the criteria specified in that regulation.

U.S.C. § 1395oo(a)(1)(3), 42 C.F.R. §§ 405.1835(a)(3) and 405.1837(a)(1) and Board Rules 4.3.2 and 7.1.1 and, as such, hereby dismisses them. Accordingly, the Board closes the above-captioned 109 cases and removes them from the Board's docket.[19] Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

2/2/2024

X Clayton J. Nix

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

Enclosure – Listing of 109 cases

cc: Wilson Leong, Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-5)
Geoff Pike, First Coast Service Options, Inc. (J-N)
Michael Redmond, Novitas Solutions, Inc. (J-H)
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Danelle Decker. National Government Services (J-K)
John Bloom, Noridian Healthcare Solutions (J-F)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Pamela VanArsdale, National Government Services, Inc. (J-6)

[19] Regardless, even if the Board had not dismissed these appeals as being untimely filed (*almost 2 months late*), the Board would find that the Providers appeals were premature as they failed to appeal from a "final determination" consistent with the jurisdictional dismissal decisions issued in: (1) Case No. 23-1498 on Nov. 27, 2023 which similarly appealed the June 9, 2023 Final Rule (available at: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-11-1-2023-through-11-30-2023.pdf (last accessed Jan. 19, 2023)); (2) Case Nos. 23-1796GC, *et al*. on Oct. 25, 2023 which appealed the § 1115 waiver day policy finalized in the August 28, 2023 FY 2024 IPPS Final Rule (available at: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-10-1-2023-through-10-31-2023.pdf (last accessed Jan. 19, 2023)). Moreover, even if it were a final determination, the Board would also need to conduct further review to confirm, *based on the information/documentation included in the relevant appeal request*, whether the Providers have established (consistent with 42 C.F.R. §§ 405.1835(b)(1) and 405.1837(c)(1), (3)) that the June 9, 2023 Final Rule is, ***in fact***, applicable to them (*i.e.*, confirm for the fiscal years at issue that either: (a) no NPR has been issued; or (b) they had a Board appeal of the Part C issue that was subsequently remanded per CMS Ruling 1739-R).

Listing of 34 CIRP Groups and 75 Individual Appeals

24-0968GC	CHS CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0989GC	SSEPR CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-0948	Parkview Medical Center Inc. (06-0020), FFY 2007
24-0949	Parkview Medical Center Inc. (06-0020), FFY 2008
24-0950	Parkview Medical Center Inc. (06-0020), FFY 2009
24-0951	Parkview Medical Center Inc. (06-0020), FFY 2010
24-0952	Parkview Medical Center Inc. (06-0020), FFY 2011
24-0953	Parkview Medical Center Inc. (06-0020), FFY 2012
24-0954	Parkview Medical Center Inc. (06-0020), FFY 2013
24-0955	MercyOne Waterloo Medical Center (16-0067), FFY 2007
24-0956	MercyOne Waterloo Medical Center (16-0067), FFY 2010
24-0957	MercyOne Waterloo Medical Center (16-0067), FFY 2011
24-0958	MercyOne Waterloo Medical Center (16-0067), FFY 2012
24-0959	MercyOne Waterloo Medical Center (16-0067), FFY 2013
24-0960	Stormont Vail Hospital (17-0086), FFY 2007
24-0961	Stormont Vail Hospital (17-0086), FFY 2008
24-0962	Stormont Vail Hospital (17-0086), FFY 2009
24-0963	Stormont Vail Hospital (17-0086), FFY 2010
24-0964	Stormont Vail Hospital (17-0086), FFY 2011
24-0966	Stormont Vail Hospital (17-0086), FFY 2012
24-0967	Stormont Vail Hospital (17-0086), FFY 2013
24-0969	Hollywood Presbyterian Medical Center (05-0063), FFY 2007
24-0970	Hollywood Presbyterian Medical Center (05-0063), FFY 2008
24-0971	Hollywood Presbyterian Medical Center (05-0063), FFY 2009
24-0972	Hollywood Presbyterian Medical Center (05-0063), FFY 2010
24-0973	Hollywood Presbyterian Medical Center (05-0063), FFY 2011
24-0974	Hollywood Presbyterian Medical Center (05-0063), FFY 2012
24-0975	Hollywood Presbyterian Medical Center (05-0063), FFY 2013
24-0976	Valley Presbyterian Hospital (05-0126), FFY 2005
24-0977	Valley Presbyterian Hospital (05-0126), FFY 2009
24-0978	University of Colorado Health Memorial Hospital Central (06-0022), FFY 2006
24-0979	University of Colorado Health Memorial Hospital Central (06-0022), FFY 2009
24-0980	Frisbie Memorial Hospital (30-0014), FFY 2011
24-0981	Frisbie Memorial Hospital (30-0014), FFY 2012
24-0982	Frisbie Memorial Hospital (30-0014), FFY 2013
24-0983	CHI St. Luke's Health Baylor College of Medicine Medical Center (45-0193), FFY 2009
24-0984	Sanford USD Medical Center (43-0027), FFY 2006
24-0985	Sanford USD Medical Center (43-0027), FFY 2008

24-0986	Sanford USD Medical Center (43-0027), FFY 2009
24-0987	San Luke's Memorial Hospital Inc. (40-0044), FFY 2011
24-0988	San Luke's Memorial Hospital Inc. (40-0044), FFY 2012
24-0990	Hospital Comunitario Buen Samaritano (40-0079), FFY 2007
24-0991	Doctors' Center Hospital, Inc. (40-0118), FFY 2013
24-0992	Arizona Regional Medical Center (03-0126), FFY 2010
24-0993	Arizona Regional Medical Center (03-0126), FFY 2011
24-0994	Arizona Regional Medical Center (03-0126), FFY 2012
24-1000GC	HonorHealth CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-1001GC	HonorHealth CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-1002GC	HonorHealth CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-1003GC	HonorHealth CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-1004GC	HonorHealth CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-1009GC	HonorHealth CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-1011GC	Atrium Health CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-1014GC	VCH CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-1015GC	VCH CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-1016GC	VCH CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-1017GC	VCH CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-1018GC	VCH CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-1028GC	Asante Health System CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-1030GC	Asante Health System CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-1031GC	Asante Health System CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-1032GC	Asante Health System CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-1033GC	Asante Health System CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-1012	Wilkes Regional Medical Center (34-0064), FFY 2011
24-1013	Via Christi Hospital Pittsburg (17-0006), FFY 2007
24-1020	Avera McKennan Hospital & University Health Center (43-0016), FFY 2005
24-1021	Avera McKennan Hospital & University Health Center (43-0016), FFY 2006
24-1022	Avera McKennan Hospital & University Health Center (43-0016), FFY 2008
24-1023	Avera McKennan Hospital & University Health Center (43-0016), FFY 2009
24-1024	Avera McKennan Hospital & University Health Center (43-0016), FFY 2010
24-1025	Avera McKennan Hospital & University Health Center (43-0016), FFY 2011
24-1026	Avera McKennan Hospital & University Health Center (43-0016), FFY 2012
24-1027	Avera McKennan Hospital & University Health Center (43-0016), FFY 2013
24-1029	Asante Three Rivers Medical Center (38-0002), FFY 2009
24-1034	Asante Rogue Regional Medical Center (38-0018), FFY 2013
24-1035	Asante Rogue Regional Medical Center (38-0018), FFY 2006
24-1036	Winter Haven Hospital (10-0052), FFY 2005

24-1037	Winter Haven Hospital (10-0052), FFY 2007
24-1038	Winter Haven Hospital (10-0052), FFY 2008
24-1039	Winter Haven Hospital (10-0052), FFY 2009
24-1046GC	Novant Health CY 2006 Treatment of Part C Days Final Rule CIRP Group
24-1047GC	CHS CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-1048GC	Novant Health CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-1049GC	Novant Health CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-1050GC	Novant Health CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-1051GC	CHS CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-1052GC	Novant Health CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-1053GC	Novant Health CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-1054GC	Novant Health CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-1065GC	WFHS CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-1066GC	WFHS CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-1067GC	WFHS CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-1068GC	WFHS CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-1069GC	WFHS CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-1070GC	WFHS CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-1044	Novant Health Presbyterian Medical Center (34-0053), FFY 2005
24-1055	Cape Fear Valley Medical Center (34-0028), FFY 2006
24-1056	Cape Fear Valley Medical Center (34-0028), FFY 2007
24-1057	Cape Fear Valley Medical Center (34-0028), FFY 2008
24-1058	Cape Fear Valley Medical Center (34-0028), FFY 2009
24-1059	Newton Medical Center (31-0028), FFY 2010
24-1060	Cape Fear Valley Medical Center (34-0028), FFY 2011
24-1061	Cape Fear Valley Medical Center (34-0028), FFY 2012
24-1062	Betsy Johnson Regional Hospital (34-0071), FFY 2010
24-1063	Betsy Johnson Regional Hospital (34-0071), FFY 2011
24-1064	Wheaton Franciscan - St. Joseph (52-0136), FFY 2007
24-1071	Covenant Medical Center (45-0040), FFY 2008
24-1072	Covenant Medical Center (45-0040), FFY 2009
24-1073	Covenant Medical Center (45-0040), FFY 2010

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

OVia Electronic Delivery

Nicholas Putnam
Strategic Reimbursement Group, LLC
360 West Butterfield Rd., Ste. 310
Elmhurst, IL 60126

Judith Cummings
CGS Administrators
P.O. Box 20020
Nashville, TN 37202

RE: ***Board Decision***
SRG Summa 2012-2013 Unmatched Medicaid Days CIRP Group
Case No. 16-1881GC

Dear Mr. Putnam and Ms. Cummings:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced-appeal in response to the Medicare Contractor's Motion to Dismiss. Nicholas Putnam of the Strategic Reimbursement Group, LLC ("SRG") is the Providers' designated representative. The Board's decision is set forth below.

Procedural History

On **June 9, 2016**, SRG filed the group appeal request to establish the CIRP group appeal with two Providers: Summa Barberton Hospital (Prov. No. 36-0019) and Summa Health System (Prov. No. 36-0020) both with fiscal year ends of December 31, 2012.

In the Statement of Group Issues, the Providers' representative summarizes its Unmatched Medicaid Days issue as follows:

> The provider contends that the Medicaid fraction of its Operating Disproportionate Share Hospital and Capital Disproportionate Share Hospital adjustment calculations (collectively "Calculations") has not been calculated in accordance with Medicare regulations and manual provisions as described in 42 CFR 412.106.
>
> The provider requests that patient days pertaining to additional patient stays that were not paid by Medicaid, but related to patients with Medicaid coverage during the stay be included in the Medicaid fraction of the Calculations.[1]

On **January 3, 2017**, Provider Summa Barberton Hospital (Prov. No. 36-0019) was transferred to the appeal from PRRB Case No. 16-1463, appealing from a Notice of Program Reimbursement dated April 6, 2016, with a fiscal year end of December 31, 2013.

[1] Statement of the Issue (Jun. 9, 2016).

On **June 26, 2023**, SRG notified the Board that the CIRP Group is fully formed. Pursuant to Board Rule 20, SRT is required to file a Rule 20 certification within 60 days of full formation of the group (*i.e.*, file that certification by Friday August 25, 2023). However, ***SRG failed to file that certification*** (whether by that deadline or otherwise).

On **June 27, 2023**, the Board sent Notice of Critical Due Dates specifying that the Group's preliminary position paper must be filed by August 26, 2023 and gave the following instruction regarding the content of that filing:

> 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.[2]

On **August 7, 2023**, SRG filed the Providers' Preliminary Position Paper. SRG contends that the necessary eligibility documentation was not available *at the time of audit* for the Providers to meet its burden of production.[3] SRG explains this was due to the "nature of processing Medicaid recipients' information as well as situations where eligibility is established 'retroactively' after the patient's stay…"[4] SRG gives multiple reasons for the inability to verify Medicaid eligibility for these days *prior to the cost report filing*, including:

- Patients obtaining retroactive eligibility subsequent to the accumulation of the Medicaid days listing.
- Delays with the initial application for Medicaid benefits by the patient.
- Later reinstatement of Medicaid benefits after appeal.
- Identification of additional updated patient demographic information after the accumulation of the Medicaid days listing needed by the vendors to provide verification confirmation.
- Corrections made to patient information within state Medicaid systems (corrections to Social Security Numbers, birth dates, etc.).
- Identification of newborn's mother's demographic information acquired during mother's or newborn's subsequent hospital visits which leads to eligibility verification.[5]

---

[2] (Italics emphasis in original and bold and underline emphasis added.)
[3] Providers' Preliminary Position Paper at 6 (Aug. 7, 2023).
[4] *Id*.
[5] *Id.* at 8.

SRG claims that the Providers are working towards meeting the documentation requests pursuant to PRRB Alert 10, and that they have procedures in place "to identify and document their patients who are eligible for Medicaid coverage."[6] However, there remain Medicaid days which continue to be unmatched or unverified at the time of audit.[7] The Providers conclude the missing Medicaid days have resulted in an inaccurate Medicare DSH adjustment payment.[8]

Significantly, the Preliminary Position Paper filing does ***not*** include a listing of days at issue, although the position paper was filed 10 years after the cost report period had closed, and over 7 years since the last provider was added to the group appeal. Nor, does the paper address what impediments remain in obtaining the information all these years later after the cost reports were filed and audited.

On **December 4, 2023**, the Medicare Contractor filed a Motion to Dismiss requesting that the Board dismiss the CIRP group. Pursuant to Board Rule 44.3, SRG had 30 days to file its response to the Motion to Dismiss. However, SRG failed to file any response.

On **December 13, 2023**, the Medicare Contractor filed its preliminary position paper.

MAC's Motion To Dismiss

The MAC filed a Motion to Dismiss on December 4, 2023. The MAC contends the CIRP Group abandoned their claim, arguing:

> a. That the Providers have failed to furnish documentation in supports of their claims for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable.
> b. That the Providers' failure to furnish such documentation (or describe why such documentation is unavailable) is in violation of PRRB Rules 7, 25.2.1 and 25.2.2.
> c. That the Providers have effectively abandoned their claim for additional Medicaid Eligible Days. . .[9]

The Group's Failed to Respond

Board Rule 44.3 requires that opposing party responses to motions must be filed within thirty (30) days from the date that the motion was sent to the opposing party and the Board. SRG failed to file any response to the Motion to Dismiss on behalf of the Providers and the time for doing so has elapsed.

---

[6] *Id* at 6-7.
[7] *Id.*
[8] *Id.* at 9.
[9] Motion to Dismiss at 4 (Dec. 4, 2023).

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2014), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

42 C.F.R. § 405.1853(b)(2)-(3) 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) . . . . 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.

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:

> **Rule 25 Preliminary Position Papers**
>
> COMMENTARY: Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will issue a notice setting deadlines for the first position paper generally at eight months after filing the appeal request for the provider, and twelve months for the Medicare contractor. Even though it will not be addressed in the Board's notice, the provider may file an *optional* response no later than ninety days following the due date for the Medicare contractor's preliminary position paper. Therefore, the Board requires preliminary position papers to present the ***fully*** developed positions of the parties and expects that parties will be diligent in planning and conducting any required investigation, discovery, and analysis well in advance of the filing deadline.
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the applicable sub-section.

25.1.1 Provider's Position Paper

The provider's preliminary position paper must:

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.

B. For ***each*** issue that has not been fully resolved, provide a ***fully*** developed narrative that:

- States the material facts that support the provider's claim.
- Identifies the controlling authority (*e.g.,* statutes, regulations, policy, or case law) supporting the provider's position.
- Provides a conclusion applying the material facts to the controlling authorities.

C. Comply with Rule 25.2 addressing Exhibits.

****

25.2.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, then provide the following information in the position papers:

1. Identify the missing documents;
2. Explain why the documents remain unavailable;
3. State the efforts made to obtain the documents; and
4. Explain when the documents will be available.

Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of

> unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.
>
> **25.2.3 List of Exhibits**
>
> Parties must attach a list of the exhibits exchanged with the position paper.
>
> **25.3 Filing Requirements to Board**
>
> The Board requires the parties file a ***complete*** preliminary position paper with a fully developed narrative (Rule 25.1), all exhibits (Rule 25.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn.[10]

The Board's June 27, 2023 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)(iii) places the burden of production on the provider, stating:

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

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

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

[10] (Bold and italics emphasis in original and underline emphasis added.)

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

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned
- upon failure of the provider or group to comply with Board procedures,
- 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
>
> (3) Take any other remedial action it considers appropriate.

The Providers have alleged that certain "patient days pertaining to additional patient stays that were not paid by Medicaid, but related to patients with Medicaid coverage during the stay" were omitted from the Medicaid fractions of their DSH payment calculations. However, the Providers did not provide any evidence with its position paper regarding the merits of the specific Medicare payment claims regarding the Unmatched Medicaid Days issue even though Board Rule 25.2 (consistent with 42 C.F.R. § 405.1853(b)(2)-(3)) requires the Providers to do so with the position paper. Indeed, the submission of that supporting evidence is consistent with the Providers' "burden of production of evidence and burden of proof [to] establish[], by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue" as set forth at 42 C.F.R. § 405.1871(a)(3). Further, they did not explain why this information was not available notwithstanding Board Rule 25.2.2 addressing unavailable/ omitted documents and explaining that, in such situations, the position paper must "provide the following information in the position papers: 1. Identify the missing documents; 2. Explain why the documents remain unavailable; 3. State the efforts made to obtain the documents; and 4.

Explain when the documents will be available."[11] Indeed, at the point when they filed their preliminary position paper on August 7, 2023, SRG and the Providers had had ***more than 7 years*** since this appeal was filed on June 9, 2016 (and even more since the 2012 and 2013 f fiscal years at issue closed) to research, request, obtain, and submit this evidence to the Board as part of its preliminary position paper in support of this appeal. However, they failed to do so even though 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1871(a)(3) clearly establishes that the Providers have the burden of proof to establish Medicaid eligibility for each day at issue.

Accordingly, the Board must assume that there are no days in controversy and the amount in controversy is in fact $0 for each of the Providers in this appeal.[12] For these reasons, the Board finds the group issue abandoned and dismisses the group appeal.

Conclusion

In sum, the Board finds the CIRP Group Appeal failed to develop its argument in its Preliminary Position Paper consistent with: (a) 42 C.F.R. §§ 405.1853(b)(2)-(3), 405.1871(a)(3), and 412.106(b)(4)(iii); (b) Board Rule 25; and (c) the Board's June 27, 2023 Notice. The Board dismisses the appeal in its entirety.

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:

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

For the Board:

2/5/2024

X Clayton J. Nix

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

Enclosure – Schedule of Providers

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

[11] Instead, the Providers' preliminary position paper is devoted to describing the process they used for identifying the Medicaid eligible days included with the as-filed cost reports at issue and why certain unspecified days may not have been included on the Medicaid eligible days listing included with those as-filed cost reports. The position paper does not address what actions, if any, that the Providers have taken following the instant appeal being established to identify the alleged missing Medicaid eligible days for which this group was established.

[12] The Board's finding that the position paper failed to met 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).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Decision***
Northwest Medical Center of Washington (Prov. No. 04-0022)
FYE 10/31/2013
Case No. 17-0381

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 17-0381. The Board's decision is set forth below.

Background:

A. Procedural History for Case No. 17-0381

On **November 3, 2016**, Northwest Medical Center of Washington County filed a request for hearing from a Notice of Program Reimbursement ("NPR") dated May 6, 2016. The hearing request included the following issues:

- Issue 1: Medicare Bad Debt Reimbursement[1]
- Issue 2: Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage-Provider Specific
- Issue 3: DSH- Medicaid Eligible Days[2]

As the Provider is commonly owned by Community Health Systems ("CHS"), the Provider also requested to directly add issues to group appeals, including 15-2694GC, Community Health Systems 2013 Post 1498-R DSH SSI Data Match CIRP.

On **August 8, 2023**, the Provider withdrew Issue 1. On **January 19, 2024**, the Provider withdrew Issue 3. As a result, the DSH Payment/SSI Percentage (Provider Specific) issue is the sole issue remaining in the appeal.

On **June 27, 2017**, the Provider filed its preliminary position paper. Similarly, on **October 31, 2017**, the Medicare Contractor filed its preliminary position paper.

[1] Provider withdrew Issue 1 on August 8, 2023.
[2] Provider withdrew Issue 3 on January 19, 2024.

On **April 23, 2018**, the Medicare Contractor filed a Jurisdictional Challenge over Issue 2- DSH SSI Provider Specific. On **May 21, 2018**, the Provider timely filed a response to the MAC's Jurisdictional Challenge.

On **May 10, 2023**, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days. The Provider did not file a response to the Motion to Dismiss within the 30-day time frame permitted under Board Rules 44.3 and 44.4.3. Board Rule 44.4.3 specifies, "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." *However, this Motion to Dismiss Issue 3 is no moot because, as noted above, the Provider withdrew Issue 3 on January 19, 2023*. Accordingly, this decision does not address the Motion to dismiss.

On **May 23, 2023**, the Provider filed its final position paper. Similarly, on **June 22, 2023**, the Medicare Contractor filed its final position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 15-2694GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).[3]

In PRRB Case No. 15-2694GC, Community Health Systems 2013 Post 1498-R DSH SSI Data Match CIRP, the Providers described its DSH/SSI Percentage (Systemic Errors) issue, which is being appealed from the same NPR as the instant appeal for the same fiscal year end, as whether the Medicare/SSI Fraction used to calculate their DSH payment accurately and correctly counted the number of patient days to be included therein. The issue statement reads, in part:

> The failure of the Fiscal Intermediary and [CMS] to properly determine the ratio of patient days for patients entitled to Medicare Part A and Supplemental Security Income (SSI) benefits (excluding

[3] Issue Statement (Nov. 3, 2016).

> 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 number of 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 DSH purposes . . .
>
> CMS's improper treatment and policy changes resulted in an underpayment to the Providers as DSH program eligible providers of services to indigent patients, and includes any other related adverse impact to DSH payments, such as reduced capital DSH payments . . . Also, this treatment is not consistent with Congressional intent to reimburse hospitals for treatment of indigent patients when determining DSH program eligibility and payment pursuant to 42 U.S.C. § 1395ww(d)(5)(F), 42 C.F.R. § 412.106, Medicare Intermediary Manual § 3610.15, or any other applicable statutes, regulations, program guidelines, or case law.
>
> ****
>
> CMS issue Ruling 1498-R on April 28, 2010 in response to the Baystate court decision. This significant Ruling sets forth, among other things, a revised and corrected data match process CMS would use to determine Providers' appropriate Medicare proxies and overall DSH adjustments. Providers assert that errors and problems still exist in the data match process, as well as improper policy changes by CMS, which are resulting in understated DSH Adjustments for Providers, including the failure to include all Dual Eligible (Medicare/Medicaid) patient days in the Medicare fraction numerator as intended by Congress or alternatively in the Medicaid fraction. CMS asserts in Ruling 1498-R that such Dually Eligible/Crossover days, including such days that are Medicare Non-Covered days, are being included in the Medicare proxy for discharges occurring on or after October 1, 2004. Providers assert that all such days are not properly being captured in the Medicare proxy of the DSH and/or LIP calculation.[4]

On May 23, 2023, the Provider submitted its final position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

[4] Group Issue Statement in PRRB Case No. 15-2694GC.

Provider Specific

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's Fiscal Year End (October 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to L*oma Linda Community Hospital v. Dept of Health and Human Services*, No. CVT94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFAIOIS, 09-07-009, which was published in the Federal Register on August 18, 2000. Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008). The [provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).

MAC's Contentions

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

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

> 42 C.F.R. § 412.106(b)(3). The Provider has not exhausted all available remedies for this issue. The MAC requests that the PRRB dismiss this issue consistent with recent jurisdictional decisions.[5]

Provider's Jurisdictional Response

The Provider argues that the issues are not duplicative because "issues #1 and 2 represent different components of the SSI issue, which was specifically adjusted during the audit."[6] Additionally, the Provider argues that the issue is not duplicative because the Provider is "not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category."[7]

Finally, the Provider contends the Provider Specific issue is appealable "because the MAC specifically adjusted the Providers SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2013, as a result of its understated SSI percentage due to errors of omission and commission."[8]

Board Analysis and Decision

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

As set forth below, the Board finds that it does not have jurisdiction over the sole remaining issue in this case – Issue 2, the DSH Payment/SSI Percentage (Provider Specific) issue. The jurisdictional analysis for Issue No. 1 has several relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage; 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period; and 3) the Provider's attempt to incorporate the arguments from *Advocate Christ*[9] litigation into its appeal.

A. First and Third Aspects of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 15-2694GC.

---

[5] Jurisdictional Challenge at 3 (Apr. 23, 2018).
[6] Jurisdictional Response at 1 (May 21, 2018).
[7] *Id*. at 2.
[8] *Id*.
[9] The Provider has included the Appellants' Reply Brief in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214 (D.C. Cir.), which is on appeal from the decision in *Advocate Christ Med. Ctr. V. Azar*, 17-cv-1519 (TSC), 2022 WL 2064830, (D.D.C. June 8, 2022). !

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[10] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[11] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[12]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 15-2694GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 15-2694GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.5[13], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 15-2694GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[14] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 15-2694GC. Indeed, in its May 2018 response to the Jurisdictional Challenge, the Provider asserts that it "has analyzed Medicare Part A records and ***has been able to identify patients*** believed to be entitled to both Medicare Part A and SSI"; however, the Provider has never in fact identified any such patients whether in that May 2018 response or in its subsequent preliminary and final position papers filed on June 27, 2017 and May 23, 2023 respectively, notwithstanding that this case has been pending now for more than 10 years.

The Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 15-2694GC, but instead refers to systemic *Baystate* data matching issues that

[10] Issue Statement at 1.
[11] *Id.*
[12] *Id.*
[13] PRRB Rules v. 1.3 (July 2015).
[14] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not may 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).

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

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

> 25.2.2 Unavailable and Omitted Documents If documents necessary to support your position are still unavailable, then provide the following information in the position papers:
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather*

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

than a Federal fiscal year. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[16]
> This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[17]

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

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 15-2694GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5, the Board dismisses this component of the DSH – SSI Percentage (Provider Specific) issue.

Finally, the Board also revied the Provider's final position paper to see if it further shed light on Issue 1. However, again, the Provider's position paper is fatally flawed in that simply recycles the claim in its preliminary position paper that it "is seeking a *full and complete* set of the Medicare Part A or [MEDPAR] database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000)" but fails to comply with its obligations under Board Rule 25.2 to specifically identify the records it is seeking (since some of those records are clearly available as discussed above), what the status of those requests are and when the documents will be made available.

Further, the final position paper raises new *substantive* arguments that were never raised in its perfunctory 5-sentence long argument section on Issue 2 in its preliminary position paper, notwithstanding the fact that these new substantive legal arguments are legal ones for which there

[16] Last accessed February 24, 2023.
[17] Emphasis added.

is no excuse for not having included them per 42 C.F.R. § 405.1853(b)(2) and Board Rule 25.[18,19] Regardless, these new *substantive* arguments are being pursued by the common issue raise in the CIRP group under Case No. 15-2694GC. In support, the Board takes administrative notice of the fact that CHS' preliminary position paper filed in Case No. 15-2694GC includes the following section headings essentially set forth the *Advocate Christ* position the Provider would like to add to the instant case:

> A. CMS Violated the Plain Language of the DSH Statute by Adopting Conflicting Interpretations of the Term "Entitled To Benefits" With Respect to Part A and SSI in Order to Undercount Providers' SSI Days; Therefore, Its Interpretation Fails Under Step One of Chevron.
>
> 1. Despite Congress's Clear Intent, CMS Does Not Consistently Interpret and Apply the Term "Entitled to Benefits."
>
> 2. CMS's Policy of Counting Only SSI Eligible Patients SSA Coded As C01, M01, and M02 in the Medicare Fraction Numerator Must Be Rejected Because It Violates the DSH Statute.
>
> 3. CMS Failed to Consider the Fact That SSI Eligible Medicare Beneficiaries Who Do Not Receive the SSI Cash Stipend in a Particular Month Remain Entitled to an Additional Benefit: Fully Subsidized Medicare Part D Coverage.
>
> 4. The Agency's Categorical Exclusion of SSI Eligible Individuals' Inpatient Days from the Medicare Fraction Numerator Conflicts with Congress's Express Intent to Capture SSI Eligible Patients Who Are Medicare Beneficiaries in the Medicare Fraction Numerator; Therefore, the Agency's Narrow Construction of "Entitled to Supplemental Security Income Benefits" Fails Under Chevron Step One.
>
> B. The Agency's Construction and Interpretation of Entitlement to SSI Benefits Leads to Results so Absurd That the Interpretation Cannot Be Ascribed to a Difference in Opinion or Agency Expertise; Therefore, It Is Arbitrary and Capricious Under Chevron Step Two.
>
> ****

[18] Indeed, the final position paper is fatally flawed in that it simply tries to incorporate the arguments made by the Providers in the *Advocate Christ* litigation in a one-sentence reference without explaining how or why its applicable to the instant case. To this end, the Provider only attached a "Reply Brief" filed by the Appellants in that case and it is unclear how that "Reply Brief" encompasses the arguments the Provider is looking to improperly add to the instant case. As noted at Board Rule 35.3: "The Board will not be responsible for supplementing any record with evidence from a previous hearing. All evidence submitted into the record, must be done by the parties."

[19] Moreover, it is not surprising since the Group Representative for Case No. 15-2694GC is also listed as counsel for the providers pursuing the *Advocate Christ* litigation. Specifically, Hall Render Killian Health & Lyman, PC is listed as CHS' designated group representative in Case No. 15-2694GC and is also listed as counsel for the Appellants in the *Advocate Christ* litigation as confirmed by the Reply Brief from the litigation included by the Provider as Exhibit P-2.

C. SSI Eligibility Data Must Be Furnished by the MAC/CMS, not the Providers.

D. Analysis of the Data for the Provider, CMS's Stated Policies and Data from CMS and SSA Demonstrate the Adverse Financial Consequences of CMS/MAC's Failure to Include All SSI Eligible Days in the Numerator of the Medicare Fraction.

1. CMS Has Conceded That It Systematically Excludes Many Categories of SSI Eligible Individuals from the Medicare Fraction Numerator, and Published SSI Data Confirms the Magnitude of the Agency's Actions on the Provider.

2. Given the Correlation Between SSI Entitlement and Eligibility for Medicaid, the Evidence Demonstrates the Profound Impact of the Agency's Erroneous Construction and Application of the DSH Statute on the Providers' DSH Reimbursement.

3. Data from MedPAC and MACPAC Validate the Providers' Analysis.

4. The Number of Individuals Who Receive SSI Payments Contrasted With the Number of Individuals Eligible for the Full Medicare Part D Subsidy Also Demonstrates that CMS/MAC Failed to Include All SSI Eligible Individuals in the Numerator of the Medicare Fraction.

****

F. CMS Continues to Use Incorrect Data Matching Methods to Determine the SSI Ratio.[20]

---

[20] In comparison, Exhibit P-2 attached to the Provider's final position paper which is the Appellant's Reply Brief filed in the *Advocate Christ* litigation includes the following headings:

I. The Secretary's construction omits indisputably poor patients from the DSH statute, violating the statutory provisions and Congressional intent.
A. "Entitled to" SSI benefits is not a term of art in the SSI program.
B. The Secretary purposefully excludes from the numerator many SSI recipients who are SSI-eligible under § 1382(a).
1. Eligible (But Not Payable) Payment Status
2. Suspended Payment Status
C. The Secretary purposefully disregards tangible benefits that inure to all SSI recipients regardless of payment.
1. Title XVI beneficiaries are eligible for vocational rehabilitation services and other enumerated support benefits.
2. The Part D subsidy is an SSI benefit, and it exposes the Secretary's disparate treatment of SSI beneficiaries in the DSH statute.
3. The Secretary's reliance on Metropolitan to defend his narrow interpretation of SSI entitlement is misplaced.
The Secretary's contentions on appeal further confirm mandamus relief is warranted.

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

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[21]

Therefore, as an alternative and independent basis, the Provider failed to properly brief Issue 1 in its position paper filings in that these filings failed to meet the minimum Board requirements for position papers set forth at 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules 25 and 27.2 consistent with the Provider's "burden of production of evidence and burden of proof [to] establish[], by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue" as set forth at 42 C.F.R. § 405.1871(a)(3). Indeed, the shortcomings of the Provider's preliminary position paper is highlighted by the fact that the Provider improperly tried to add new substantive arguments in its final position paper that were not part of its preliminary position paper and then failed to properly brief those new legal arguments in the final position paper (or explain how they were not subject to the CIRP group rules and not duplicative of their participation in Case No. 15-2694GC).

B. Second Aspect of Issue 1

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

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

[21] (Emphasis added).

indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board dismisses this aspect of the appeal.[22]

****

In summary, the Board hereby dismisses the sole remaining issue in this case, Issue 2 (the SSI Provider Specific Issue) from this appeal because: (1) the first and third aspects of the issue are duplicative of the issue in Case No. 15-2694GC and are common issues required to be pursued in a CIRP; (2) there is no final determination for the second aspect of the issue concerning SSI realignment from which the Provider can appeal; and (3) as an alternative and independent basis, the Provider failed to properly brief Issue 1 in its position paper filings in that these filings failed to meet the minimum Board requirements for position papers set forth at 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules 25 and 27.2 consistent with the Provider's "burden of production of evidence and burden of proof [to] establish[], by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue" as set forth at 42 C.F.R. § 405.1871(a)(3).[23]

As there are no more issues still pending in the appeal, the Board closes the case and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

2/5/2024

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[22] Indeed, the Provider abandons this aspect of the Issue 2 by failing to brief it in either its preliminary position paper or its final position paper.

[23] The Board's finding that the position paper failed to met 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).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

February 5, 2024

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

Byron Lamprecht
Supervisor - Cost Report Appeals
WPS Government Health Administrators (J-5)
1000 N 90th Street, Suite 302
Omaha, NE 68114-2708

RE: Notice of Dismissal - Reissuance
CHS CY 2008 Treatment of Part C Days Final Rule CIRP Group
PRRB Case Number: 24-0968GC, et. al.

Dear Mr. Ravindran and Mr. Lamprecht:

On February 2, 2024, The Provider Reimbursement Review Board issued the attached Notice of Dismissal for 109 cases. We have discovered that not all impacted Medicare Contractors were appropriately notified of the dismissals. Therefore, we are reissuing this letter to all Medicare Contractors for awareness. We apologize for inconvenience this error may have caused.

Sincerely,

Lisa Ogilvie-Barr
Director, DHD

cc: Wilson Leong, Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-5)
Geoff Pike, First Coast Service Options, Inc. (J-N)
Michael Redmond, Novitas Solutions, Inc. (J-H)
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Danelle Decker. National Government Services (J-K)
John Bloom, Noridian Healthcare Solutions (J-F)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Pamela VanArsdale, National Government Services, Inc. (J-6)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal of Untimely Appeals***
Case Nos. 24-0968GC, *et al.* (*see* attached listing of 109 cases)

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("PRRB") is in receipt of the above-captioned 75 individual and 34 common issue related party ("CIRP") group appeals that were filed on January 30, and 31, 2024 and February 1, 2024, by the Providers' designated representative, James Ravindran of Quality Reimbursement Services, Inc. ("QRS") based on an appeal of the final rule published in the Federal Register on June 9, 2023 ("June 9, 2023 Final Rule") involving Part C days as used in the disproportionate share calculation ("DSH") by the Centers for Medicare and Medicaid Services ("CMS").[1] Set forth below is the Board's decision dismissing the above-captioned 109 individual and CIRP group cases for failure of the Providers' to *timely* file their appeals of the June 9, 2023 Final Rule by the Wednesday, December 6, 2023 filing deadline consistent with 42 U.S.C. § 1395oo(a)(1)(3), 42 C.F.R. §§ 405.1835(a)(3) and 405.1837(a)(1) and Board Rules 4.3.2 and 7.1.1.

Background

On January 30, and 31, 2024 and February 1, 2024, QRS filed appeal requests in the Office of Hearings Case and Document Management System ("OH CDMS") to establish the above-captioned 75 individual and 34 CIRP group cases. The appeal request filed for each case identifies the final determination being appealed as the June 9, 2023, Final Rule and describe the statement of issue as follows:

> **ISSUE TITLE**
>
> [DSH] – Inclusion of Part C Days in Denominator of the Medicare Fraction- Challenge to Part C Days retroactive final rule.
>
> **STATEMENT OF ISSUE**
>
> The issue is whether Part C days are properly included in the denominator of the Medicare Fraction per a July 8, 2023, retroactive final rule issued by [CMS], which is binding on the [Medicare contractor], or whether such final rule is illegal and cannot be enforced.

[1] 88 Fed. Reg. 37772 (June 9, 2023).

> The Provider appeals [Providers appeal] the Secretary's determination, which it calls a "final action," embodied in a July 8, 2023, retroactive final rule, that requires Part C Days to be included in the Medicare Fraction of the disproportionate payment percentage for discharges occurring prior to October 1, 2013 ("the Part C Days Final Rule"). The Part C Days Final Rule ***became effective on August 8, 2023***. The Providers challenge the procedural and substantive validity of the Part C Days Final Rule. Specifically, the Providers assert that the Part C Days Final Rule is procedurally invalid the retroactive nature of the rule violates the rulemaking provisions of the Social Security Act and the Administrative Procedure Act, and is contrary to the D.C. Circuit's opinion in *Northeast Hospital v. Sebelius*, and established precedent regarding the applicability of a pre-existing rule when a later rule is vacated (as was the 2004 final rule on Part C days). The Part C Days Final Rule is substantively invalid because it is arbitrary and capricious. Specifically, the Part C Days Final Rule is arbitrary and capricious because CMS did acknowledge that putting Part C Days in the Medicare Fraction was a departure from its policy or practice prior to the vacated 2004 rule. The Part C Days Final Rule also failed to account for hospitals' reliable interest on the pre-2004 final rule practice or policy, and also failed to recognize the enormous adverse financial impact on hospitals due to the change from the pre-2004 final rule practice or policy.[2]

However, each of these 109 individual and group appeals were filed more than ***180 days*** after the publication of the June 9, 2023 Final Rule provision that implemented the Final Rule for "Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage."[3] Notwithstanding, each of these appeal requests identified, *in error*, that the "final determination date" from which they are appealing is August 8, 2023 – the ***effective date*** of the provision, rather than the date of ***notice***, *i.e.*, the publication date, of June 9, 2023.

Decision of the Board

The Board finds that the above-captioned 109 appeals were ***not*** timely filed as required by the Board's enabling statute at 42 U.S.C. § 1395oo(a)(3), which specifies that appeals of Federal Register Notices (i.e., appeals under 42 U.S.C. § 1395(a)(1)(ii)) must be filed "*within . . . 180 days after* ***notice*** *of the Secretary's final determination.*"[4] These appeals were filed in OH CDMS ***almost 2 months after*** the filing deadline of 180 days after the issuance of the June 9, 2023 Federal

[2] Providers' Appeals Issue Statement.
[3] 88 Fed. Reg. 37772 (June 9, 2023). *See also Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ("[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") and *Dist. of Columbia Hosp. Ass'n Wage Index Group Appeal*, HCFA Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993) (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).
[4] (Emphasis added.)

Register provision that implemented the Final Rule for "Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage."

Consistent with 42 U.S.C. § 1395oo(a)(3), 42 C.F.R. § 405.1835(a)(3) specifies that a provider's appeal request must be filed no later than 180 days after the "date of receipt" of the final determination being appealed:

> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.

The regulation at 42 C.F.R. § 405.1837(a)(1) makes clear that this requirement applies to provider's participating in a group appeal whether by transfer or direct add.[5] To this end, Board Rule 7.1.1 specifies that the appeal request must "[i]dentify the date the final determination ***was issued***"[6] and Board Rule 4.3.2 specifies in connection with appeals based on a Federal Register Notice that: (1) "[t]he date of receipt of a Federal Register Notice is the date the Federal Register is published"; and (2) "[t]he appeal period begins on the date of publication and ends 180 days from that date."

The Board is bound by all of the provisions of Title XVIII of the Act (the Social Security Act, as amended) and the regulations issued thereunder.[7] The Board cannot apply a regulation or instruction which is contrary to a statute and other regulations that deal specifically with the matter at hand: the date a provider is deemed to have notice of the contents of the Federal Register. In this case, the laws and regulations governing the publication of Federal Register notices specifically define the time of notice as that of publication. These laws and regulations have been incorporated into Title XVIII.

The Secretary[8] has enacted Part 401 of Title 42 of the Code of Federal Regulations which is entitled "General Administrative Requirements." Subpart B, §§ 401.101(a)(1) and (2) of this Part states that "[t]he regulations in this subpart: (1) Implement section 1106(a)[9] of the Social Security Act [relating to disclosure of information] as it applies to [CMS] . . . [and] (2) Relate to the availability to the public, under 5 U.S.C. § 552,[10] of records of CMS." These laws and regulations set out which records are available and how they may be obtained, and they supplement the regulations of

---

[5] 42 C.F.R. § 405.1837(a)(1) specifies that a provider's right to participate in a group is dependent, in part, on the "[t]he provider satisfy[ying] 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)." NOTE – none of the providers in these 109 appeals have alleged that they are appealing from the nonissuance of an NPR or revised NPR consistent with § 405.1835(c) and, to that end, there is no information in the records for these cases to support such an allegation consistent with Board Rule 7.5.

[6] (Emphasis added.)

[7] *See* 42 C.F.R. § 405.1867.

[8] of the Department of Health and Human Services.

[9] 42 U.S.C. § 1306(a).

[10] 5 U.S.C. § 550 *et seq.* contains the Administrative Procedures Act; 5 U.S.C. § 552 deals with the availability of government information and is known as the Freedom of Information Act ("FOIA").

CMS relating to the availability of information. Section 401.106 of this subpart, which deals with publication of materials under 5 U.S.C. § 552, requires publication to serve as notice and identifies the Federal Register as the vehicle to be used to give notice. Section 552(a) states in part that:

> (1) Each agency shall separately state and currently publish in the Federal Register for the guidance of the public-
>
> * * * *
>
> (D) substantive rules of general applicability adopted as authorized by law, and statements of general policy or interpretations of general applicability formulated and adopted by the agency; and
> (E) each amendment, revision, or repeal of the foregoing.

In order to comply with the statutes and regulations requiring that public notice be given, the Secretary annually publishes the schedules of the Inpatient Prospective Payment System ("IPPS") rates as well as other IPPS policies in the Federal Register pursuant to the requirements of 42 C.F.R. § 412.8(b)(2). The Secretary may issue other changes as Federal Register Notices outside of this annual ratesetting process as was done here with the issuance of the Part C days policy published in the June 9, 2023 Final Rule. These processes were created to comply with 5 U.S.C. § 552 of the Freedom of Information Act which requires that agencies publish regulations and notices in the Federal Register.[11]

With regard to the Notices published in the Federal Register, 44 U.S.C. § 1507 states in part that:

> A document required. . .to be published in the Federal Register is not valid as against a person who has not had actual knowledge of it until the duplicate originals or certified copies of the document have been filed with the Office of the Federal Register and a copy made available for public inspection as provided by section 1503. . . . *[F]iling of a document, required or authorized to be published [in the Federal Register] by section 1505. . .is sufficient to give notice* of the contents of the document to a person subject to or affected by it.[12]

Reflecting new technology and the ability to transmit information immediately upon publication, the Government Printing Office ("GPO") promulgated 1 C.F.R. § 5.10 which authorizes publication of the Federal Register on the internet at the GPO website.[13] The GPO website containing the Federal Register is updated daily at 6 a.m. Monday through Friday, except holidays.[14] Consequently, the Provider is deemed to have notice of the Part C days policy at issue on the date the Federal Register was published and made available online. Indeed, the Board notes that Notices are often available for public inspection several days ***prior to*** the official

[11] *See also* 42 C.F.R. Part 401, Subpart B.
[12] (Emphasis added).
[13] *See also* 44 U.S.C. § 4101 (the Superintendent of Documents is to maintain an electronic director and system of online access to the Federal Register).
[14] *See* http://www.gpo.gov/help/index.html#about_federal_register.htm.

publication date and, here, the June 9, 2023 Final Rule was posted to the public at 4:15 pm on June 7, 2023, 2 days in advance of the June, 9, 2023 publication date.[15]

With respect to statutes and regulations dealing with the Federal Register, the Supreme Court has found that:

> Congress has provided that the appearance of rules and regulations in the Federal Register give legal notice of their contents . . . .
>
> . . . Regulations [are] binding on all who sought to come within the [Act], regardless of actual knowledge of what is in the Regulations or of the hardship resulting from innocent ignorance.[16]

The statutes governing the Board (44 U.S.C. § 1507 as applied through the requirements of 42 C.F.R. § 401.101 and the Administrative Procedures Act ("APA")) are clear on their face: ***the date of publication*** of the Federal Register is the date the Providers are deemed to have notice of the June 9, 2023 Final Rule. The Board is bound by all of the provisions of Title XVIII which includes, by reference, the provisions of the Administrative Procedures Act and the Public Printing and Documents law which require that CMS publish its notices and regulations in the Federal Register. In publishing materials in the Federal Register, CMS must comply with the statutes and regulations governing the Superintendent of Documents and the Governing Printing Office.

Pursuant 42 U.S.C. § 1395oo(a)(3), the Board's enabling statute, providers have 180 days "after *notice* of the Secretary's final determination" to file an appeal. To this end, Board Rule 4.3.2 confirms that the appeal period for a final rule published in the Federal Register appeal ends 180 days from the date of ***publication***, not the effective date that may be listed in a provision:

> The date of receipt of a Federal Register Notice is the date the Federal Register is ***published***. The appeal period begins on the date of publication and ends 180 days from that date.[17]

In this case, the notice of the Secretary's determination is, by law, the date the Federal Register is issued by the Superintendent of Documents, or June 9, 2023. Here, the 180th day for appealing was ***Wednesday, December 6, 2023***. The above-captioned appeals were not filed with the Board until ***almost 2 months after this deadline*** (specifically between January 30, 2024 and February 1, 2024) and, thus, were not timely filed.[18]

Based on the above findings, the Board concludes that it does not have jurisdiction over the above-captioned 109 appeals for failure of the Providers' to *timely* file these appeals of the June 9, 2023 Final Rule by the Wednesday, December 6, 2023 filing deadline consistent with 42

---

[15] https://www.federalregister.gov/public-inspection/2023/06/07 (last accessed Jan. 19, 2024).
[16] *Fed. Crop Ins. Corp. v. Merrill*, 332 U.S. 380, 385 (1947).
[17] Emphasis added.
[18] The Providers in these 109 appeals have not requested good cause exception under 42 C.F.R. § 405.1836 and have not presented any evidence suggesting that they would qualify under the criteria specified in that regulation.

U.S.C. § 1395oo(a)(1)(3), 42 C.F.R. §§ 405.1835(a)(3) and 405.1837(a)(1) and Board Rules 4.3.2 and 7.1.1 and, as such, hereby dismisses them. Accordingly, the Board closes the above-captioned 109 cases and removes them from the Board's docket.[19] Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

2/2/2024

X Clayton J. Nix

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

Enclosure – Listing of 109 cases

cc: Wilson Leong, Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-5)
Geoff Pike, First Coast Service Options, Inc. (J-N)
Michael Redmond, Novitas Solutions, Inc. (J-H)
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Danelle Decker. National Government Services (J-K)
John Bloom, Noridian Healthcare Solutions (J-F)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Pamela VanArsdale, National Government Services, Inc. (J-6)

[19] Regardless, even if the Board had not dismissed these appeals as being untimely filed (*almost 2 months late*), the Board would find that the Providers appeals were premature as they failed to appeal from a "final determination" consistent with the jurisdictional dismissal decisions issued in: (1) Case No. 23-1498 on Nov. 27, 2023 which similarly appealed the June 9, 2023 Final Rule (available at: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-11-1-2023-through-11-30-2023.pdf (last accessed Jan. 19, 2023)); (2) Case Nos. 23-1796GC, *et al*. on Oct. 25, 2023 which appealed the § 1115 waiver day policy finalized in the August 28, 2023 FY 2024 IPPS Final Rule (available at: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-10-1-2023-through-10-31-2023.pdf (last accessed Jan. 19, 2023)). Moreover, even if it were a final determination, the Board would also need to conduct further review to confirm, *based on the information/documentation included in the relevant appeal request*, whether the Providers have established (consistent with 42 C.F.R. §§ 405.1835(b)(1) and 405.1837(c)(1), (3)) that the June 9, 2023 Final Rule is, ***in fact***, applicable to them (*i.e.*, confirm for the fiscal years at issue that either: (a) no NPR has been issued; or (b) they had a Board appeal of the Part C issue that was subsequently remanded per CMS Ruling 1739-R).

Listing of 34 CIRP Groups and 75 Individual Appeals

24-0968GC	CHS CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0989GC	SSEPR CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-0948	Parkview Medical Center Inc. (06-0020), FFY 2007
24-0949	Parkview Medical Center Inc. (06-0020), FFY 2008
24-0950	Parkview Medical Center Inc. (06-0020), FFY 2009
24-0951	Parkview Medical Center Inc. (06-0020), FFY 2010
24-0952	Parkview Medical Center Inc. (06-0020), FFY 2011
24-0953	Parkview Medical Center Inc. (06-0020), FFY 2012
24-0954	Parkview Medical Center Inc. (06-0020), FFY 2013
24-0955	MercyOne Waterloo Medical Center (16-0067), FFY 2007
24-0956	MercyOne Waterloo Medical Center (16-0067), FFY 2010
24-0957	MercyOne Waterloo Medical Center (16-0067), FFY 2011
24-0958	MercyOne Waterloo Medical Center (16-0067), FFY 2012
24-0959	MercyOne Waterloo Medical Center (16-0067), FFY 2013
24-0960	Stormont Vail Hospital (17-0086), FFY 2007
24-0961	Stormont Vail Hospital (17-0086), FFY 2008
24-0962	Stormont Vail Hospital (17-0086), FFY 2009
24-0963	Stormont Vail Hospital (17-0086), FFY 2010
24-0964	Stormont Vail Hospital (17-0086), FFY 2011
24-0966	Stormont Vail Hospital (17-0086), FFY 2012
24-0967	Stormont Vail Hospital (17-0086), FFY 2013
24-0969	Hollywood Presbyterian Medical Center (05-0063), FFY 2007
24-0970	Hollywood Presbyterian Medical Center (05-0063), FFY 2008
24-0971	Hollywood Presbyterian Medical Center (05-0063), FFY 2009
24-0972	Hollywood Presbyterian Medical Center (05-0063), FFY 2010
24-0973	Hollywood Presbyterian Medical Center (05-0063), FFY 2011
24-0974	Hollywood Presbyterian Medical Center (05-0063), FFY 2012
24-0975	Hollywood Presbyterian Medical Center (05-0063), FFY 2013
24-0976	Valley Presbyterian Hospital (05-0126), FFY 2005
24-0977	Valley Presbyterian Hospital (05-0126), FFY 2009
24-0978	University of Colorado Health Memorial Hospital Central (06-0022), FFY 2006
24-0979	University of Colorado Health Memorial Hospital Central (06-0022), FFY 2009
24-0980	Frisbie Memorial Hospital (30-0014), FFY 2011
24-0981	Frisbie Memorial Hospital (30-0014), FFY 2012
24-0982	Frisbie Memorial Hospital (30-0014), FFY 2013
24-0983	CHI St. Luke's Health Baylor College of Medicine Medical Center (45-0193), FFY 2009
24-0984	Sanford USD Medical Center (43-0027), FFY 2006
24-0985	Sanford USD Medical Center (43-0027), FFY 2008

24-0986	Sanford USD Medical Center (43-0027), FFY 2009
24-0987	San Luke's Memorial Hospital Inc. (40-0044), FFY 2011
24-0988	San Luke's Memorial Hospital Inc. (40-0044), FFY 2012
24-0990	Hospital Comunitario Buen Samaritano (40-0079), FFY 2007
24-0991	Doctors' Center Hospital, Inc. (40-0118), FFY 2013
24-0992	Arizona Regional Medical Center (03-0126), FFY 2010
24-0993	Arizona Regional Medical Center (03-0126), FFY 2011
24-0994	Arizona Regional Medical Center (03-0126), FFY 2012
24-1000GC	HonorHealth CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-1001GC	HonorHealth CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-1002GC	HonorHealth CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-1003GC	HonorHealth CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-1004GC	HonorHealth CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-1009GC	HonorHealth CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-1011GC	Atrium Health CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-1014GC	VCH CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-1015GC	VCH CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-1016GC	VCH CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-1017GC	VCH CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-1018GC	VCH CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-1028GC	Asante Health System CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-1030GC	Asante Health System CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-1031GC	Asante Health System CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-1032GC	Asante Health System CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-1033GC	Asante Health System CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-1012	Wilkes Regional Medical Center (34-0064), FFY 2011
24-1013	Via Christi Hospital Pittsburg (17-0006), FFY 2007
24-1020	Avera McKennan Hospital & University Health Center (43-0016), FFY 2005
24-1021	Avera McKennan Hospital & University Health Center (43-0016), FFY 2006
24-1022	Avera McKennan Hospital & University Health Center (43-0016), FFY 2008
24-1023	Avera McKennan Hospital & University Health Center (43-0016), FFY 2009
24-1024	Avera McKennan Hospital & University Health Center (43-0016), FFY 2010
24-1025	Avera McKennan Hospital & University Health Center (43-0016), FFY 2011
24-1026	Avera McKennan Hospital & University Health Center (43-0016), FFY 2012
24-1027	Avera McKennan Hospital & University Health Center (43-0016), FFY 2013
24-1029	Asante Three Rivers Medical Center (38-0002), FFY 2009
24-1034	Asante Rogue Regional Medical Center (38-0018), FFY 2013
24-1035	Asante Rogue Regional Medical Center (38-0018), FFY 2006
24-1036	Winter Haven Hospital (10-0052), FFY 2005

24-1037	Winter Haven Hospital (10-0052), FFY 2007
24-1038	Winter Haven Hospital (10-0052), FFY 2008
24-1039	Winter Haven Hospital (10-0052), FFY 2009
24-1046GC	Novant Health CY 2006 Treatment of Part C Days Final Rule CIRP Group
24-1047GC	CHS CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-1048GC	Novant Health CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-1049GC	Novant Health CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-1050GC	Novant Health CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-1051GC	CHS CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-1052GC	Novant Health CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-1053GC	Novant Health CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-1054GC	Novant Health CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-1065GC	WFHS CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-1066GC	WFHS CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-1067GC	WFHS CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-1068GC	WFHS CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-1069GC	WFHS CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-1070GC	WFHS CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-1044	Novant Health Presbyterian Medical Center (34-0053), FFY 2005
24-1055	Cape Fear Valley Medical Center (34-0028), FFY 2006
24-1056	Cape Fear Valley Medical Center (34-0028), FFY 2007
24-1057	Cape Fear Valley Medical Center (34-0028), FFY 2008
24-1058	Cape Fear Valley Medical Center (34-0028), FFY 2009
24-1059	Newton Medical Center (31-0028), FFY 2010
24-1060	Cape Fear Valley Medical Center (34-0028), FFY 2011
24-1061	Cape Fear Valley Medical Center (34-0028), FFY 2012
24-1062	Betsy Johnson Regional Hospital (34-0071), FFY 2010
24-1063	Betsy Johnson Regional Hospital (34-0071), FFY 2011
24-1064	Wheaton Franciscan - St. Joseph (52-0136), FFY 2007
24-1071	Covenant Medical Center (45-0040), FFY 2008
24-1072	Covenant Medical Center (45-0040), FFY 2009
24-1073	Covenant Medical Center (45-0040), FFY 2010

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

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

RE: ***Board Decision***
Abilene Regional Medical Center (Prov. No. 45-0558)
FYE: 08/31/2016
Case No.: 19-1311

Dear Mr. Summar and Mr. Lamprecht,

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

Background:

A. ***Procedural History for Case No. 19-1311***

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

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

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

As the Provider is owned by Community Health Systems, Inc. (hereinafter "Community Health") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2 and 5 to Community Health groups on September 24, 2019. After the withdrawal of Issue 3, the remaining issues in this appeal are Issues 1 and 4.

[1] On Sept. 24, 2019, this issue was transferred to PRRB Case No. 19-1409GC.
[2] This issue was withdrawn on March 2, 2023.
[3] On Sept. 24, 2019, this issue was transferred to PRRB Case No. 19-1409GC.

On May 20, 2019, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 4.[4] The Provider filed a response on June 7, 2019.

On October 2, 2019, the Provider submitted its preliminary position paper.

On January 24, 2020, the Medicare Contractor filed its preliminary position paper.

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

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

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

As the Provider is commonly owned by Community Health, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 19-1409GC, CHS CY 2016 DSH SSI Percentage CIRP Group, on September 24, 2019. The Group Issue Statement in Case No. 19-1409GC reads, in part:

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

[4] The Jurisdictional Challenge also contended the jurisdiction of Issue No. 5. But that was subsequently transferred, as noted above.
[5] Issue Statement at 1 (Feb. 5, 2019).

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

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $2,523.

On October 2, 2019, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

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

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

> ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[7]

MAC's Contentions

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

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

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of the reimbursement impact.
>
> . . .
>
> The Provider's appeal of this item is premature. The Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3); therefore, the Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue. The MAC requests that the PRRB dismiss this issue consistent with recent jurisdictional decisions.[8]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are duplicates.[9]

Issue 4 – UCC Distribution Pool

[7] Provider's Preliminary Position Paper at 8-9 (Oct. 2, 2019).
[8] Jurisdictional Challenge at 6 (Aug. 5, 2020).
[9] *Id*. at 5-6.

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)."[10]

Further, the MAC posits that Issue 4 is duplicative of the Provider's participation in PRRB Case Nos. 15-1134GC and 16-0769GC.[11]

Provider's Jurisdictional Response

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

The Provider argues that the issues are not duplicative because "issues #1 and 2 represent different components of the SSI issue, which was specifically adjusted during the audit."[12] Additionally, the Provider argues that the issue is not duplicative because the Provider is "not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category."[13]

Finally, the Provider contends the Provider Specific issue is appealable "because the MAC specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2016, as a result of its understated SSI percentage due to errors of omission and commission."[14]

Issue 4 – UCC Distribution Pool

In response to the MAC's position that the Provider is violating PRRB Rule 4.6.2 by appealing from the same issue from distinct determinations in multiple appeals, the Provider argues:

> Providers (sic) have appealed from the Federal Register dated August 22, 2014, August 17, 2015 and from the NPR. In this instance, Provider's appeals in PRRB CN 15-1134GC, CN 16-0769GC and 19-1311 are from separate and distinct determinations, and appeal rights associated with Federal Register Publications vary from those of appeal rights based upon NPRs. Therefore, Provider contends there is no conflict with PRRB Rule 4.6.2, and Provider wishes to preserve their appeals for both types of appeals.[15]

[10] *Id*. at 9-10.
[11] *Id*. at 10.
[12] Jurisdictional Response at 1 (Oct. 10, 2019).
[13] *Id*. at 2.
[14] *Id*.
[15] *Id*. at 3.

Board Analysis and Decision:

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

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

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

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

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

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

PRRB Rule 4.6[19], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 19-1409GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[20] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-1409GC.

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

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[21]

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

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[22]
> This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[23]

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 19-1409GC are the same issue.[24] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the

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

Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

B. UCC Distribution Pool

The Board finds that it does not have jurisdiction over the DSH UCC payment issue in the above-referenced appeal because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).[25]

1. Bar on Administrative Review

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

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[26]
>
> (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*"),[27] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[28] 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

---

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

[26] 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.

[27] 830 F.3d 515 (D.C. Cir. 2016).

[28] 89 F. Supp. 3d 121 (D.D.C. 2015).

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."[29] 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.[30]

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.[31]

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*").[32] 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."[33] 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.[34]

[29] 830 F.3d 515, 517.
[30] *Id.* at 519.
[31] *Id.* at 521-22.
[32] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[33] *Id.* at 506.
[34] *Id.* at 507.

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[35] 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.[36] 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.[37] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[38] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[39]

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.[40]

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

[35] 514 F. Supp. 249 (D.D.C. 2021).
[36] *Id.* at 255-56.
[37] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[38] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.
[39] *Id.*
[40] *Id.* at 262-64.
[41] *Id.* at 265.

review is precluded by statute, the criteria in *Scranton* were not met.[42] 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.[43]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[44] 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*").[45] 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.[46] 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."[47] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[48] 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***."[49]

The Board finds that the same findings are applicable to the Provider's challenge to their FFY 2016 UCC payments. The Providers here are challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2016. The challenge to CMS' notice and comment procedures focuses

---

[42] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[43] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[44] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[45] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[46] *Id.* at *4.
[47] *Id.* at *9.
[48] 139 S. Ct. 1804 (2019).
[49] *Ascension* at *8 (bold italics emphasis added).

on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 19-1409GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. Finally, the Board dismisses the UCC Distribution Pool issue as the Board does not have jurisdiction because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation. As no issues remain pending, the Board hereby closes Case No. 19-1311 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

2/6/2024

X Robert A. Evarts, Esq.

Robert A. Evarts, Esq.
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Decision***
Tennova Healthcare - Clarksville (Provider Number 44-0035)
FYE: 09/30/2017
Case Number: 22-0797

Dear Mr. Summar,

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 22-0797 pursuant to a jurisdictional challenge filed by the Medicare Administrative Contractor ("MAC"). The Board's decision is set forth below.

Pertinent Facts

A. Procedural History for Case No. 22-0797

On August 25, 2021, the Provider, Tennova Healthcare - Clarksville, was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2017.

On February 16, 2022, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. DSH – SSI Percentage (Provider Specific)
2. DSH – SSI Percentage (Systemic Errors)[1]
3. DSH – Medicaid Eligible Days
4. Medicare Managed Care Part C Days – SSI & Medicaid Fraction[2]
5. Dual Eligible Days – SSI & Medicaid Fraction[3]

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), and thereby, subject to the mandatory Common Issue Related Party ("CIRP") regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2, 4, and 5 to CHS groups on September 8, 2022. As a result, the remaining issues in this appeal are Issues 1 and 3.

On October 3, 2022, the Provider filed its preliminary position paper.

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

On January 17, 2023, the Medicare Contractor filed a jurisdictional challenge with the Board over Issues 1 and 3. The Provider did not file a jurisdictional response.

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

B. Description of Issue 1 in the Provider's Preliminary Position Paper and the Provider's Participation in Case No. 20-0997GC

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

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Tennessee and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Tennessee and has learned that similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services,* No CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from [s]tate records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS,09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS' 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.[4]

The Group Issue Statement in Case No. 20-0997GC CHS CY 2017 DSH SSI Percentage CIRP Group reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security

[4] Provider's Preliminary Position Paper at 8-9 (Oct. 3, 2022).

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

MAC's Contentions

Issue 1 – DSH – SSI Percentage (Provider Specific)

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

> According to the Provider's appeal request, Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. As noted above, the Provider transferred Issue 2 to the Group Case No. 20-0997GC, "CHS CY 2017 DSH SSI Percentage CIRP Group". The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of the issue under appeal in Group Case No. 20-0997GC. Here the MAC relies on PRRB Rule 4.6.1, which prohibits a provider from appealing the same issue from a single determination in more than

[5] Group Issue Statement, Case No. 20-0997GC.

> one appeal.[6]

The MAC also argues that the portion of the issue related to SSI realignment was abandoned, or alternatively, the appeal is premature because the Provider has not requested realignment in accordance with 42 C.F.R. § 412.106(b)(3):

> With respect to SSI realignment, the MAC contends that this issue has been abandoned. The Provider did not brief the issue of SSI realignment within its preliminary position paper. As a result, it should be considered withdrawn in accordance with Board Rule 25.3. Alternatively, even if the Board determines that the issue was not withdrawn, the MAC asserts that the Board does not have jurisdiction over realignment. There was no final determination over the SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies. This issue should be dismissed. It should also be noted that the Provider's fiscal year end is the same as the federal fiscal year end (September 30). The result of the Medicare computation based on the Provider's fiscal year end would therefore be the same as the Medicare computation based on the federal fiscal year end.[7]

Finally, the MAC argues the Provider failed to follow Board rules:

> Lastly, Issue 1 should be dismissed because the Provider failed to file a complete preliminary position paper including all supporting exhibits to document the merits of its argument in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25.[8]

Issue 3 – DSH – Medicaid Eligible Days

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

> The Provider has abandoned the DSH – Medicaid Eligible Days issue. Pursuant to Board Rule 25.3, parties should file a complete preliminary position paper with a fully developed narrative, all exhibits, a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853.[9]

---

[6] Jurisdictional Challenge at 2 (Jan. 17, 2023).
[7] *Id.*
[8] *Id.*
[9] *Id.*

Provider's Jurisdictional Response

The Board Rules require that a Provider's Response to the MAC's Jurisdictional Challenge must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[10] The Provider has not filed a response to the Jurisdictional Challenge or Motion to Dismiss and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Similarly, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Board Decision

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

A. DSH Payment/SSI Percentage (Provider Specific)

The jurisdictional analysis for Issue 1 has three relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period, and 3) individuals who are eligible for SSI but did not receive SSI payment. As set forth below, the Board should dismiss all three aspects of Issue 1.

1. *First and Third Aspects of Issue 1*

The first and third aspects of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage and individuals who are eligible for SSI but did not receive SSI payment —are duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 20-0997GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[11] 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)."[12] The Provider argues that "disagrees with the MAC's calculation of the

[10] Board Rule 44.4.3, v. 2.0 (Aug. 2018).
[11] Issue Statement at 1.
[12] *Id.*

computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[13] The Provider also notes that CMS "refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment."[14]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-0997GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, including paid days vs. eligible days, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board should find the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-0997GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[15], the Board hereby dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 20-0997GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[16] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-0997GC.

To this end, the Board has also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1 and finds that the Provider does not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-0997GC. Instead, the Provider refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal.

Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." For example, the Provider asserts that it "has learned that . . . the SSI entitlement of individuals can be ascertained from State records" but fails to explain what that means, what the basis for the alleged fact is,[17] or why that is even relevant to the issue. Here, it is clear that the Provider failed to *fully* develop the merits of its position on

---

[13] *Id.*
[14] *Id.*
[15] PRRB Rules v. 2.0 (Nov. 2021).
[16] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[17] There are no exhibits or citations to state records or any examples of how SSI entitlement can be ascertained from state records.

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

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

> **25.2.2 Unavailable and Omitted Documents**
>
> If documents necessary to support your position are still unavailable, then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the Federal Freedom of Information Act (also known as FOIA requests), or similar requests of information pending with a state Medicaid agency.

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[18]

[18] Last accessed January 4, 2024.

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[19]

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

Accordingly, *based on the record before it*, the Board finds that the SSI Provider Specific issue in Case No. 22-0797 and the group issue from Group Case 20-0997GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses these components of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

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

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) (Nov. 2021) 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.

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

[19] Emphasis added.

> (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.[20]

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

> **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**
>
> The Provider's preliminary position paper must:
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
> B. For *each* issue that has not been fully resolved, provide a *fully* developed narrative. . .
> C. Comply with Rule 25.2 addressing Exhibits.
>
> **25.2 Position Paper Exhibits**
>
> **25.2.1 General**
>
> With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. The Medicare contractor must also give the provider all evidence the Medicare contractor considered in making the determination (see 42 C.F.R. § 405.1853(a)(3)) and identify any documentary

[20] (Bold emphasis added.)

> evidence that the Medicare contractor believes is necessary for resolution but has not been submitted by the provider. When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.
>
> **25.2.2 Unavailable and Omitted Documents**
>
> If documents necessary to support your position are still unavailable, then provide the following information in the position papers:
>
> 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. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.
>
> **25.2.3 List of Exhibits**
>
> Parties must attach a list of the exhibits exchanged with the position paper.
>
> **25.3 Filing Requirements to the Board**
>
> The Board requires the parties file a *complete* preliminary position paper with a fully developed narrative (Rule 25.1), all exhibits (Rule 25.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn.

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

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

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

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

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

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

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

On October 3, 2022, the Provider filed its preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[21] The position paper did not identify how many Medicaid eligible days remained in dispute in this case.

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

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).

[21] Provider's Preliminary Position Paper at 8 (Oct. 3, 2022).

> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2017 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[22]

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

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The Medicare Contractor thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[23]

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled, consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25.

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

Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove

---

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

[23] *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.

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, 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.

****

In summary, based on the record before it,[25] the Board hereby dismisses the SSI Provider Specific issue as there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to meet the Board requirements for position papers. Further, the first and third aspects of the issue are duplicative of the group issue in CIRP Case No. 20-0097GC, to which the Provider transferred its Issue #2.

The Board also hereby dismisses the DSH Medicaid Eligible Days issue, as the Provider has failed to meet the Board requirements for position papers for this issue relative to developing the merits of its case and filing supporting exhibits as required under 42 C.F.R. §§ 412.106(b)(4)(iii) and 4015.1853(b)(2)-(3) and Board Rule 25. Significantly, the Provider has not provided any timely explanation to the MAC as to why the documentation was absent or what is being done to obtain it.

As there are no issues remaining in the appeal, the case is closed and removed from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

2/6/2024

X Kevin D. Smith, CPA

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

cc: Wilson Leong, Federal Specialized Services
Cecile Huggins, Palmetto GBA c/o National Government Services, Inc. (J-J)

[24] (Emphasis added.)
[25] Again, the Provider failed to timely respond to the jurisdictional challenge (or respond at all, as of this decision) and, per Board Rule 44.4.3, the Board will make a determination based on the record before it.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal of Untimely Appeals***
Case Nos. 24-1075, *et al.* (*see* attached listing of 149 cases)

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("PRRB") is in receipt of the above-captioned one-hundred-thirty (130) individual and nineteen (19) common issue related party ("CIRP") group appeals that were filed between February 2, 2024 to February 4, 2024 by the Providers' designated representative, James Ravindran of Quality Reimbursement Services, Inc. ("QRS") based on an appeal of the final rule published in the Federal Register on June 9, 2023 ("June 9, 2023 Final Rule") involving Part C days as used in the disproportionate share calculation ("DSH") by the Centers for Medicare and Medicaid Services ("CMS").[1] Set forth below is the Board's decision dismissing the above-captioned 149 individual and CIRP group cases for failure of the Providers' to *timely* file their appeals of the June 9, 2023 Final Rule by the Wednesday, December 6, 2023 filing deadline consistent with 42 U.S.C. § 1395oo(a)(1)(3), 42 C.F.R. §§ 405.1835(a)(3) and 405.1837(a)(1) and Board Rules 4.3.2 and 7.1.1.

Background

Between February 2, 2024 to February 4, 2024, QRS filed appeal requests in the Office of Hearings Case and Document Management System ("OH CDMS") to establish the above-captioned 149 individual and CIRP group cases. The appeal request filed for each case identifies the final determination being appealed as the June 9, 2023, Final Rule and describe the statement of issue as follows:

> **ISSUE TITLE**
>
> [DSH] – Inclusion of Part C Days in Denominator of the Medicare Fraction- Challenge to Part C Days retroactive final rule.
>
> **STATEMENT OF ISSUE**
>
> The issue is whether Part C days are properly included in the denominator of the Medicare Fraction per a July 8, 2023, retroactive

[1] 88 Fed. Reg. 37772 (June 9, 2023).

> final rule issued by [CMS], which is binding on the [Medicare contractor], or whether such final rule is illegal and cannot be enforced.
>
> The Provider appeals [Providers appeal] the Secretary's determination, which it calls a "final action," embodied in a July 8, 2023, retroactive final rule, that requires Part C Days to be included in the Medicare Fraction of the disproportionate payment percentage for discharges occurring prior to October 1, 2013 ("the Part C Days Final Rule"). The Part C Days Final Rule ***became effective on August 8, 2023***. The Providers challenge the procedural and substantive validity of the Part C Days Final Rule. Specifically, the Providers assert that the Part C Days Final Rule is procedurally invalid the retroactive nature of the rule violates the rulemaking provisions of the Social Security Act and the Administrative Procedure Act, and is contrary to the D.C. Circuit's opinion in *Northeast Hospital v. Sebelius*, and established precedent regarding the applicability of a pre-existing rule when a later rule is vacated (as was the 2004 final rule on Part C days). The Part C Days Final Rule is substantively invalid because it is arbitrary and capricious. Specifically, the Part C Days Final Rule is arbitrary and capricious because CMS did acknowledge that putting Part C Days in the Medicare Fraction was a departure from its policy or practice prior to the vacated 2004 rule. The Part C Days Final Rule also failed to account for hospitals' reliable interest on the pre-2004 final rule practice or policy, and also failed to recognize the enormous adverse financial impact on hospitals due to the change from the pre-2004 final rule practice or policy.[2]

However, each of these 149 individual and group appeals were filed more than ***180 days*** after the publication of the June 9, 2023 Final Rule provision that implemented the Final Rule for "Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage."[3] Notwithstanding, each of these appeal requests identified, *in error*, that the "final determination date" from which they are appealing is August 8, 2023 – the ***effective date*** of the provision, rather than the date of ***notice***, *i.e.*, the publication date, of June 9, 2023.

Decision of the Board

The Board finds that the above-captioned 149 appeals were ***not*** timely filed as required by the Board's enabling statute at 42 U.S.C. § 1395oo(a)(3), which specifies that appeals of Federal Register Notices (i.e., appeals under 42 U.S.C. § 1395(a)(1)(ii)) must be filed "*within . . . 180 days after **notice** of the Secretary's final determination.*"[4] These appeals were filed in OH CDMS

[2] Providers' Appeals Issue Statement
[3] 88 Fed. Reg. 37772 (June 9, 2023). *See also Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ("[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") and *Dist. of Columbia Hosp. Ass'n Wage Index Group Appeal*, HCFA Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993) (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).
[4] (Emphasis added.)

approximately ***2 months past*** the filing deadline of 180 days after the issuance of the June 9, 2023 Federal Register provision that implemented the Final Rule for "Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage."

Consistent with 42 U.S.C. § 1395oo(a)(3), 42 C.F.R. § 405.1835(a)(3) specifies that a provider's appeal request must be filed no later than 180 days after the "date of receipt" of the final determination being appealed:

> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.

The regulation at 42 C.F.R. § 405.1837(a)(1) makes clear that this requirement applies to provider's participating in a group appeal whether by transfer or direct add.[5] To this end, Board Rule 7.1.1 specifies that the appeal request must "[i]dentify the date the final determination ***was issued***"[6] and Board Rule 4.3.2 specifies in connection with appeals based on a Federal Register Notice that: (1) "[t]he date of receipt of a Federal Register Notice is the date the Federal Register is published"; and (2) "[t]he appeal period begins on the date of publication and ends 180 days from that date."

The Board is bound by all of the provisions of Title XVIII of the Act (the Social Security Act, as amended) and the regulations issued thereunder.[7] The Board cannot apply a regulation or instruction which is contrary to a statute and other regulations that deal specifically with the matter at hand: the date a provider is deemed to have notice of the contents of the Federal Register. In this case, the laws and regulations governing the publication of Federal Register notices specifically define the time of notice as that of publication. These laws and regulations have been incorporated into Title XVIII.

The Secretary[8] has enacted Part 401 of Title 42 of the Code of Federal Regulations which is entitled "General Administrative Requirements." Subpart B, §§ 401.101(a)(1) and (2) of this Part states that "[t]he regulations in this subpart: (1) Implement section 1106(a)[9] of the Social Security Act [relating to disclosure of information] as it applies to [CMS] . . . [and] (2) Relate to the availability to the public, under 5 U.S.C. § 552,[10] of records of CMS." These laws and regulations set out which records are available and how they may be obtained, and they

---

[5] 42 C.F.R. § 405.1837(a)(1) specifies that a provider's right to participate in a group is dependent, in part, on the "[t]he provider satisfy[ying] 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)." NOTE – none of the providers in these 149 appeals have alleged that they are appealing from the nonissuance of an NPR or revised NPR consistent with § 405.1835(c) and, to that end, there is no information in the records for these cases to support such an allegation consistent with Board Rule 7.5.

[6] (Emphasis added.)

[7] *See* 42 C.F.R. § 405.1867.

[8] of the Department of Health and Human Services.

[9] 42 U.S.C. § 1306(a).

[10] 5 U.S.C. § 550 *et seq.* contains the Administrative Procedures Act; 5 U.S.C. § 552 deals with the availability of government information and is known as the Freedom of Information Act ("FOIA").

supplement the regulations of CMS relating to the availability of information. Section 401.106 of this subpart, which deals with publication of materials under 5 U.S.C. § 552, requires publication to serve as notice and identifies the Federal Register as the vehicle to be used to give notice. Section 552(a) states in part that:

> (1) Each agency shall separately state and currently publish in the Federal Register for the guidance of the public-
>
> * * * *
>
> (D) substantive rules of general applicability adopted as authorized by law, and statements of general policy or interpretations of general applicability formulated and adopted by the agency; and
> (E) each amendment, revision, or repeal of the foregoing.

In order to comply with the statutes and regulations requiring that public notice be given, the Secretary annually publishes the schedules of the Inpatient Prospective Payment System ("IPPS") rates as well as other IPPS policies in the Federal Register pursuant to the requirements of 42 C.F.R. § 412.8(b)(2). The Secretary may issue other changes as Federal Register Notices outside of this annual ratesetting process as was done here with the issuance of the Part C days policy published in the June 9, 2023 Final Rule. These processes were created to comply with 5 U.S.C. § 552 of the Freedom of Information Act which requires that agencies publish regulations and notices in the Federal Register.[11]

With regard to the Notices published in the Federal Register, 44 U.S.C. § 1507 states in part that:

> A document required. . .to be published in the Federal Register is not valid as against a person who has not had actual knowledge of it until the duplicate originals or certified copies of the document have been filed with the Office of the Federal Register and a copy made available for public inspection as provided by section 1503. . . . *[F]iling of a document, required or authorized to be published [in the Federal Register] by section 1505. . .is sufficient to give notice* of the contents of the document to a person subject to or affected by it.[12]

Reflecting new technology and the ability to transmit information immediately upon publication, the Government Printing Office ("GPO") promulgated 1 C.F.R. § 5.10 which authorizes publication of the Federal Register on the internet at the GPO website.[13] The GPO website containing the Federal Register is updated daily at 6 a.m. Monday through Friday, except holidays.[14] Consequently, the Provider is deemed to have notice of the Part C days policy at issue on the date the Federal Register was published and made available online. Indeed, the Board notes that Notices are often available for public inspection several days ***prior to*** the official publication date and, here, the June 9, 2023

[11] *See also* 42 C.F.R. Part 401, Subpart B.
[12] (Emphasis added).
[13] *See also* 44 U.S.C. § 4101 (the Superintendent of Documents is to maintain an electronic director and system of online access to the Federal Register).
[14] *See* http://www.gpo.gov/help/index.html#about_federal_register.htm.

Final Rule was posted to the public at 4:15 pm on June 7, 2023, 2 days in advance of the June, 9, 2023 publication date.[15]

With respect to statutes and regulations dealing with the Federal Register, the Supreme Court has found that:

> Congress has provided that the appearance of rules and regulations in the Federal Register give legal notice of their contents . . . .
>
> . . . Regulations [are] binding on all who sought to come within the [Act], regardless of actual knowledge of what is in the Regulations or of the hardship resulting from innocent ignorance.[16]

The statutes governing the Board (44 U.S.C. § 1507 as applied through the requirements of 42 C.F.R. § 401.101 and the Administrative Procedures Act ("APA")) are clear on their face: ***the date of publication*** of the Federal Register is the date the Providers are deemed to have notice of the June 9, 2023 Final Rule. The Board is bound by all of the provisions of Title XVIII which includes, by reference, the provisions of the Administrative Procedures Act and the Public Printing and Documents law which require that CMS publish its notices and regulations in the Federal Register. In publishing materials in the Federal Register, CMS must comply with the statutes and regulations governing the Superintendent of Documents and the Governing Printing Office.

Pursuant 42 U.S.C. § 1395oo(a)(3), the Board's enabling statute, providers have 180 days "after *notice* of the Secretary's final determination" to file an appeal. To this end, Board Rule 4.3.2 confirms that the appeal period for a final rule published in the Federal Register appeal ends 180 days from the date of ***publication***, not the effective date that may be listed in a provision:

> The date of receipt of a Federal Register Notice is the date the Federal Register is ***published***. The appeal period begins on the date of publication and ends 180 days from that date.[17]

In this case, the notice of the Secretary's determination is, by law, the date the Federal Register is issued by the Superintendent of Documents, or June 9, 2023. Here, the 180th day for appealing was ***Wednesday, December 6, 2023***. The above-captioned appeals were not filed with the Board until *approximately* ***2 months after this deadline*** (specifically between February 2, 2024 and February 4, 2024) and, thus, were not timely filed.[18]

Based on the above findings, the Board concludes that the Providers in the above-captioned 149 cases failed to meet the claims-filing requirements for a Board hearing request[19] due to the

---

[15] https://www.federalregister.gov/public-inspection/2023/06/07 (last accessed Jan. 19, 2024).
[16] *Fed. Crop Ins. Corp. v. Merrill*, 332 U.S. 380, 385 (1947).
[17] Emphasis added.
[18] The Providers in these 149 appeals have not requested good cause exception under 42 C.F.R. § 405.1836 and have not presented any evidence suggesting that they would qualify under the criteria specified in that regulation.
[19] *See* 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

failure of the Providers' to *timely* file their appeals of the June 9, 2023 Final Rule by the Wednesday, December 6, 2023 filing deadline consistent with 42 U.S.C. § 1395oo(a)(3), 42 C.F.R. §§ 405.1835(a)(3) and 405.1837(a)(1) and Board Rules 4.3.2 and 7.1.1 and, as such, the Board hereby dismisses them. Accordingly, the Board closes the above-captioned 149 cases and removes them from the Board's docket.[20] Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

2/6/2024

X Clayton J. Nix

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

Enclosure – Listing of 149 cases covered by the Notice

cc: Wilson Leong, Federal Specialized Services
John Bloom, Noridian Healthcare Solutions
Byron Lamprecht, WPS Government Health Administrators
Michael Redmond, Novitas Solutions, Inc.
Danelle Decker, National Government Services
Lorraine Frewert, Noridian Healthcare Solutions
Cecile Huggins, Palmetto GBA
Judith Cummings, CGS Administrators
Geff Pike, First Coast Service Options, Inc.

---

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).

[20] Regardless, even if the Board had not dismissed these appeals as being untimely filed (approximately *2 months late*), the Board would find that the Providers appeals were premature as they failed to appeal from a "final determination" consistent with the jurisdictional dismissal decisions issued in: (1) Case No. 23-1498 on Nov. 27, 2023 which similarly appealed the June 9, 2023 Final Rule (available at: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-11-1-2023-through-11-30-2023.pdf (last accessed Jan. 19, 2023)); (2) Case Nos. 23-1796GC, *et al*. on Oct. 25, 2023 which appealed the § 1115 waiver day policy finalized in the August 28, 2023 FY 2024 IPPS Final Rule (available at: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-10-1-2023-through-10-31-2023.pdf (last accessed Jan. 19, 2023)). Moreover, even if it were a final determination, the Board would also need to conduct further review of the claims-filing requirements to confirm, *based on the information/documentation included in the relevant appeal request*, whether the Providers have established (consistent with 42 C.F.R. §§ 405.1835(b)(1) and 405.1837(c)(1), (3)) that the June 9, 2023 Final Rule is, ***in fact***, applicable to them (*i.e*., confirm for the fiscal years at issue that either: (a) no NPR has been issued; or (b) they had a Board appeal of the Part C issue that was subsequently remanded per CMS Ruling 1739-R).

LISTING OF 149 CASES

130 INDIVIDUAL AND 19 CIRP GROUP CASES

24-1075	Regional Health Rapid City Hospital (43-0077), FFY 2005
24-1076	Regional Health Rapid City Hospital (43-0077), FFY 2008
24-1077	Regional Health Rapid City Hospital (43-0077), FFY 2009
24-1078	Denver Health Medical Center (06-0011), FFY 2010
24-1079	St. Francis Medical Center (19-0125), FFY 2012
24-1081	Baptist St. Anthony's Hospital (45-0231), FFY 2004
24-1083	Baptist St. Anthony's Hospital (45-0231), FFY 2006
24-1084	Baptist St. Anthony's Hospital (45-0231), FFY 2008
24-1085	Baptist St. Anthony's Hospital (45-0231), FFY 2009
24-1086	Waterbury Hospital (07-0005), FFY 2005
24-1087	Waterbury Hospital (07-0005), FFY 2006
24-1088	Waterbury Hospital (07-0005), FFY 2007
24-1089	Waterbury Hospital (07-0005), FFY 2008
24-1090	Waterbury Hospital (07-0005), FFY 2009
24-1091	Waterbury Hospital (07-0005), FFY 2010
24-1092	Waterbury Hospital (07-0005), FFY 2011
24-1093GC	CHS CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-1095	Waterbury Hospital (07-0005), FFY 2012
24-1096	Waterbury Hospital (07-0005), FFY 2013
24-1097	Bristol Hospital (07-0029), FFY 2008
24-1098	Bristol Hospital (07-0029), FFY 2009
24-1099	Bristol Hospital (07-0029), FFY 2010
24-1100	Bristol Hospital (07-0029), FFY 2011
24-1101	Bristol Hospital (07-0029), FFY 2012
24-1102	Bristol Hospital (07-0029), FFY 2013
24-1103	Monongahela Valley Hospital (39-0147), FFY 2006
24-1104	Monongahela Valley Hospital (39-0147), FFY 2007
24-1105	Monongahela Valley Hospital (39-0147), FFY 2008
24-1106	Monongahela Valley Hospital (39-0147), FFY 2009
24-1107	Monongahela Valley Hospital (39-0147), FFY 2010
24-1108	Monongahela Valley Hospital (39-0147), FFY 2011
24-1109	Monongahela Valley Hospital (39-0147), FFY 2012
24-1110	Monongahela Valley Hospital (39-0147), FFY 2013
24-1111GC	CHS CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-1112	Pacifica Hospital of the Valley (05-0378), FFY 2006
24-1113	Pacifica Hospital of the Valley (05-0378), FFY 2009
24-1114	Pacifica Hospital of the Valley (05-0378), FFY 2011
24-1115	Bakersfield Heart Hospital (05-0724), FFY 2008
24-1116	Bakersfield Heart Hospital (05-0724), FFY 2009
24-1117	Bakersfield Heart Hospital (05-0724), FFY 2010
24-1118	Bakersfield Heart Hospital (05-0724), FFY 2011
24-1119	Bakersfield Heart Hospital (05-0724), FFY 2012
24-1120GC	HonorHealth CY 2013 Treatment of Part C Days Final Rule CIRP Group

24-1121	Hamilton Medical Center (11-0001), FFY 2008
24-1122	Hamilton Medical Center (11-0001), FFY 2009
24-1123	Hamilton Medical Center (11-0001), FFY 2010
24-1124	Hamilton Medical Center (11-0001), FFY 2012
24-1125	Opelousas General Health System (19-0017), FFY 2009
24-1126	Opelousas General Health System (19-0017), FFY 2010
24-1127	Opelousas General Health System (19-0017), FFY 2012
24-1128	Opelousas General Health System (19-0017), FFY 2013
24-1129	Thibodaux Regional Medical Center (19-0004), FFY 2007
24-1130	Thibodaux Regional Medical Center (19-0004), FFY 2008
24-1131	Thibodaux Regional Medical Center (19-0004), FFY 2009
24-1132	Thibodaux Regional Medical Center (19-0004), FFY 2010
24-1133	Thibodaux Regional Medical Center (19-0004), FFY 2011
24-1134	Thibodaux Regional Medical Center (19-0004), FFY 2012
24-1135	Natchitoches Regional Medical Center (19-0007), FFY 2013
24-1136	Abbeville General Hospital (19-0034), FFY 2009
24-1137	Abbeville General Hospital (19-0034), FFY 2011
24-1138	Abbeville General Hospital (19-0034), FFY 2012
24-1139	Lake Charles Memorial Hospital (19-0060), FFY 2010
24-1140	Lake Charles Memorial Hospital (19-0060), FFY 2011
24-1141	Lake Charles Memorial Hospital (19-0060), FFY 2013
24-1202GC	St. Luke's Health CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-1203GC	St. Luke's Health CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-1142	Avoyelles Hospital (19-0099), FFY 2011
24-1143	Louisiana Heart Hospital (19-0250), FFY 2010
24-1144	Louisiana Heart Hospital (19-0250), FFY 2011
24-1145	Louisiana Heart Hospital (19-0250), FFY 2012
24-1146	Oaklawn Hospital (23-0217), FFY 2011
24-1147	Oaklawn Hospital (23-0217), FFY 2012
24-1148	F. F. Thompson Hospital (33-0074), FFY 2011
24-1149	F. F. Thompson Hospital (33-0074), FFY 2012
24-1150	King's Daughters' Medical Center (18-0009), FFY 2007
24-1151	Methodist Hospital of Southern CA (05-0238), FFY 2005
24-1152	Methodist Hospital of Southern CA (05-0238), FFY 2006
24-1153	Methodist Hospital of Southern CA (05-0238), FFY 2007
24-1154	Methodist Hospital of Southern CA (05-0238), FFY 2008
24-1155	Salem Hospital (38-0051), FFY 2005
24-1156	Salem Hospital (38-0051), FFY 2007
24-1157	Salem Hospital (38-0051), FFY 2008
24-1158	Salem Hospital (38-0051), FFY 2009
24-1159	Salem Hospital (38-0051), FFY 2010
24-1160	Salem Hospital (38-0051), FFY 2011
24-1161	Salem Hospital (38-0051), FFY 2013
24-1162	UF Health Jacksonville (10-0001), FFY 2006
24-1163	UF Health Jacksonville (10-0001), FFY 2007
24-1164	Bethesda Hospital East (10-0002), FFY 2005

24-1165	Bethesda Hospital East (10-0002), FFY 2006
24-1166	Bethesda Hospital East (10-0002), FFY 2008
24-1167	Bethesda Hospital East (10-0002), FFY 2009
24-1168	Leesburg Regional Medical Center (10-0084), FFY 2008
24-1169	University Hospital (11-0028), FFY 2009
24-1170	AU Medical Center (11-0034), FFY 2006
24-1171	AU Medical Center (11-0034), FFY 2007
24-1172	AU Medical Center (11-0034), FFY 2008
24-1173	AU Medical Center (11-0034), FFY 2009
24-1174	AU Medical Center (11-0034), FFY 2010
24-1175	AU Medical Center (11-0034), FFY 2012
24-1176	AU Medical Center (11-0034), FFY 2013
24-1177	John D. Archbold Memorial Hospital (11-0038), FFY 2007
24-1178	John D. Archbold Memorial Hospital (11-0038), FFY 2008
24-1179	John D. Archbold Memorial Hospital (11-0038), FFY 2009
24-1180	Floyd Medical Center (11-0054), FFY 2007
24-1181	Alhambra Hospital Medical Center (05-0281), FFY 2011
24-1182	Alhambra Hospital Medical Center (05-0281), FFY 2012
24-1183	Alhambra Hospital Medical Center (05-0281), FFY 2013
24-1184	Loma Linda University Medical Center (05-0327), FFY 2007
24-1185	Kentuckiana Medical Center LLC (15-0176), FFY 2011
24-1186	Kentuckiana Medical Center LLC (15-0176), FFY 2012
24-1187	Ozarks Medical Center (26-0078), FFY 2009
24-1188	Ozarks Medical Center (26-0078), FFY 2010
24-1189	Ozarks Medical Center (26-0078), FFY 2011
24-1190	Ozarks Medical Center (26-0078), FFY 2012
24-1191	University of Utah Hospitals and Clinics (46-0009), FFY 2007
24-1192	University of Utah Hospitals and Clinics (46-0009), FFY 2008
24-1193	University of Utah Hospitals and Clinics (46-0009), FFY 2009
24-1194	University of Utah Hospitals and Clinics (46-0009), FFY 2010
24-1195	University of Utah Hospitals and Clinics (46-0009), FFY 2011
24-1196	University of Utah Hospitals and Clinics (46-0009), FFY 2012
24-1197	St. Luke's Hospital of Kansas City (26-0138), FFY 2004
24-1198	St. Luke's Hospital of Kansas City (26-0138), FFY 2005
24-1199	Saint Luke's East Lee's Summit Hospital (26-0216), FFY 2007
24-1200	St. Luke's Hospital of Kansas City (26-0138), FFY 2008
24-1201	Saint Luke's East Lee's Summit Hospital (26-0216), FFY 2009
24-1204	Saint Luke's East Lee's Summit Hospital (26-0216), FFY 2012
24-1205	St. Luke's Hospital of Kansas City (26-0138), FFY 2013
24-1208GC	BJC Healthcare CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-1209GC	BJC Healthcare CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-1210GC	BJC Healthcare CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-1211GC	BJC Healthcare CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-1212GC	CHS CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-1213GC	BJC Healthcare CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-1214GC	BJC Healthcare CY 2012 Treatment of Part C Days Final Rule CIRP Group

24-1215GC	BJC Healthcare CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-1216GC	AHMC Healthcare CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-1217GC	AHMC Healthcare CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-1218GC	AHMC Healthcare CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-1219GC	AHMC Healthcare CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-1220GC	AHMC Healthcare CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-1221GC	AHMC Healthcare CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-1206	Saint Luke's North Hospital (26-0062), FFY 2009
24-1207	Saint Luke's North Hospital (26-0062), FFY 2012
24-1222	Central Washington Hospital (50-0016), FFY 2006
24-1223	Central Washington Hospital (50-0016), FFY 2007
24-1224	Central Washington Hospital (50-0016), FFY 2008
24-1225	Central Washington Hospital (50-0016), FFY 2009
24-1226	Central Washington Hospital (50-0016), FFY 2010

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Ms. Kelly Carroll
Hooper, Lundy & Bookman, P.C.
401 9th St. NW, Suite 550
Washington, DC 20004

RE: ***Notice of Dismissal***
24-0504GC UNC Health CY 2020 UC DSH - Allina Case CIRP Group
24-0505GC UNC Health CY 2020 UC DSH - Best Available Data CIRP Group
24-0506GC UNC Health CY 2020 UC DSH – Medicare Part C Days CIRP Group
24-0507GC UNC Health CY 2020 UC DSH - Uninsured Percentage Estimate CIRP Grp
24-0509GC UNC Health CY 2020 UC DSH - Medicaid Expansion CIRP Group

Dear Ms. Carroll:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the five (5) above-referenced common issue related party ("CIRP") group cases. Set forth below is the decision of the Board to dismiss the appeals challenging the Providers' Disproportionate Share Hospital ("DSH") for Uncompensated Care ("UCC") payments.

Background

The Providers are represented before the Board by Hooper, Lundy & Bookman, P.C. ("Hooper Lundy") and are appealing from fiscal years ending in 2020. The Board received the Providers' appeals on December 15, 2023.

The only issue in each Group is a challenge to the DSH payment for UCC. The issue statements are very similar, but for the first and last sentence of each appeal that references the specific UCC sub-issue – i.e., Allina, Best Available Data, Part C, Uninsured Percentage Estimate, and Medicaid expansion. For example, the issue statement in Case No. 24-0504GC reads:

> Whether the Hospitals' FY 2020 Medicare UC-DSH payments were understated because the calculation of Factor 1 did not properly take into account the **decision in *Allina Health Servs. v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014) and subsequent related cases**. The UC-DSH payment was established under §3133 of the Patient Protection and Affordable Care Act ("ACA"). 42 U.S.C. §1395ww(r); *see also* 42 CFR 412.106(f)-(h). The purpose of the UC-DSH payment is to compensate DSH hospitals for "uncompensated care" provided to "uninsured" patients. Thus,

> beginning with Federal Fiscal Year 2014, a DSH hospital received two separate DSH payments. The first payment, known as the "empirical DSH payment," is 25% of the amount due to the hospital under the historical DSH methodology. The second payment, known as the "UC-DSH payment," is the hospital's share of 75% of the amount of the national total traditional DSH payment, with each DSH hospital's specific share calculated using the new methodology in ACA §3133. Under the new methodology in ACA §3133, CMS calculates the UC-DSH payment for each DSH hospital based on the following three factors:
>
> Factor 1 – A pool consisting of 75% of CMS's estimate of the traditional DSH payment that would be made for the coming FFY.
>
> Factor 2 – An adjustment to that pool to reflect CMS's estimate of the percentage change in the national uninsured rate for "the most recent period for which data is available" as compared with a baseline uninsured rate for 2013, less a small statutory reduction.
>
> Factor 3 – Each qualifying DSH hospital's uncompensated care as a percentage of the total uncompensated care for all qualifying DSH hospitals.
>
> *See* 42 U.S.C. 1395ww(r)(2). The Hospitals challenge their FY 2020 UC-DSH payments as being improperly understated because the calculation of **Factor 1 did not properly take into account the *Allina* decisions**.[1]

The only difference in the issue statements from case to case is the bold and underlined text – and what the Factors did not properly take into account: the decision in *Allina*; the best available data; Medicare Part C days; uninsured percentage; and Medicaid expansion.

Decision of the Board:

As set forth below, the Board hereby ***dismisses*** the Providers' appeals. The Board finds that it does not have jurisdiction over the DSH UCC payment issues in the above-referenced appeals because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).

A. Bar on Administrative Review

The Board does not generally have jurisdiction over Uncompensated Care DSH payment issues because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and

[1] Group Issue Statement in CN 24-0504GC; 24-0505GC; 24-0506GC; 24-0507GC; and 24-0509GC at 1.

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).[2]
>
> (B) Any period selected by the Secretary for such purposes.

B. Interpretation of Bar on Administrative Review

1. 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*"),[3] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[4] 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."[5] 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.[6]

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

---

[2] 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.
[3] 830 F.3d 515 (D.C. Cir. 2016).
[4] 89 F. Supp. 3d 121 (D.D.C. 2015).
[5] 830 F.3d 515, 517.
[6] *Id.* at 519.

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.[7]

2. 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*").[8] 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."[9] 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.[10]

3. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[11] 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.[12] 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.[13] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[14] Nevertheless, the Secretary used each

---

[7] *Id.* at 521-22.
[8] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[9] *Id.* at 506.
[10] *Id.* at 507.
[11] 514 F. Supp. 249 (D.D.C. 2021).
[12] *Id.* at 255-56.
[13] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[14] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.

hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[15]

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.[16]

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."[17] 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.[18] 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.[19]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[20] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

---

[15] *Id.*
[16] *Id.* at 262-64.
[17] *Id.* at 265.
[18] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[19] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[20] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).

4. 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*").[21] 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.[22] 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."[23] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[24] 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***."[25]

In summary, the Board concludes that the same findings are applicable to the Providers' various challenges to their FFY 2020 UCC payments. The Providers here are challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2020. For some of these providers, the arguments centering on the *Allina* decision claim that certain data should be recalculated or revised. However, 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 hereby dismisses Cases 24-0504GC; 24-0505GC, 24-0506GC; 24-0507GC; and 24-0509GC. 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.

[21] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[22] *Id*. at *4.
[23] *Id*. at *9.
[24] 139 S. Ct. 1804 (2019).
[25] *Ascension* at *8 (bold italics emphasis added).

Board Members Participating:

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

For the Board:

2/6/2024

X Robert A. Evarts, Esq.

Robert A. Evarts, Esq.
Board Member
Signed by: PIV

cc: Dana Johnson, Palmetto GBA, c/o National Government Services, Inc. (J-M)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nicholas Putnam
Strategic Reimbursement Group, LLC
360 West Butterfield Rd., Ste. 310
Elmhurst, IL 60126

RE: ***Board Determination Regarding Deficient CIRP Group***
Case No. 15-0244GC – SRI Aurora FY 2011 SSI Calculation Error CIRP Group

Dear Mr. Putnam:

The Provider Reimbursement Review Board (the "Board") has reviewed the subject common issue related party ("CIRP") group appeal in response to the Medicare Contractor's December 19, 2023 "Motion to Dismiss" and the Board's December 19, 2023 "Scheduling Order – Rule 20 Certification." The Board notes that Case No. 15-0244GC was filed prior to the implementation of the Office of Hearing Case & Document Management System ("OH CDMS").[1] The electronic record for the CIRP group, which is considered a "Legacy" case, has not yet been populated. Below is a discussion of the background and pertinent facts, the Regulations and Board Rules related to the specific deficiencies in this case, and the Board's determination.

Background:

On **November 1, 2021**, the Board issued revised Rules which changed certain procedures for group appeals. Specifically, Rule 20 addresses the population of Issues/Providers in the Office of Hearings Case & Document Management System ("OH CDMS"). Rule 20 advises that, "***within (60) sixty days of the full formation of the group***, the group representative must file a statement certifying that the group is fully populated in OH CDMS with the relevant supporting jurisdictional documentation (i.e., all participants in the group are shown under the Issues/Providers Tab for the group in OH CDMS with the relevant supporting jurisdictional documentation."[2] In contrast, Board Rule 20.1 specifies that if one or more participants are ***not*** listed behind the Participants tab, then the group representative must file a PDF copy of the traditional Schedule of Providers with supporting jurisdictional documentation. Here, there are no participants listed behind the Participants tab in OH CDMS. Accordingly, Rule 20.1 is applicable.

On **November 7, 2022**, the Board issued Alert 23, which gave notice that effective December 7, 2022, the Board was resuming its normal operations following the COVID- 19 Pandemic. The Alert 23 included a reminder to the Parties regarding the Rule 20 Certification requirement.

[1] The group was filed on October 29, 2014.
[2] Emphasis added.

Pertinent Facts:

On **August 30, 2023**, Strategic Reimbursement Group, LLC ("Strategic"/"Group Representative") designated the subject CIRP group to be fully formed. A Rule 20 Certification or a PDF Schedule of Providers with support pursuant to Board Rule 20.1 was due 60 days later. Because the deadline fell on Sunday, October 29, 2023, the due date rolled over to the following business day, Monday, October 30, 2023.

On **September 1, 2023**, the Board issued a Group Completion and Critical Due Dates notification for the subject group case, setting new deadlines for the appeal. The Group's preliminary position paper deadline was set for October 31, 2023.

On **October 11, 2023**, Strategic timely filed the Group's preliminary position paper.

On **December 19, 2023**, the Medicare Contractor filed a Motion to Dismiss the group. In its Motion, the Medicare Contractor advised that the Group Representative failed to comply with Board Rule 20/20.1. The Medicare Contractor indicated that, on December 11, 2023, it had conferred with Strategic via email about the Rule 20 letter. Nevertheless, Strategic failed to file a Rule 20 Certification or SoP.

On **December 19, 2023**, the Board issued a "Scheduling Order – Rule 20 Certification" in which it ordered Strategic to file its response to the Motion to Dismiss (*and the required Rule 20 Certification or PDF SoP with Support*) by **Tuesday, January 2, 2024**. The Board warned that failure of the Group Representative to respond in a timely manner would result in the Board making a decision regarding the Motion to Dismiss for failure to comply.

To date, Strategic has failed to file a Rule 20 Certification, a PDF Schedule of Provider with support, or a response to the Motion to Dismiss, notwithstanding the Board's Scheduling Order requiring a response to be filed by Tuesday, January 2, 2024.

Discussion of Regulations, Rules and Specific Deficiencies:

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, in pertinent, 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]

The Board recognizes that its Critical Due Dates notifications do not include a deadline for filing, as relevant, the Rule 20 Certification or the traditional SoP under Board Rule 20.1. However, making the applicable filing under Board Rules 20 and 20.1 *is **and** remains* a requirement under Board Rules and must be made ***within 60 days of full formation,*** or in this case should have been made when the Medicare Contractor brought it to the Representative's attention.

The Board is also cognizant of the fact that, on numerous occasions, it has explained the background and requirements of Board Rule 20 and Rule 20.1. Many times, as a courtesy, the Board has extended Strategic additional time to correct such deficiencies, however Strategic continues to miss or make deficient filings related to this Board Rule. Indeed, notwithstanding this history, Strategic has failed to respond to the Motion to Dismiss within the time frame specified in the Board's Scheduling Order.

Board Determination:

In this case, the Board notes that the Medicare Contractor made Strategic aware of the Rule 20/20.1 deficiency in this group and the Board issued a Scheduling Order requiring Strategic's response ***and*** that Strategic file the requisite Rule 20 or 20.1 documentation as relevant. However, Strategic failed to timely file its response to the Motion to Dismiss with the requisite documentation necessary for the Medicare Contractor to perform its jurisdictional review by the Board deadline set in the Board's Scheduling Order. The Board is perplexed that Strategic timely filed its preliminary position paper in October 2023, but missed the deadline for filing the Rule 20 Certification or SoP with support required under Rule 20.1 – which was due around the same date. Because Strategic failed to respond when it was made aware of the deficiency in the Medicare Contractor's Motion to Dismiss, and because Strategic failed to **timely** respond to the Board's Scheduling Order by the deadline with the requisite Rule 20/20.1 documentation and response to the Motion to Dismiss, the Board finds it appropriate to dismiss Case No. 15-0244GC pursuant to its authority under 42 C.F.R. § 405.1868. The Board hereby dismisses Case No. 15-0244GC from its docket, and the appeal is now closed.

[3] Emphasis added.

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

Board Members:
Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

2/7/2024

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Pam VanArsdale, National Government Services, Inc. (J-6)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

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

RE: ***Dismissal of SSI Percentage (Provider Specific) Issue***
Kentucky River Medical Center (Provider Number 18-0139)
FYE: 8/31/2015
Case Number: 17-1693

Dear Messrs. Ravindran and Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in the above referenced appeal filed on behalf of Kentucky River Medical Center ("Provider"). The background of these cases and the decision of the Board is set forth below.

Background:

A. *Procedural History for Case No. 17-1693*

On January 5, 2017, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end August 31, 2015.

On June 15, 2017, The Provider filed this individual appeal request. The appeal request contained four (4) issues:

- Issue 1: Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage- Provider Specific
- Issue 2: DSH- Medicaid Eligible Days[1]
- Issue 3: Uncompensated Care ("UCC") Distribution Pool[2]
- Issue 4: 2 Midnight Census IPPS Payment Reduction[3]

As the Provider is owned by Quorum Health and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 3 and 4 to Quorum

[1] The Provider withdrew this issue on August 23, 2023.
[2] The Provider transferred this issue to Case No. 18-0594GC on January 31, 2018.
[3] The Provider transferred this issue to Case No. 18-0595GC on January 31, 2018.

Health groups. The Provider also withdrew Issue No. 2. As a result, the remaining issue in Case No. 17-1693 is Issue 1.

On April 5, 2018, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1, 2, and 3. As issues 2 and 3 have since been withdrawn and transferred, respectively, this decision will only address the challenge with respect to Issue 1.[4]

On December 6, 2023, the Provider filed its final position paper.

On December 20, 2023, the Medicare Contractor filed its final position paper.

B. Description of Issue 1 in Case No. 17-1693 and the group issue in Case No. 18-1333GC

In Case No. 17-1693, filed by QRS, the DSH Payment/SSI Percentage (Provider Specific) issue is summarized as follows:

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

Although this Provider is not yet a participant, there is a Quorum CIRP group for the SSI Percentage issue under 18-1333GC, QRS Quorum 2015 DSH SSI Percentage CIRP Group. The Group Issue Statement in Case No. 18-1333GC reads, in part:

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

[4] The Medicare Contractor also filed a separate Motion to Dismiss the Medicaid eligible days issue on March 2, 2023, however the Provider has since withdrawn that issue.
[5] Issue Statement at 1 (June 15, 2017).

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

On December 6, 2023, QRS filed the Provider's final position paper. The following is the Provider's ***complete*** position on the SSI Percentage Provider Specific issue set forth therein:

> The Provider contends that the MAC's determination for Medicare reimbursement for Disproportionate Share Payments was not in accordance with the Medicare statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi).
>
> **Calculation of the SSI Percentage**
>
> The Provider contends that the MAC's determination of Medicare Reimbursement for DSH payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(S)(F)(i). The Provider contends that the SSI percentage calculated by [CMS] and used by the MAC to settle their Cost Report was incorrectly computed because of the following reasons:

[6] Group Issue Statement, Case No. 18-1333GC.

Issue #1: Provider Specific

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

The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra[7]

Medicare Contractor's Contentions

The MAC contends that:

> this issue is suitable for reopening, but it is not an appealable issue. The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election, not a MAC determination.[8]

The realignment issue should be dismissed because there was no final determination over SSI realignment and the Provider's appeal is premature as the Provider has not exhausted all available remedies.

Provider's Jurisdictional Response

The Provider did not file a response to the Jurisdictional Challenge. Board Rule 44.4.3 specifies, "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to

[7] Provider's Final Position Paper (Dec. 6, 2023).
[8] MAC's Jurisdictional Challenge at 3.

respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision

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

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that is being appealed in CIRP Group Case No. 18-1333GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[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 that was included in the appeal request that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[11]

The DSH/SSI Percentage (Systemic Errors) issue in group Case No. 18-1333GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 17-1693 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 18-1333GC.

[9] Issue Statement at 1.
[10] *Id.*
[11] *Id.*

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider should be pursuing that issue as part of the CIRP group under Case No. 18-1333GC. 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.[12] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 18-1333GC.

To this end, the Board also reviewed the Provider's Final Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 18-1333GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal.[13] Moreover, the Board finds that the Provider's Final Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of the any alleged "errors" in its Final Position Paper and include *all* exhibits.

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

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

---

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

[13] It is also not clear whether this is a systemic issue for Quorum 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.

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

https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[14]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[15]

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

Accordingly, *based on the record before it*, the Board finds that the SSI Provider Specific issue in Case No. 17-1693 and the group issue from Group Case 18-1333GC are the same issue. The Board does not have a record of this Provider being a participant in Case No. 18-1333GC. As the Provider is owned by Quorum Health and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Board is requiring that the Provider transfer the SSI percentage issue to Case No. 18-1333GC ***within 15 days*** of the date of this letter. Failure to do so will result in the Board deeming the SSI Percentage issue abandoned for this Provider and closing Case No. 17-1693.

[14] Last accessed January 4, 2024.
[15] Emphasis added.

2. Second Aspect of Issue 1

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

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

* * * * *

In summary, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue from Case No. 17-1693 is duplicative of the issue in Case No. 18-1333GC and requires the Provider to transfer that issue to the CIRP group in order to comply with 42 C.F.R. § 405.1837(b)(1) ***within 15 days*** of the date of this letter. Failure to do so will result in the Board deeming the SSI Percentage issue abandoned for this Provider and closing Case No. 17-1693. The Board also finds that there is no final determination from which the Provider can appeal the SSI realignment portion of the issue and dismisses that aspect of the issue.

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

Board Members Participating:

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

For the Board:

2/7/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Clarification Regarding Notice of Dismissal of Untimely Appeals***
Case Nos. 24-0643GC, *et al.* (*see* Appendices A – D listing 339 cases)

Dear Mr. Ravindran:

The Board recently issued notices of dismissal in the above-captioned 339 cases (as listed in Appendices A to D) wherein the Board dismissed these cases based on its conclusion that the Board did not have jurisdiction over those appeals for failure of the Providers' to *timely* file these appeals of the June 9, 2023 Final Rule by Wednesday, December 6, 2023 filing deadline consistent with 42 U.S.C. § 1395oo(a)(1)(3), 42 C.F.R. §§ 405.1835(a)(3) and 405.1837(a)(1) and Board Rules 4.3.2 and 7.1.1. These dismissal notices dismissed the 46 cases as listed in **Appendix A** on January 19, 2024, the 80 cases as listed in **Appendix B** on January 25, 2024, the 104 cases listed in **Appendix C** on January 30, 2024, and the 109 cases listed in **Appendix D** on February 2, 2024.

The Board is issuing this letter to clarify that its reference to "jurisdiction" in the relevant notice of dismissal for these cases was in the context of the claim filing requirements specified in 42 C.F.R. § 405.1840(a)(2) and was not intended to suggest that *timely filing an appeal with the Board* is a jurisdictional requirement *per se*. The Board notes that, although this regulation is entitled "Board jurisdiction,"[1] it also addresses certain claim filing requirements such as timeliness or filing

[1] The regulation at 405.1840 Board jurisdiction reads, in pertinent part:

> (a) *General rules.* (1) After a request for a Board hearing is filed under § 405.1835 or § 405.1837 of this part, the Board must determine in accordance with paragraph (b) of this section, whether or not it has jurisdiction to grant a hearing on each of the specific matters at issue in the hearing request.
> (2) The Board must make a preliminary determination of the scope of its jurisdiction (that is, whether the request for hearing was timely, and whether the amount in controversy requirement has been met), if any, over the matters at issue in the appeal before conducting any of the following proceedings . . . .
> (3) The Board may revise a preliminary determination of jurisdiction at any subsequent stage of the proceedings in a Board appeal, and must promptly notify the parties of any revised determination. . . .
> (4) If the Board finally determines it lacks jurisdiction over every specific matter at issue in the appeal, the Board must issue a dismissal decision under paragraph (c)(2) of this section.
> (5) Final jurisdictional findings and dismissal decisions by the Board under paragraphs (c)(1) and (c)(2) of this section are subject to Administrator and judicial review in accordance with paragraph (d) of this section.
> (b) *Criteria.* Except with respect to the amount in controversy requirement, the jurisdiction of the Board to grant a hearing must be determined separately for each specific matter at issue in each contractor or Secretary determination for each cost reporting period under appeal. The Board has jurisdiction to grant a hearing over a specific matter at issue in an appeal only if the provider has a right to a Board hearing as a single provider appeal under § 405.1835 of this subpart or as part of a group appeal under § 405.1837 of this subpart, as applicable. . . .

deadlines, and timely fling an appeal within the prescribed 180-time frame is ***not*** a jurisdictional requirement *per se* but rather is a claims filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr*., 568 U.S. 145 (2013) ("*Auburn*")[2]. Accordingly, the Board is issuing this letter to clarify that, consistent with *Auburn*, the dismissals issued in the above-referenced 339 cases is due to failure to meet the claims filing requirement that an appeal be filed within 180 days of the final determination being appealed.

Board Members Participating:

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

For the Board:

2/7/2024

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-5)
Geoff Pike, First Coast Service Options, Inc. (J-N)
Michael Redmond, Novitas Solutions, Inc. (J-H, J-L)
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Danelle Decker. National Government Services (J-K)
John Bloom, Noridian Healthcare Solutions (J-F)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Pamela VanArsdale, National Government Services, Inc. (J-6)
Cecile Huggins, Palmetto GBA (J-J)

[2] 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 other claim filing requirements).

Appendix A
Listing of 46 Cases

24-0643GC	CHS CY 2005 Treatment of Part C Days Final Rule CIRP Group
24-0639GC	Hartford Health CY 2006 Treatment of Part C Days Final Rule CIRP Group
24-0645GC	Hartford Health CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0646GC	Hartford Health CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0647GC	Hartford Health CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0648GC	Hartford Health CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0649GC	Hartford Health CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0644	The Hospital of Central Connecticut (07-0035), FFY 2007
24-0650	The Hospital of Central Connecticut (07-0035), FFY 2013
24-0652GC	BS&W Health CY 2005 Treatment of Part C Days Final Rule CIRP Group
24-0654GC	BS&W Health CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-0655GC	BS&W Health CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0656GC	BS&W Health CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0657GC	BS&W Health CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0658GC	BS&W Health CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0659GC	BS&W Health CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0660GC	Houston Methodist CY 2005 Treatment of Part C Days Final Rule CIRP Group
24-0661GC	Houston Methodist CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0662GC	Houston Methodist CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0663GC	Houston Methodist CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0664GC	Houston Methodist CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0665GC	Houston Methodist CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0666GC	WVU Medicine CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-0667GC	WVU Medicine CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0673GC	WVU Medicine CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0674GC	WVU Medicine CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-0675GC	CHS CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-0677GC	Univ of Washington Med CY 2006 Treatment of Part C Days Final Rule CIRP Group
24-0678GC	Univ of Washington Med CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-0676	Harborview Medical Center (50-0064), FFY 2005
24-0679GC	Univ of Washington Med CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0680GC	Univ of Washington Med CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0681GC	Univ of Washington Med CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0682GC	Univ of Washington Med CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0683GC	Univ of Washington Med CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0684GC	Univ of Washington Med CY 2013 Treatment of Part C Days Final Rule CIRP Group

24-0686GC	Providence Health CY 2004 Treatment of Part C Days Final Rule CIRP Group
24-0687GC	Providence Health CY 2005 Treatment of Part C Days Final Rule CIRP Group
24-0691GC	Providence Health CY 2006 Treatment of Part C Days Final Rule CIRP Group
24-0692GC	Providence Health CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-0693GC	Providence Health CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0694GC	Providence Health CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0697GC	Providence Health CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0698GC	Providence Health CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0700GC	Providence Health CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0701GC	Providence Health CY 2013 Treatment of Part C Days Final Rule CIRP Group

Appendix B
Listing of 80 Cases

24-0669GC	WVU Medicine CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0670GC	WVU Medicine CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0671GC	CHS CY 2006 Treatment of Part C Days Final Rule CIRP Group
24-0672GC	WVU Medicine CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0709GC	Ballad Health CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-0712GC	Ballad Health CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0713GC	Ballad Health CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0716GC	Ballad Health CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0719GC	Ballad Health CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0721GC	Ballad Health CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0723GC	Ballad Health CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-0738GC	MultiCare Health CY 2006 Treatment of Part C Days Final Rule CIRP Group
24-0740GC	MultiCare Health CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-0741GC	MultiCare Health CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0743GC	MultiCare Health CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0745GC	MultiCare Health CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0746GC	MultiCare Health CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0747GC	MultiCare Health CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0748GC	MultiCare Health CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-0749	Community Memorial Hospital San Buenaventura (05-0394), FFY 2006
24-0750	Community Memorial Hospital San Buenaventura (05-0394), FFY 2007
24-0751	Community Memorial Hospital San Buenaventura (05-0394), FFY 2008
24-0752	Community Memorial Hospital San Buenaventura (05-0394), FFY 2009
24-0753	Community Memorial Hospital San Buenaventura (05-0394), FFY 2010
24-0754	Community Memorial Hospital San Buenaventura (05-0394), FFY 2013
24-0755	Saint Francis Hospital and Medical Center (07-0002), FFY 2006
24-0756	Saint Francis Hospital and Medical Center (07-0002), FFY 2007
24-0757	Saint Francis Hospital and Medical Center (07-0002), FFY 2008
24-0758	Saint Francis Hospital and Medical Center (07-0002), FFY 2009
24-0759	Saint Francis Hospital and Medical Center (07-0002), FFY 2010
24-0760	Saint Francis Hospital and Medical Center (07-0002), FFY 2011
24-0761	Saint Francis Hospital and Medical Center (07-0002), FFY 2012
24-0762	Saint Francis Hospital and Medical Center (07-0002), FFY 2013
24-0763	Stamford Hospital (07-0006), FFY 2005
24-0764	Stamford Hospital (07-0006), FFY 2006
24-0765	Stamford Hospital (07-0006), FFY 2007
24-0766	Stamford Hospital (07-0006), FFY 2008

24-0767	Stamford Hospital (07-0006), FFY 2009
24-0768	Stamford Hospital (07-0006), FFY 2010
24-0769	Stamford Hospital (07-0006), FFY 2011
24-0770	Stamford Hospital (07-0006), FFY 2012
24-0771	Stamford Hospital (07-0006), FFY 2013
24-0773	Saint Mary's Hospital (07-0016), FFY 2007
24-0775	Saint Mary's Hospital (07-0016), FFY 2008
24-0776	Middlesex Hospital (07-0020), FFY 2005
24-0777	Middlesex Hospital (07-0020), FFY 2006
24-0778	Middlesex Hospital (07-0020), FFY 2007
24-0779	Middlesex Hospital (07-0020), FFY 2008
24-0780	Middlesex Hospital (07-0020), FFY 2009
24-0781	Middlesex Hospital (07-0020), FFY 2010
24-0783	Middlesex Hospital (07-0020), FFY 2011
24-0784	Middlesex Hospital (07-0020), FFY 2012
24-0785	Middlesex Hospital (07-0020), FFY 2013
24-0786	Backus Hospital (07-0024), FFY 2006
24-0787	Backus Hospital (07-0024), FFY 2008
24-0788	Backus Hospital (07-0024), FFY 2009
24-0789	Backus Hospital (07-0024), FFY 2010
24-0790	Backus Hospital (07-0024), FFY 2011
24-0791	Backus Hospital (07-0024), FFY 2012
24-0792	Backus Hospital (07-0024), FFY 2013
24-0793	Naples Community Hospital (10-0018), FFY 2006
24-0794	Naples Community Hospital (10-0018), FFY 2007
24-0795	Naples Community Hospital (10-0018), FFY 2008
24-0796	Naples Community Hospital (10-0018), FFY 2009
24-0797	Naples Community Hospital (10-0018), FFY 2010
24-0798	Naples Community Hospital (10-0018), FFY 2011
24-0799	Naples Community Hospital (10-0018), FFY 2012
24-0800	Naples Community Hospital (10-0018), FFY 2013
24-0803	Cox Medical Centers (26-0040), FFY 2007
24-0804	Cox Medical Centers (26-0040), FFY 2008
24-0806	Cox Medical Centers (26-0040), FFY 2009
24-0807	Cox Medical Centers (26-0040), FFY 2010
24-0808	Cox Medical Centers (26-0040), FFY 2011
24-0809	Cox Medical Centers (26-0040), FFY 2012
24-0811	Cox Medical Centers (26-0040), FFY 2013
24-0813	The Nebraska Medical Center (28-0013), FFY 2008
24-0814	The Nebraska Medical Center (28-0013), FFY 2009

24-0816	The Nebraska Medical Center (28-0013), FFY 2011
24-0817	The Nebraska Medical Center (28-0013), FFY 2012
24-0818	The Nebraska Medical Center (28-0013), FFY 2013

Appendix C
Listing of 104 Cases

24-0827GC	Yale-New Haven CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-0829GC	Yale-New Haven CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0830GC	Yale-New Haven CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0831GC	Yale-New Haven CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0832GC	Yale-New Haven CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0833GC	Yale-New Haven CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0834GC	Yale-New Haven CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-0837GC	Banner Health CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0838GC	Banner Health CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0839GC	Banner Health CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-0840GC	Nuvance Health CY 2006 Treatment of Part C Days Final Rule CIRP Group
24-0841GC	Nuvance Health CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-0842GC	Nuvance Health CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0826	Yale New Haven Hospital (07-0022), FFY 2006
24-0835	Banner University Medical Center Tucson (03-0064), FFY 2009
24-0848GC	Nuvance Health CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-0849GC	Nuvance Health CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0850GC	Nuvance Health CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0851GC	Nuvance Health CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0852	Norwalk Hospital Association (07-0034), FFY 2013
24-0853	Mary Lanning Healthcare (28-0032), FFY 2008
24-0854	Mary Lanning Healthcare (28-0032), FFY 2009
24-0855	Mary Lanning Healthcare (28-0032), FFY 2010
24-0856	Mary Lanning Healthcare (28-0032), FFY 2011
24-0857	Mary Lanning Healthcare (28-0032), FFY 2012
24-0858	Mary Lanning Healthcare (28-0032), FFY 2013
24-0861	New York Downtown Hospital (33-0064), FFY 2005
24-0862	New York Downtown Hospital (33-0064), FFY 2006
24-0863	New York Downtown Hospital (33-0064), FFY 2007
24-0864	New York Downtown Hospital (33-0064), FFY 2008
24-0865	New York Downtown Hospital (33-0064), FFY 2009
24-0866	New York Downtown Hospital (33-0064), FFY 2012
24-0867	St. Vincent Hospital (39-0009), FFY 2005
24-0868	St. Vincent Hospital (39-0009), FFY 2007
24-0869	St. Vincent Hospital (39-0009), FFY 2008
24-0870	St. Vincent Hospital (39-0009), FFY 2009
24-0871	St. Vincent Hospital (39-0009), FFY 2010
24-0872	St. Vincent Hospital (39-0009), FFY 2012

24-0873	St. Vincent Hospital (39-0009), FFY 2013
24-0874	University Medical Center (45-0686), FFY 2006
24-0875	University Medical Center (45-0686), FFY 2007
24-0876	University Medical Center (45-0686), FFY 2008
24-0877	University Medical Center (45-0686), FFY 2009
24-0878	University Medical Center (45-0686), FFY 2010
24-0879	University Medical Center (45-0686), FFY 2011
24-0886	Virginia Mason Memorial Hospital (50-0036), FFY 2007
24-0887	Virginia Mason Memorial Hospital (50-0036), FFY 2008
24-0889	Virginia Mason Memorial Hospital (50-0036), FFY 2009
24-0890	Virginia Mason Memorial Hospital (50-0036), FFY 2010
24-0891	Virginia Mason Memorial Hospital (50-0036), FFY 2011
24-0892	Virginia Mason Memorial Hospital (50-0036), FFY 2012
24-0893	Virginia Mason Memorial Hospital (50-0036), FFY 2013
24-0895	Harrison Medical Center (50-0039), FFY 2007
24-0896	Harrison Medical Center (50-0039), FFY 2008
24-0897	Harrison Medical Center (50-0039), FFY 2009
24-0898	Harrison Medical Center (50-0039), FFY 2011
24-0899	Harrison Medical Center (50-0039), FFY 2012
24-0900	Harrison Medical Center (50-0039), FFY 2013
24-0901	Olympic Medical Center (50-0072), FFY 2007
24-0902	Olympic Medical Center (50-0072), FFY 2008
24-0903	University of Kansas Hospital (17-0040), FFY 2009
24-0904	University of Kansas Hospital (17-0040), FFY 2010
24-0905	University of Kansas Hospital (17-0040), FFY 2011
24-0906	University of Kansas Hospital (17-0040), FFY 2012
24-0907	University of Kansas Hospital (17-0040), FFY 2013
24-0908	John Dempsey Hospital (07-0036), FFY 2005
24-0909	John Dempsey Hospital (07-0036), FFY 2006
24-0910	John Dempsey Hospital (07-0036), FFY 2007
24-0911	John Dempsey Hospital (07-0036), FFY 2008
24-0912	John Dempsey Hospital (07-0036), FFY 2009
24-0913	John Dempsey Hospital (07-0036), FFY 2010
24-0914	John Dempsey Hospital (07-0036), FFY 2011
24-0915	John Dempsey Hospital (07-0036), FFY 2012
24-0916	John Dempsey Hospital (07-0036), FFY 2013
24-0917	Indian River Memorial Hospital, Inc. (10-0105), FFY 2005
24-0918	Indian River Memorial Hospital, Inc. (10-0105), FFY 2007
24-0919	Indian River Memorial Hospital, Inc. (10-0105), FFY 2008
24-0920	Indian River Memorial Hospital, Inc. (10-0105), FFY 2009

24-0921	Indian River Memorial Hospital, Inc. (10-0105), FFY 2010
24-0922	Indian River Memorial Hospital, Inc. (10-0105), FFY 2011
24-0923	Indian River Memorial Hospital, Inc. (10-0105), FFY 2012
24-0924	Indian River Memorial Hospital, Inc. (10-0105), FFY 2013
24-0925	MedStar Washington Hospital Center (09-0011), FFY 2006
24-0926	St. Cloud Hospital (24-0036), FFY 2006
24-0927	St. Cloud Hospital (24-0036), FFY 2008
24-0928	St. Cloud Hospital (24-0036), FFY 2009
24-0929	St. Cloud Hospital (24-0036), FFY 2010
24-0930	CHI St. Alexius Health (35-0002), FFY 2007
24-0931	CHI St. Alexius Health (35-0002), FFY 2008
24-0932	CHI St. Alexius Health (35-0002), FFY 2009
24-0933	CHI St. Alexius Health (35-0002), FFY 2010
24-0934	CHI St. Alexius Health (35-0002), FFY 2011
24-0935	Sanford Medical Center Bismarck (35-0015), FFY 2006
24-0936	Sanford Medical Center Bismarck (35-0015), FFY 2007
24-0937	Sanford Medical Center Bismarck (35-0015), FFY 2008
24-0938	Sanford Medical Center Bismarck (35-0015), FFY 2009
24-0939	Sanford Medical Center Bismarck (35-0015), FFY 2010
24-0940	Christus Mother Frances Hospital (45-0102), FFY 2010
24-0941	Christus Mother Frances Hospital (45-0102), FFY 2011
24-0942	Christus Mother Frances Hospital (45-0102), FFY 2012
24-0943	Longmont United Hospital (06-0003), FFY 2007
24-0944	Longmont United Hospital (06-0003), FFY 2008
24-0945	Longmont United Hospital (06-0003), FFY 2010
24-0946	Longmont United Hospital (06-0003), FFY 2010

Appendix D
Listing of 109 Cases

24-0968GC	CHS CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-0989GC	SSEPR CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-0948	Parkview Medical Center Inc. (06-0020), FFY 2007
24-0949	Parkview Medical Center Inc. (06-0020), FFY 2008
24-0950	Parkview Medical Center Inc. (06-0020), FFY 2009
24-0951	Parkview Medical Center Inc. (06-0020), FFY 2010
24-0952	Parkview Medical Center Inc. (06-0020), FFY 2011
24-0953	Parkview Medical Center Inc. (06-0020), FFY 2012
24-0954	Parkview Medical Center Inc. (06-0020), FFY 2013
24-0955	MercyOne Waterloo Medical Center (16-0067), FFY 2007
24-0956	MercyOne Waterloo Medical Center (16-0067), FFY 2010
24-0957	MercyOne Waterloo Medical Center (16-0067), FFY 2011
24-0958	MercyOne Waterloo Medical Center (16-0067), FFY 2012
24-0959	MercyOne Waterloo Medical Center (16-0067), FFY 2013
24-0960	Stormont Vail Hospital (17-0086), FFY 2007
24-0961	Stormont Vail Hospital (17-0086), FFY 2008
24-0962	Stormont Vail Hospital (17-0086), FFY 2009
24-0963	Stormont Vail Hospital (17-0086), FFY 2010
24-0964	Stormont Vail Hospital (17-0086), FFY 2011
24-0966	Stormont Vail Hospital (17-0086), FFY 2012
24-0967	Stormont Vail Hospital (17-0086), FFY 2013
24-0969	Hollywood Presbyterian Medical Center (05-0063), FFY 2007
24-0970	Hollywood Presbyterian Medical Center (05-0063), FFY 2008
24-0971	Hollywood Presbyterian Medical Center (05-0063), FFY 2009
24-0972	Hollywood Presbyterian Medical Center (05-0063), FFY 2010
24-0973	Hollywood Presbyterian Medical Center (05-0063), FFY 2011
24-0974	Hollywood Presbyterian Medical Center (05-0063), FFY 2012
24-0975	Hollywood Presbyterian Medical Center (05-0063), FFY 2013
24-0976	Valley Presbyterian Hospital (05-0126), FFY 2005
24-0977	Valley Presbyterian Hospital (05-0126), FFY 2009
24-0978	University of Colorado Health Memorial Hospital Central (06-0022), FFY 2006
24-0979	University of Colorado Health Memorial Hospital Central (06-0022), FFY 2009
24-0980	Frisbie Memorial Hospital (30-0014), FFY 2011
24-0981	Frisbie Memorial Hospital (30-0014), FFY 2012
24-0982	Frisbie Memorial Hospital (30-0014), FFY 2013
24-0983	CHI St. Luke's Health Baylor College of Medicine Medical Center (45-0193), FFY 2009
24-0984	Sanford USD Medical Center (43-0027), FFY 2006
24-0985	Sanford USD Medical Center (43-0027), FFY 2008

24-0986	Sanford USD Medical Center (43-0027), FFY 2009
24-0987	San Luke's Memorial Hospital Inc. (40-0044), FFY 2011
24-0988	San Luke's Memorial Hospital Inc. (40-0044), FFY 2012
24-0990	Hospital Comunitario Buen Samaritano (40-0079), FFY 2007
24-0991	Doctors' Center Hospital, Inc. (40-0118), FFY 2013
24-0992	Arizona Regional Medical Center (03-0126), FFY 2010
24-0993	Arizona Regional Medical Center (03-0126), FFY 2011
24-0994	Arizona Regional Medical Center (03-0126), FFY 2012
24-1000GC	HonorHealth CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-1001GC	HonorHealth CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-1002GC	HonorHealth CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-1003GC	HonorHealth CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-1004GC	HonorHealth CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-1009GC	HonorHealth CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-1011GC	Atrium Health CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-1014GC	VCH CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-1015GC	VCH CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-1016GC	VCH CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-1017GC	VCH CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-1018GC	VCH CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-1028GC	Asante Health System CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-1030GC	Asante Health System CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-1031GC	Asante Health System CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-1032GC	Asante Health System CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-1033GC	Asante Health System CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-1012	Wilkes Regional Medical Center (34-0064), FFY 2011
24-1013	Via Christi Hospital Pittsburg (17-0006), FFY 2007
24-1020	Avera McKennan Hospital & University Health Center (43-0016), FFY 2005
24-1021	Avera McKennan Hospital & University Health Center (43-0016), FFY 2006
24-1022	Avera McKennan Hospital & University Health Center (43-0016), FFY 2008
24-1023	Avera McKennan Hospital & University Health Center (43-0016), FFY 2009
24-1024	Avera McKennan Hospital & University Health Center (43-0016), FFY 2010
24-1025	Avera McKennan Hospital & University Health Center (43-0016), FFY 2011
24-1026	Avera McKennan Hospital & University Health Center (43-0016), FFY 2012
24-1027	Avera McKennan Hospital & University Health Center (43-0016), FFY 2013
24-1029	Asante Three Rivers Medical Center (38-0002), FFY 2009
24-1034	Asante Rogue Regional Medical Center (38-0018), FFY 2013
24-1035	Asante Rogue Regional Medical Center (38-0018), FFY 2006
24-1036	Winter Haven Hospital (10-0052), FFY 2005
24-1037	Winter Haven Hospital (10-0052), FFY 2007

24-1038	Winter Haven Hospital (10-0052), FFY 2008
24-1039	Winter Haven Hospital (10-0052), FFY 2009
24-1046GC	Novant Health CY 2006 Treatment of Part C Days Final Rule CIRP Group
24-1047GC	CHS CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-1048GC	Novant Health CY 2007 Treatment of Part C Days Final Rule CIRP Group
24-1049GC	Novant Health CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-1050GC	Novant Health CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-1051GC	CHS CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-1052GC	Novant Health CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-1053GC	Novant Health CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-1054GC	Novant Health CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-1065GC	WFHS CY 2008 Treatment of Part C Days Final Rule CIRP Group
24-1066GC	WFHS CY 2009 Treatment of Part C Days Final Rule CIRP Group
24-1067GC	WFHS CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-1068GC	WFHS CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-1069GC	WFHS CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-1070GC	WFHS CY 2013 Treatment of Part C Days Final Rule CIRP Group
24-1044	Novant Health Presbyterian Medical Center (34-0053), FFY 2005
24-1055	Cape Fear Valley Medical Center (34-0028), FFY 2006
24-1056	Cape Fear Valley Medical Center (34-0028), FFY 2007
24-1057	Cape Fear Valley Medical Center (34-0028), FFY 2008
24-1058	Cape Fear Valley Medical Center (34-0028), FFY 2009
24-1059	Newton Medical Center (31-0028), FFY 2010
24-1060	Cape Fear Valley Medical Center (34-0028), FFY 2011
24-1061	Cape Fear Valley Medical Center (34-0028), FFY 2012
24-1062	Betsy Johnson Regional Hospital (34-0071), FFY 2010
24-1063	Betsy Johnson Regional Hospital (34-0071), FFY 2011
24-1064	Wheaton Franciscan - St. Joseph (52-0136), FFY 2007
24-1071	Covenant Medical Center (45-0040), FFY 2008
24-1072	Covenant Medical Center (45-0040), FFY 2009
24-1073	Covenant Medical Center (45-0040), FFY 2010

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Scott Berends, Esq.
Federal Specialized Services
1701 South Racine Ave.
Chicago, IL 60608

RE: ***Closure of Group Appeals Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii)***[1]
Case No. 14-3788GC – Ardent Health Servs 2012 Post 1498-R DSH Medicaid Fract. Dual Elig. Days
Case No. 14-3791GC – Ardent Health Servs. 2012 Post 1498-R DSH SSI Fract. Dual Elig. Days

Dear Messrs. Ravindran and Berends:

As the parties are aware, Quality Reimbursement Services, Inc. ("QRS" or "Group Representative"), the Providers' designated representative, filed a *consolidated* request for expedited judicial review ("EJR") on June 9, 2022 involving, in the aggregate, 2 group cases and five (5) participants each. As discussed in further detail *infra*, the Group Representative filed a complaint in the U.S. District Court for the District of Columbia ("D.C. District Court") on June 10, 2022,[2] ***one day after the EJR request was filed with the Board***, *but without any notification to the Board until more than 3 months later, on September 14, 2022*.

Due to the fact that the groups were formed on June 8 2022 and the MAC normally has 60 days following full formation to review for potential jurisdictional challenges (per Board Rule 22), Federal Specialized Services ("FSS"), the Medicare Contractors' representative, filed a request on June 13, 2022 to extend by 60 days the time permitted under Board Rules to review those cases. QRS did *not* file any opposition to FSS' extension request.

On June 23, 2022, the Board issued its first Scheduling Order ("First Scheduling Order") for all the group cases in the consolidated EJR request. The First Scheduling Order:

1. Extended the time for FFS to file its response to the EJR request until July 14, 2022 to complete its review of the Providers' jurisdictional documents in Case Nos. 14-3791GC and 14-3788GC.
2. Required that the Providers file their response to FSS' filing by August 3, 2022.
3. Required the Providers' response to also address the following issues:

    a. "show cause why Case Nos. 14-3791GC and 14-3788GC should not be dismissed due to the participation of Baptist St. Anthony's Hospital (Prov. No. 45-0231) in the optional groups under Case Nos. 19-0704G and 19-0706G for FY

[1] In review of its docket, the Board has identified these cases as needing to be closed that unfortunately were not closed earlier similar to other QRS cases involving the same type of closure circumstances triggered by 42 C.F.R. § 405.1842(h)(3)(iii).
[2] *Baylor University Medial Center v. Becerra*, Case No. 1:22CV01678 (D.D.C., filed June 10, 2022).

2012. The optional groups became complete on February 22, 2020, QRS requested EJR on January 12, 2022 and then filed a lawsuit in federal district court on February 14, 2022, contrary to the Board's January 24, 2022 Notice of Stay and Scheduling Order and without notice to the Board or the opposing parties (*see* Attachment A). The Providers' response must include verifiable documentation from Ardent Health (*e.g*. affidavit, purchase agreement, etc.) in support of its argument to not dismiss Case Nos. 14-3791GC and 14-3788GC."[3]

b. Explain:

I. Whether QRS is the authorized representative of these providers because There are two different representative letters in Case Nos. 14-3791G and 14-3788GC. The first one relating to QRS is dated January 30, 2015 and lists Baptist St. Anthony's Hospital (without qualification) on the list of "Ardent Health Services ***Owned*** Facilities"21 for FY 2012. The second one related to Duane Morris LLP authorizes representation for a list of "providers . . . commonly owned and/or operated by Ardent Health Services" relating to fiscal years "on or after June 30, 2007" and include Baptist St. Anthony's Hospital without qualification.

II. Whether QRS is the authorized representative of these providers because the FY 2012 NPR for Baptist St. Anthony's Hospital (as included in the SoPs for Case Nos. 19-0704G and 19-0706G was issued to the corporate headquarters for Ardent Health (*i.e*., One Burton Hills Blvd, Ste. 250, Nashville TN 37215).

III. Whether QRS is the authorized representative of these providers because Baptist St. Anthony's Hospital is a participant in several Ardent Health CIRP group appeals for FY 2022 from the relevant final rules published in the Federal Register (*see, e.g.*, Case Nos. 22-0733GC and 22-0087GC).

IV. Discuss whether this appeal is viable because, per 42 C.F.R. § 405.1837(b)(1)(i), commonly owned or controlled providers must pursue a common issue for a particular calendar year as part of a CIRP group.

V. Discuss whether the Board may conduct any further proceedings in Case Nos. 19-0704G and 19-0706G because: (1) QRS has filed a complaint in federal district court for these 2 cases in the U.S. District Court for the California Central District based on the ***alleged*** failure of the Board to issue an EJR determination within 30 days of the EJR request (*see* Attachment A); and (2) 42 C.F.R. § 405.1842(h)(3)(iii) specifies that "[i]f the lawsuit is filed before a final EJR decision is issued on the legal question, *the Board may* ***not*** *conduct any further proceedings* on the legal question or the matter at issue until the lawsuit is resolved." As a result of this regulatory prohibition, the Board is foreclosed from exercising its discretion under 42 C.F.R. §

[3] In addition, the First Scheduling Order specified: "Both parties should brief as to why the Board should not dismiss the open appeals as duplicative and, if not, whether the EJR request, as currently draft remains applicable to Case Nos. 16-0607GC and 17-0952GC. In their response, the Providers must include, from Case Nos. 16-0607GC and 17-0952GC, a copy of the group issue statement, the September 30, 2020 EJR determination, as well as any other relevant documents in support of their position."

405.1885 to consider (as an alternative to dismissing Case Nos. 14-3791GC and 14-3788GC) the *potential* remedial action of reopening Case Nos. 19-0704G and 19-0706G to dismiss Baptist St. Anthony's Hospital from them.

VI. Address the Board's jurisdiction over Case No. 15-0560GC and whether the portion of that CIRP group that pertains to CY 2007 is a prohibited duplicate of the University of Washington CIRP group for 2007 under Case No. 10-1325GC" and required "the Providers [to] include, from Case No. 10-1325GC, a copy of the group issue statement and August 22, 2016 EJR determination as well as any other relevant documents in support of their position"[4]

VII. "[I]identify the group issue statement for Case Nos. 14-0560GC and 15-0561GC and whether the EJR request falls outside the scope of the group issue statement for those cases" and required "[t]he Providers in their response must include a copy of the group issue statement from Case No. 09-0271GC and any other relevant documentation in support of their position" since the 2 CIRP groups were formed based on bifurcation from Case No. 09-0271GC.[5]

The First Scheduling Order further notified the parties that the 30-day period for the Board to rule on an EJR request had not begun and that the Board would notify them when it did begin:

> [A]s jurisdiction is a prerequisite to consideration of an EJR request, this Scheduling Order necessarily affects the 30-day period for the Board's determination of authority required to decide the EJR request. Specifically, this Scheduling Order, "confirm[s] . . . that the 30-day period for the Board to rule on the EJR request has been stayed because the EJR request is incomplete and the Board does not yet have all the information necessary to rule on the EJR request." Further, in issuing this Scheduling Order, the Board is mindful of the Covid-19 pandemic. *Notwithstanding, be advised that the above filing deadlines in this Scheduling Order are* ***firm*** *and the Board is* ***exempting*** *them from the Alert 19 suspension of Board filing deadlines*. The Board will continue its review of the jurisdiction in these appeals, as well as review the Providers' request for EJR, upon receipt of the requested information, or the August 25, 2022 filing deadline, whichever occurs first.[6]

Following the Board's First Scheduling Order, the Providers filed ***no objections*** *or requests for clarification with regard to the Scheduling Order itself*. As a result, the Board and FSS continued to take actions consistent with that Scheduling Order. The Medicare Contractors were

[4] In particular, the Board noted that "The Board's records reflect that, on August 22, 2016, it granted EJR in Case No. 10-1325GC "Univ. of Washington 2007 SSI Covered vs. Total Days CIRP Group."
[5] The Board noted that "it is the Board's understanding that these 2 CIRPs were formed based on bifurcation from Case No. 09-0271GC."
[6] (Emphasis in original and footnotes omitted.)

required to file, through FSS, any response to the Group Representative's EJR Request no later than July 14, 2022. The Provider were required to respond to the Medicare Contractor's filing as well as the Board's information requests no later than August 3, 2022.

On August 2, 2022, QRS filed a response to the Board's information requests simply stating that it was "working with Ardent Health to determine the ownership ("CIRP") status of Baptist St. Anthony's Hospital (Prov. No. 45-0231 FY 2012." QRS further stated that it was awaiting an affidavit from Ardent Health, following legal review and requesting an additional 12 days to submit the Providers' full response to the Board's request. On August 12, 2022, QRS submitted an affidavit from Ardent Health that Baptist St. Anthony's Hospital (Prov. No. 45-0231 FY 2012 was not owned or controlled by Ardent. No other information was provided in QRS' August 12, 2022 communication.

The Board issued a second Scheduling Order ("Second Scheduling Order") on August 18, 2022 for all the group cases in the consolidated EJR request. The Second Scheduling Order noted that the Supreme Court issued a decision in *Becerra v. Empire Health Foundation* ("*Empire*")[7] *after* QRS filed the EJR request in these appeals. Since the *Empire* decision was directly relevant to the issues in the EJR Request, but the request and responses did not discuss the case, the Board exercised its authority under 42 C.F.R. § 405.1842(e)(3) to issue a Scheduling Order requiring QRS to file a response within 28 days (*i.e.*, by Friday, September 15, 2022):

1. Giving updates on whether the groups' participants were still pursuing the EJR Request;
2. Requesting withdrawals for each case not being pursued; and
3. Updating, or clarifying as relevant, the EJR request to discuss the impact of *Empire* on the EJR request challenging (whether in whole or in part) the Secretary's policy of including no-pay/exhausted Part A days in the Medicare fraction for each case being pursued.[8]

Following the Board's Second Scheduling Order, the Providers filed ***no objections*** *or requests for clarification with regard to the Second Scheduling Order itself.* As a result, the Board and FSS continued to take actions consistent with that Scheduling Order. The Medicare Contractors were required to file, through FSS, any response to the Group Representative's response no later than 21 days after it was filed.

QRS filed a timely response to the Second Scheduling Order on September 14, 2022 notifying the Board (for the first time) of the litigation it had filed in the D.C. District Court:

> The Administrator of the Centers for Medicare & Medicaid Services ("CMS") was required to notify, and presumably has or will notify, the Board that the Providers have commenced an action in the District Of Columbia District Court in the case of BAYLOR UNIVERSITY MEDICAL CENTER et al v.

[7] 142 S. Ct. 2354 (2022).
[8] The Board noted this information was necessary for the Board to determine jurisdiction over the groups and underlying participants and, if the Board found the prerequisite jurisdiction (*see* 42 C.F.R. § 405.1842(b)(1)-(2)), to then rule on the EJR request. *See* 42 C.F.R. § 405.1842(f)(2)(iii).

> BECERRA, Case No. 22-01678-TSC attached as Exhibit 1. The Providers served the Secretary of Health and Human Services on August 18, 2022. *Accordingly, the Providers respectfully submit that the Board does* ***not*** *at present* ***possess jurisdiction*** *over the captioned cases*. 42 C.F.R. § 405.1842(h)(3)(iii).[9]

A review of public records confirmed that QRS had filed litigation ninety-seven (97) days prior to its September 14, 2022 notice to the Board and, more egregiously, just ***one day after the EJR request was filed with the Board***. Specifically, on June 10, 2022, without notice to the Board or the opposing parties in these cases, QRS bypassed the ongoing jurisdictional review process by filing a complaint in the D.C. District Court, Case No. 22-01678-TSC seeking judicial review on the merits of its EJR Request in these 2 group cases. This less-than-30-days timing demonstrates that QRS had *no intention* of allowing the Board to process its EJR requests pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulation at 42 C.F.R. § 405.1842 that implemented the statutory provision. QRS' failure to immediately notify the Board and the opposing parties of this litigation filing demonstrates QRS' lack of good faith and the disingenuous nature of its filings before the Board.

QRS' egregious action in these cases is not new to the Board. To provide context for these cases, and the ongoing malfeasance by QRS, the Board attaches and incorporates a copy of the Board's June 10, 2022 closure letter, in response to QRS initiating federal litigation in connection with the consolidated EJR request QRS filed on January 20, 2022 involving 80 group cases for the same issue with 950+ participants in the aggregate, as **Appendix B**.

Procedural Background:

The Scheduling Orders issued in these cases explained that, per 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), and (e)(3)(ii), "jurisdiction is a prerequisite to consideration of an EJR request" and "the 30-day period for [the Board] responding to the EJR request has not yet commenced for these CIRP group appeals and will not commence until the Board completes its jurisdictional review of these CIRP groups." The Board also explained that a Board finding of jurisdiction is a ***prerequisite*** to any review of an EJR request pursuant to 42 C.F.R. § 405.1842.

The Board's conclusion that the 30-day period had not begun is further supported by 42 C.F.R. § 405.1842(b)(2) which states in pertinent part: "the 30-day period for the Board to make a determination under [42 U.S.C. § 1395oo(f)(1)] does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete." Accordingly, 42 C.F.R. § 405.1842(a)(4)(ii) states that a provider may seek EJR review in federal court without an EJR determination by the Board, "*only if* . . . [t]he Board fails to make a determination of its authority to decide the legal question no later than 30 days *after* finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete." Consistent with these regulatory provisions, Board Rule 42.1 states, in pertinent part:

> Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any

[9] (Emphasis added and footnote omitted.)

> substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days *after* it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.

Thus, it is clear that the 30-day clock does not start until *after* the Board determines that it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) underlying an EJR request.[10]

Under Board Rule 44.3, if a party intends to respond to a motion, it must do so within 30 days, unless the Board imposes a different deadline. Significantly, QRS did not file any objection to FSS' extension requests in Case Nos. 14-3788GC and 14-3791GC. Nor did QRS file any objection to the Scheduling Orders issued in these cases.

QRS made clear by filing the Complaint in federal district court on June 10, 2022, that it was bypassing and abandoning the Board's prerequisite jurisdictional review process.

If the Providers were successful on the merits of their claims in federal court, then bypassing the Board's jurisdictional review process could result in millions of dollars being improperly paid. To illustrate this very point, the Board has included as **Appendix B**, a non-exhaustive listing of some of the jurisdictional issues that the Board has identified thus far. The Board expects that additional, material, jurisdictional and/or claim filing issues would be identified if it were to complete the jurisdictional review process.

Board Findings:

The Board must consider the significant impact on the proceedings caused by QRS filing a lawsuit in connection with the above-referenced six (6) group cases.

A. The 30-day Period For the Board to Respond to the Consolidated EJR Request Has Not Yet Begun and Bypassing the Completion of that Process Raises Fraud, Waste and Abuse Issues.

Parties to a Board appeal may request EJR, pursuant to the provisions of 42 U.S.C. § 1395oo(f)(1), which states in relevant part:

> Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. ***If a provider of services may obtain a hearing under subsection (a)*** and has filed a request for such a hearing, such provider

[10] (Footnote omitted and bold and underline emphasis added.)

> may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). *The Board shall render such determination in writing within thirty days* ***after the Board receives the request and such accompanying documents and materials***, and the determination shall be considered a final decision and not subject to review by the Secretary.[11]

To implement this statutory provision, the Secretary promulgated the regulation at 42 C.F.R. § 405.1842, setting forth the process for obtaining EJR, and the Board's obligations under the statute. As demonstrated by the following excerpts, 42 C.F.R. § 405.1842 makes clear that the 30-day clock for processing an EJR request does not begin until ***after*** the Board rules on jurisdiction:

> (a) *Basis and scope*. (1) This section implements provisions in section 1878(f)(1) of the Act that give **a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal <u>if there is Board jurisdiction to conduct a hearing on the matter</u>** (as described in § 405.1840 of this subpart), and the Board determines it lacks the authority to decide the legal question (as described in § 405.1867 of this subpart, which explains the scope of the Board's legal authority).
>
> (2) A provider may request a Board decision that the provider is entitled to seek EJR or the Board may consider issuing a decision on its own motion. **Each EJR decision by the Board must include a specific jurisdictional finding on the matter(s) at issue**, and, where the Board determines that it does have jurisdiction on the matter(s) at issue, a separate determination of the Board's authority to decide the legal question(s).
>
> ****
>
> (4) **The provider has a right to seek EJR** of the legal question under section 1878(f)(1) of the Act ***only if***—
>
> (i) **The final EJR decision of the Board or the Administrator, as applicable, includes a finding of Board jurisdiction over the specific matter at issue** and a determination by the Board that it has no authority to decide the relevant legal question; or
>
> (ii) The Board fails to make a determination of its authority to decide the legal **question no later than 30 days <u>after finding jurisdiction</u> over the matter at issue <u>and</u> notifying the provider that the provider's EJR request is complete**.

[11] (Emphasis added.)

> (b) *General*—(1) *Prerequisite of Board jurisdiction*. The Board (or the Administrator) **must find that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question**.
>
> (2) *Initiating EJR procedures*. A provider or group of providers may request the Board to grant EJR of a specific matter or matters under appeal . . . . Under paragraphs (d) and (e) of this section, **a provider may request** a determination of the Board's authority to decide a legal question, but **the 30-day period for the Board to make a determination under section 1878(f)(1) of the Act** [*i.e.*, 42 U.S.C. § 1395oo(f)(1)] **does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete**.[12]

Clearly, when implementing 42 U.S.C. § 1395oo(f)(1) through 42 C.F.R. § 405.1842, the Secretary recognized that the 30-day period "does not begin to run ***until the Board finds jurisdiction*** to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete."[13] Moreover, the Board is bound by this regulation because, as stated in 42 C.F.R. § 405.1867, "[i]n exercising its authority to conduct proceedings under this subpart, *the Board must comply with all* the provisions of Title XVIII of the Act *and* ***regulations issued thereunder*** . . . ." Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

> Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.[14]

---

[12] (Emphasis added).

[13] 42 C.F.R. § 405.1842(b)(2) (emphasis added). *See also* 69 Fed. Reg. 35716, 35730 (June 25, 2004) (proposed rule explaining: "In proposed § 405.1842(b), we would set forth an overview of the EJR process. We believe that an overview would be helpful given the complexity of the process. In § 405.1842(b)(l), ***we would emphasize that a Board finding that it has jurisdiction*** *over the specific matter at issue* ***is a prerequisite*** *for its determination of its authority to decide the legal question*, and for the ensuing stages of the EJR process. Section 1878(f)(1) of the Act states that a provider may file a request for EJR '[i]f [such] provider of services may obtain a hearing under subsection (a) [which sets forth the jurisdictional requirements for obtaining a Board hearing].' In § 405.1842(b)(2) we would state that the EJR procedures may be initiated in two ways. First, a provider or group of providers may request the Board to grant EJR, or, second, the Board may consider on its own motion whether to grant EJR. We would also state in paragraph (b)(2), ***consistent with*** *the requirement that a Board finding of jurisdiction is a prerequisite of both the provider's ability to obtain EJR and the Board's authority to issue an EJR Decision*, that ***the 30-day time limit*** specified in section 1878(f)(l) of the Act for the Board to act on a provider's complete request ***does not begin to run until the Board has found jurisdiction*** on the specific matter at issue." (emphasis added)).

[14] (Emphasis added.)

Thus, it is clear that the 30-day clock does not start until ***after*** the Board determines it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) in the appeals underlying an EJR request. Note that the Board's use of the term "stay" (as used in this and prior similar situations) in relation to the 30-day period for responding to the parties' EJR requests, was an inartful use of that term because the Board's intent was to simply notify the parties that the Board had not yet finished its jurisdictional review of the parties' EJR requests and, as such, the 30-day period for the review of the EJR requests had not yet commenced.

The Board notes that the Secretary had a sound basis for issuing 42 C.F.R. § 405.1842(b)(2). The statute itself states that a provider may be authorized to request EJR "***if*** [it] ***may obtain a hearing under subsection (a). . . .***"[15] Thus, as the Court in *Alexandria Hospital v. Bowen* ("*Alexandria*") noted, "the statute itself suggests that an EJR request need not be considered before the Board determines it has jurisdiction over an appeal. Moreover, the legislative history makes clear that in enacting the EJR provision, Congress sought solely to expedite resolution of the *legal* controversies in Medicare reimbursement appeals."[16] The Court in *Alexandria* continued, stating:

> Nor will the hospitals be heard to argue that the filing of an EJR request requires the PRRB to determine its jurisdiction over an appeal *and* respond to the EJR request within 30 days. Such an argument confuses what are in reality two separate analyses: jurisdiction and EJR. *The jurisdictional analysis determines whether the PRRB may consider a provider's appeal*. The EJR inquiry, on the other hand, determines whether a party properly before the PRRB raises issues which must be resolved before a court rather than the Board. *The language of the statute supports this distinction*. EJR requests relate to the authority of the PRRB to decide questions of law, not whether an appeal is properly before them. While Congress has clearly imposed a 30-day limit on the PRRB's evaluation of EJR requests, no such limits have been placed on the PRRB's evaluation of its jurisdiction. . . .
>
> The court is also unconvinced that Congress meant to require evaluation of EJR requests within a 30-day time frame when the PRRB has not made a jurisdictional determination. It makes no sense to require the PRRB to evaluate an EJR request they might never reach if the appeal is not properly before the Board. *Thus, the hospitals' argument that the PRRB absolutely must make an EJR determination within 30 days of document receipt is* ***without merit***.[17]

---

[15] 42 U.S.C. § 1395oo(f)(1) (emphasis added).
[16] *See* H.R. Rep. No. 96–1167, *reprinted in* 1980 U.S. Code Cong. & Ad. News at 5757; *Alexandria Hosp. v. Bowen*, 631 F. Supp. 1237, 1244 (W.D. Va. 1986); *San Francisco General Hosp. v. Shalala,* No. C 98-00916, 1999 WL 717830 (N.D. Cal. Sept. 8, 1999); *Total Care, Inc. v. Sullivan,* 754 F. Supp. 1097 (W.D. N.C. 1991); *Abington Mem'l Hosp. v. Bowen,* Civ. A No. 86-7262, 1988 WL 71367 (E.D. Pa. July 1, 1988); *Good Samaritan Hosp. v. Heckler*, No. CV84-L-459, 1986 WL 68497 (D. Neb. June 27, 1986).
[17] *Alexandria Hosp. v. Bowen*, 631 F. Supp. at 1244.

The *Alexandria* Court's conclusions are also supported by the practical considerations involved in the EJR process. If EJR requests were permitted to supersede jurisdictional determinations, there would be only two logical outcomes. The first is that jurisdictional determinations need never be made in cases where EJR requests are filed before a jurisdictional determination is reached by the Board. This would result in fraud, waste and abuse concerns if parties, unable to meet the Board's jurisdictional requirements, could still prevail in federal court, merely by filing an EJR request. The second conclusion is that federal trial courts would be forced to resolve jurisdictional disputes.[18] Not only are the federal trial courts ill-suited for making such determinations, it is a task assigned to the Board, *by statute*.

Significantly, in these two (2) group cases, with ten (10) participants, the Board has not yet completed its jurisdictional review to confirm whether it has jurisdiction to hear all of the providers' disputes raised in the EJR request. The Board stopped this process after it learned that QRS had bypassed the completion of this process on June 10, 2023, even before 30 days had elapsed. Having sufficient time to complete the jurisdictional and substantive claim review[19] process is vital to ensure that the groups, and all of the underlying providers, are properly before the Board both generally and for the issue(s) raised in the EJR request. Further, the jurisdictional and substantive claim review process ensures that the groups, and underlying providers, have complied with the applicable Board regulations and rules (*e.g.*, have not previously withdrawn or been dismissed without being reinstated; are not pursuing a prohibited duplicate appeal of the same issue for the same year; and have complied with the mandatory CIRP group rules). Without a proper jurisdictional review, fraud, waste and abuse concerns arise. Indeed, these concerns are very real and evident in these 2 group cases as highlighted in **Appendix A**.

The above discussion makes it clear that, per the regulations at 42 C.F.R. §§ 405.1837(a)(4)(ii) and 405.1837(b)(2), the 30-day EJR review period, specified at 42 U.S.C. § 1395oo(f)(1), does not begin until the Board completes its jurisdictional review process *and* finds jurisdiction.[20] QRS' filing of the Complaint in federal district court ***one day after the EJR Request was filed***, without notice to the Board or opposing party, is contemptuous of the Board's authority. It also demonstrates that QRS had no intention of allowing the Board to complete its jurisdictional review, much less the 30-day EJR review period to rule on the EJR request.

---

[18] It is hard to see federal courts deciding jurisdictional issues, including determining whether a case or provider: (a) has been previously withdrawn or dismissed without being reinstated; (b) is pursuing a prohibited duplicate appeal of the same issue for the same year; or (c) has complied with the mandatory CIRP group rules. Indeed, ***subsequent to filing its Complaint on June 3, 2022***, QRS continued to expand the record and take actions in the Board proceedings in these group cases (*e.g.*, indicating in its July 19, 2022 correspondence with the Board that an updated EJR Request would be filed based on the Supreme Court's *Empire* decision) and it is unclear how a federal court is equipped to keep track of those actions and their import when there has been no jurisdictional determination and/or EJR decision in these cases.

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

[20] "Indeed, the statute and regulation by their terms do not impose *any* time constraints on the Board's determination of jurisdiction. *See* 42 U.S.C. 1395oo(f)(1); 42 CFR § 405.1842. The Hospitals' proffered interpretation of the regulation is so wildly disconnected from the text as to `warrant[] little attention.'" *St. Francis Medical Center, et al v. Xavier Becerra*, Memorandum Opinion, No. 1:22-cv-1960-RCL, at 8 (D.D.C. Sept. 27, 2023) (*citing Cape Cod Hosp. v. Leavitt*, 565 F. Supp. 2d 137, 141 (D.D.C. 2008)).

B. Effect of QRS' Concurrent Filing of the Complaint on the 6 Group Cases

The regulation at 42 C.F.R. § 405.1842(h)(3) addresses how Provider lawsuits relating to an EJR request affect Board proceedings:

> (3) *Provider lawsuits*. (i) If the provider files a lawsuit seeking judicial review (whether on the basis of the EJR provisions of section 1878(f)(1) of the Act or on some other basis) pertaining to a legal question that is allegedly relevant to a specific matter at issue in a Board appeal to which the provider is a party and that is allegedly not within the Board's authority to decide, the Office of the Attorney Advisor must promptly provide the Board with written notice of the lawsuit and a copy of the complaint.
>
> ****
>
> (iii) *If the lawsuit is filed before a final EJR request is issued on the legal question*, ***the Board may not conduct any further proceedings*** on the legal question or the matter at issue until the lawsuit is resolved.[21]

This regulation ***bars any further Board proceedings*** in these 2 group cases, including proceedings on *pre-requisite* jurisdictional issues or other procedural issues. Consistent with FRCP 62.1, the Board issues this ruling on a Motion for Relief that is barred by a pending appeal and, as explained below, is deferring further action in these 6 group cases until, or if, the Administrator remands these cases back to the Board.

To confirm the proper application of § 405.1842(h)(3), the Board reviewed the preambles to the proposed rule, dated June 5, 2004,[22] and the May 23, 2008 final rule[23] that promulgated the regulation at 42 C.F.R. § 405.1842(h)(3)(iii). The preamble to the proposed rule described this regulation as follows:

> Proposed § 405.1842(h)(3) would specify the effect that a provider lawsuit would have on the Board's ability to conduct further proceeding on the legal matter at issue. In general, if a provider files a lawsuit on the same legal issue for the same cost year that is currently pending before the Board - that is, the provider goes into court without waiting for a final administrative decision on EJR, we would seek to have the lawsuit dismissed, and we would prohibit the Board from conducting further proceedings on that issue until the lawsuit is resolved.[24]

---

[21] (Emphasis added.)
[22] 69 Fed. Reg. 35716 (June 25, 2004).
[23] 73 Fed. Reg. 30190 (May 23, 2008).
[24] 69 Fed. Reg. at 35732.

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

> *Comment*: One commenter stated that the proposed rule would provide that, if any allegedly relevant lawsuit was filed before a final EJR decision, the Board would be precluded from conducting any further proceedings on the EJR decision until the lawsuit was resolved, and that it appears that the proposed policy would apply, regardless of the basis for the lawsuit. The commenter suggested that the final rule provide that the Board be required to conduct further proceedings on an EJR decision when the provider subsequently files a lawsuit brought on jurisdictional grounds other than the Social Security Act. If the Board were allowed to grant EJR, the issues jurisdictionally under the Medicare statute could be added to the pending matter in court, thus preserving judicial resources and avoiding multiple lawsuits.
>
> *Response*: The commenter is correct that the proposed policy would apply regardless of the jurisdictional basis for the lawsuit. However, we decline to adopt the commenter's suggestion that we make a distinction based on the jurisdictional basis pleaded in the complaint. **We do not agree that it would be appropriate for the Board or the intermediary to spend its limited resources to spend time on a Board appeal if the provider has filed a complaint that involves a legal matter that is relevant to a legal issue in the Board appeal**. If the court properly has jurisdiction over the appeal, the decision, that it or a higher court renders, may resolve the issue or issues in the Board case, or otherwise inform the Board in reaching a decision, or affect the parties' decision as to whether they should attempt to settle the Board case. On the other hand, where the basis for the court's jurisdiction is defective (which we believe would most likely be the situation when a provider attempts to file a complaint based on a legal issue related to an appeal still pending before the Board), a contrary rule would not discourage providers from filing improper appeals with the court. We believe our proposal to be in line with the general rule practiced by courts that an appeal to a higher court deprives the lower court of jurisdiction to conduct further proceedings until the appeal is resolved by the higher court.[25]

Based on the above explanation regarding the intent and purpose for 42 C.F.R. § 405.1842(h)(3)(iii), the Board finds that QRS' concurrent filing of the Complaint in the D.C. District Court on June 10, 2022 prohibits the Board from conducting any further proceedings on the consolidated EJR request for the two (2) cases at issue therein as filed, including any proceedings related to the prerequisite jurisdiction and claims filing requirements.

[25] 73 Fed. Reg at 30214-15 (bold and underline emphasis added).

C. QRS' Actions

The Board finds that QRS' decision to withhold notice from the Board and the opposing parties of its filing of the federal district court litigation is tantamount to bad faith and actively created confusion surrounding the status of these cases at the Board because it ignored the 30-day Board review period as provided at 42 U.S.C. § 1395oo(f)(1) ***and*** *implemented at 42 C.F.R. § 405.1842*. Indeed, QRS' preemptive actions, taken without notice to the Board or the opposing parties, demonstrate that QRS had no intent to exhaust its administrative remedies before the Board. Pursuant to Board Rule 1.3 (Nov. 1, 2022),[26] QRS had a duty to communicate early, and in good faith, with the Board and the opposing parties (in that regard the Secretary is not a party per 42 C.F.R. § 405.1843(b)):

> **1.3 Good Faith Expectations**
>
> In accordance with the regulations, the Board expects the parties to an appeal to communicate early, act in good faith, and attempt to negotiate a resolution to areas of misunderstanding and differences. The duty to communicate early and act in good faith applies to dealings with the opposing party, the Board, and/or any relevant nonparty.

Similarly, pursuant to Board Rule 5.2 (Nov. 1, 2021), QRS, as the Providers' designated representative, is responsible for being familiar with, and following, Board rules and procedures and governing regulations (including 42 C.F.R. § 405.1842(b)(2)), and timely responding to correspondence or requests from the Board or the opposing party:

> **5.2 Responsibilities**
>
> *The case representative is responsible for being familiar with the following rules and procedures* for litigating before the Board:
>
> - The Board's governing statute at 42 U.S.C. § 1395oo;
> - *The Board's governing regulations at 42 C.F.R. Part 405, Subpart R*; and
> - *These Rules*, which include any relevant Orders posted at https://www.cms.gov/Regulations-and-Guidance/ReviewBoards/PRRBReview/PRRB-Instructions (see Rule 1.1).

[26] The recent changes to the Rules (effective Nov. 1, 2021) were first published in June 16, 2021 and, in advance of their effective date, invited comments from all interested individuals, providers, government contractors and other organization to be submitted by July 30, 2021. Subsequently on September 30, 2021, based on its review of that feedback, the Board then published further revisions to the Rules (effective Nov. 1, 2021). *See* Board Order No. 1 (available at: https://www.cms.gov/files/document/revised-prrb-rules-v-30-cover-order-1-superseded-v-31.pdf); Board Alerts 21 and 22 (available at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Alerts); Board Order No. 2 (https://www.cms.gov/files/document/current-prrb-rules-v-31-cover-order-2-november-1-2021.pdf).

> Further, *the case representative is responsible for*:
>
> - Ensuring his or her contact information is current with the Board, including a current email address and phone number;
> - Meeting the Board's deadlines; and
> - *Responding timely to correspondence or requests from the Board or the opposing party*.
>
> Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.[27]

Indeed, the following action (or inaction) by QRS reinforce the Board's finding that QRS has no basis to claim that proceedings before the Board have been exhausted:

1. QRS did not notify the Board, FSS, or the Medicare Contractors, of its opposition to FSS' motion to extend the Medicare Contractor's time to file jurisdictional challenges in these two (2) group cases.

2. QRS failed to promptly and timely notify the Board of its objection to the Board's ruling on the extension, and the associated Scheduling Orders for these 2 group cases requesting information from both parties. QRS' failure to file and preserve its objection to the Board's ruling and Scheduling Orders (including information requests) violates QRS' obligations under Board Rules 1.3, 5.2, and 44. QRS' failures further deprived the Board of an opportunity to reconsider its ruling and Scheduling Orders and, if necessary, correct or clarify that ruling and/or the Scheduling Orders.[28]

3. The Board made known to the parties in these cases its position regarding the 30-day period to respond to the EJR request at issue, based on 42 U.S.C. § 1395oo(f), 42 C.F.R.

---

[27] (Italics emphasis added.) *See also, Baptist Mem'l Hosp.-Golden Triangle v. Sebelius*, 566 F.3d 226, 227 (D.C. Cir. 2009) wherein the Circuit Court affirmed the District Court's granting of summary judgment to the Secretary because the Providers failed to follow Board Rules, stating, "The court therefore granted summary judgment to the Board. Because the Board's procedural rules mean what they say and say what they mean, and because the hospitals did not follow them, we affirm."

[28] While the Board is not bound by the FRCP, the Board refers to them for guidance and notes that the principles of FRCP 46 are similar. FRCP 46 applies to trial-like proceedings and "requires that a party seeking to preserve an objection to the court's ruling must 'make known to the court the action which the party desires the court to take or the party's objection to the action of the court and the grounds therefor.'" *Beach Aircraft Corp. v. Rainey*, 488 U.S. 163 (1988). *See also Cain v. J.P. Productions*, 11 Fed. Appx 714 (9th Cir. 2001). Similarly, the purpose behind Rule 46 is also relevant: "As pointed out in the discussions of Rule 46, the function of an exception was to bring pointedly to the attention of the trial judge the importance of the ruling from the standpoint of the lawyer and to give the trial judge an opportunity to make further reflection regarding his ruling. Proceedings of Institute, Washington, D.C., 1938, p. 87. In justifying the rule, it was stated 'the exception is no longer necessary, if you have made your point clear to the court below.' Proceedings of Institute, Cleveland, 1938, p. 312. 'But of course it is necessary that a man should not spring a trap on the court * * *, so the rule requires him to disclose the grounds of his objections fully to the court.' Proceedings of Institute, Washington, D.C., 1938, p. 145; see also p. 87." *Bucy v. Nevada Const. Co.*, 125 F.3d 213, 218 (9th Cir. 1942).

§§ 405.1842(b)(2), 405.1801(d)(2).[29] Specifically, the Board notified the parties that the Board had the authority to stay the start of the 30-day period. The Board's notice was based on 42 C.F.R. § 405.1842(b)(2) which specifies that jurisdiction is a prerequisite to Board consideration of an EJR request ***and*** that the 30-day period to review the EJR request does ***not*** begin until the Board finds jurisdiction. To that end, the Board issued its First Scheduling Order for these 2 group cases to memorialize, and effectuate, the necessity to conduct the jurisdictional review process and delay the start of the 30-day period to review the EJR request. QRS failed to notify the Board of its objection to the Scheduling Orders. QRS' failure to timely file any objection violates Board Rules 1.3, 5.2 and 44. Indeed, QRS' actions interfered with the speedy, orderly and fair conduct of Board proceedings and prejudiced the Board by depriving it of an opportunity to reconsider its rulings and, if necessary, correct or clarify them,[30] or take other actions, ***prior to*** QRS filing its May 27, 2022 Complaint. Indeed, QRS' preemptive actions did not even allow completion of the 30-day EJR review deadline, ***as alleged by QRS to be established in 42 U.S.C. § 1395oo(f)(1) (and which QRS alleges in its litigation the Board missed)***, to pass, and, under QRS' strained interpretation that ignores the Secretary's regulations, permitted federal litigation to be pursued.[31]

4. QRS' failure to promptly notify the Board that it had filed the lawsuit in the D.C. District Court violates Board Rule 1.3, and prevented the Board and the Medicare Contractors from understanding the nature of QRS' position relative to the 30-day period specified in 42 U.S.C. § 1395oo(f)(1). The following circumstances make it clear that QRS had an affirmative obligation to notify the Board of the Complaint being filed, and that QRS should have been aware of that affirmative obligation:

   a. The Board, in its First and Second Scheduling Orders issued for these cases (as well as for other cases prior to May 27, 2022 as set forth in **Appendix B**), made clear the Board's position that the 30-day period for responding to the EJR request would not commence until the Board had completed its jurisdictional review and issued its jurisdictional findings.

   b. The Board and the Medicare Contractors were all acting in reliance on the authority of those Scheduling Orders.

D. Board Actions

These facts demonstrate that QRS had a duty, pursuant to Board Rule 1.3, "to communicate early and act in good faith [with regard] [] to dealings with the opposing party, the Board, and/or any relevant nonparty." Indeed, QRS' failure to comply with Board Rule 1.3, through prompt notification of the lawsuit on, or about, June 10, 2022, prejudiced the Board, FSS and the

---

[29] The Board's Notice was clear that a Board finding of jurisdiction is a prerequisite to any review of an EJR request citing to 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), (e)(3)(ii).

[30] For example, the Board could have explained how reliance ***solely*** on 42 U.S.C. § 1395oo(f)(1) would be misplaced, given the Secretary's implementation of that statute at 42 C.F.R. § 405.1842 (including in particular § 405.1842(b)(2)) as promulgated in the May 23, 2008 final rule and the Secretary's explanation of that regulation in the June 25, 2004 proposed rule. *See supra* notes 11-17 and accompanying text.

[31] *See supra* note 28 (discussing how the FRCP supports the Board's position).

Medicare Contractors. Specifically, it interfered with the speedy, orderly and fair conduct of the Board proceedings (on these and other cases) and deprived both the Board, and the Medicare Contractors, of the opportunity to decide whether to delay or cease work on these two (2) group cases and the underlying 10 participants in favor of other time-sensitive work such as ***other*** EJR requests filed by QRS *and* by other representatives. Indeed, QRS' failure to ***timely*** notify the Board, and the opposing parties, of this lawsuit filed in the D.C. District Court, raises very serious concerns about prejudicial sandbagging by QRS to benefit prior, current and subsequent EJR requests that QRS filed on behalf of other providers ***or*** by other representatives for EJR requests filed for the same issue.[32] The prejudicial sandbagging is highlighted by the facts that:

1. Across the 6-month period from December 20, 2021 to June 30, 2022, record concentrations of EJR requests were filed covering 642 group cases involving 2000+ participants (with the overlay of challenges caused by the surge in the Omicron variant of the COVID-19 virus at the beginning of that 6-month period); and

2. 80 percent of these requests were filed by either QRS or another representative, Healthcare Reimbursement Services ("HRS") (specifically QRS filed EJR requests covering 359 cases and HRS filed EJR requests covering 148 cases during this 6-month period).[33]

As a point of reference and context for these serious violations by QRS, the Board has included, at **Appendix B**, a copy of the closure letter it issued in 80 QRS cases that were included in a February 14, 2022 Federal Complaint in the California Central District Court. Finally, this is not an isolated event because it is the Board's understanding that: (1) QRS and HRS jointly filed the Complaint in the California Central District Court on April 20, 2022 establishing Case No. 22-cv-02648 covering 178 cases with 969 participants and did so without completing the jurisdictional review process, much less receiving the Board's jurisdictional decision, and without notice to the Board;[34] and (2) QRS filed at least two similar Complaints in the D.C. District Court on April 20, 2022 under Case No. 22-cv-02648,[35] and on June 3, 2022 under Case No. 22-cv-01582.[36]

---

[32] *See Fink v. Gomez*, 239 F.3d 989 (9th Cir. 2001) ("[T]he cases discussed above make clear that sanctions are available if the court specifically finds bad faith or conduct tantamount to bad faith. Sanctions are available for a variety of types of willful actions, including recklessness when combined with an additional factor such as frivolousness, harassment, or an improper purpose. Therefore, we hold that an attorney's reckless misstatements of law and fact, when coupled with an improper purpose, such as an attempt to influence or manipulate proceedings in one case in order to gain tactical advantage in another case, are sanctionable under a court's inherent power.").

[33] It is the Board's understanding that, on February 14, 2022, QRS established the initial ongoing litigation in the California Central District Court covering 80 group cases with 950+ participants in the aggregate, and that QRS and another representative, HRS *joined* the following additional cases to that lawsuit through the Amended Complaint filed on March 30, 2022 (without any notice to the Board or the opposing party). Similar litigation involving other EJR requests filed by QRS has been filed both in California and the District of Columbia. *See infra* notes 34 to 36 and accompanying text.

[34] Under separate cover, the Board closed the QRS cases by letters dated September 30, 2022 (Grouping A for Case Nos. 13-3842GC, *et al*.; Grouping B for Case Nos. 17-2150GC, *et al*.; and Grouping C for Case Nos. 18-0037GC, *et al*.) , and the HRS cases dated October 19, 2022 (Grouping A for Case Nos. 14-2400GC, *et al*.; and Grouping B for Case Nos. 15-055G, *et al*.). These closure letters included similar findings as in these QRS group cases.

[35] The Board addressed the cases' impacted by this litigation under separate cover dated September 29, 2023 (lead Case No. 21-0971GC) similar to the letter issued in the instant cases.

[36] The Board addressed the cases' impacted by this litigation under separate cover dated September 29, 2023 (lead Case No. 13-3814GC) similar to the letter issued in the instant cases.

It is clear the Providers are pursuing the merits of their cases in these two (2) group cases as part of their lawsuit in the D.C. District Court. Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii), the Board is prohibited from further proceedings in these cases. Therefore, the Board must close these cases.[37]

However, the Board cannot permit QRS' reckless and contemptuous disregard for its ***basic*** responsibilities and due diligence as a representative appearing before the Board, its bypassing and abandonment of the jurisdictional review process, and its disregard for the Board's authority, orders and process, to remain unanswered. Accordingly, *if these cases are remanded for further proceedings*, the Board will complete its jurisdictional review and weigh: (a) the severity of QRS' violations of, as well as failure to comply with, Board Rules, regulations and Orders; (b) the prejudice to the Board and the opposing parties; (c) the interference with the speedy, orderly and fair conduct of the Board proceedings (regarding both these cases and others); and (d) the effect on the operations of the Board, when determining what, if any, remedial actions will be taken per 42 C.F.R. § 405.1868.[38] Examples of available remedial actions that the Board may consider to defend its authority resulting from QRS' numerous, egregious regulatory violations and abuses include, but are not limited to:

1. Dismissal of the two (2) group cases and all underlying participants.

2. Dismissal of any group case in which the Board identifies any jurisdictional or material procedural errors occurred, whether by one participant or more.

3. Dismissal of any participant for which there is an open jurisdictional challenge regardless of the merit of such challenge.

These potential actions are well within the Board's authority pursuant to 42 C.F.R. § 405.1868(a)-(b),[39] as confirmed in the preamble to the May 23, 2008 final rule:

---

[37] As noted in 42 C.F.R. § 405.1837(a), a group appeal may only have "a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." Similarly, as explained at 42 C.F.R. § 405.1842(d), "[a] provider (or, in the case of a group appeal, a group of providers) may request a determination by the Board that it lacks the authority to decide a legal question relevant to a specific matter at issue in an appeal." Accordingly, the Board must assume there are no other issues, particularly since: (1) the existence of other issues would necessarily mean that the Board would not have jurisdiction over the group until that defect was cured; and (2) the Providers did not identify any concurrent issues with the filing of the consolidated EJR request but rather claimed therein that the Board had jurisdiction over the groups.

[38] The Board's planned actions are consistent with those planned for QRS as laid out in **Appendix B**.

[39] 42 C.F.R. § 405.1868 states:

> (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.

(Emphasis added.)

> Most of the comments we received on this subject came from providers, and reflect a perceived disparate treatment by the Board when a provider, rather than an intermediary, fails to follow a procedural rule or timeframe set by the Board. We proposed two possible actions by the Board, one applicable to a provider and the other applicable to an intermediary. That is, the worst case scenario for a provider would be a dismissal of the appeal by the Board, while the harshest remedy for an intermediary would be the issuance of a decision by the Board based on the written record established at the point of the intermediary's violation. However, we note that, because providers are the proponents of a case, they are responsible for moving the case forward by meeting all deadlines. Additionally, at section 1878(e) of the Act, the Congress has given the Board authority to make rules and establish procedures to carry out its function. Moreover, we note that the Board will have broad discretion to weigh the particular facts at hand in order to decide whether or not an offense merits remedial action.
>
> ****
>
> Again, we are clarifying that the proposed rule did not identify a complete listing of all potential Board sanctions. The Board has the authority to take appropriate action against either party for procedural violations, but appropriate action does not necessarily mean a dismissal or the early issuance of a decision by the Board. We believe that these provisions will alert both parties that the Board has a mechanism in place to effectively stop a delaying tactic, or to redress other procedural violations. As a result, the parties should be less inclined to ignore procedural requirements and, accordingly, be more motivated to meet the deadlines set by the Board.[40]

Pursuant to the above, the Board has broad authority to sanction QRS for its repeated, and ongoing, malfeasance.

E. Board Decision and Order

Based on QRS' misconduct, the Board hereby takes the following actions:

1. Closes the two (2) group cases consistent with 42 C.F.R. § 405.1842(h)(3)(iii); and
2. Suspends the ongoing jurisdictional review process; and
3. Defers consideration of citing QRS for contempt and dismissing these group cases (and/or taking other remedial action to uphold the authority of the Board) based on QRS' numerous, egregious, regulatory violations and abuses until there is an

[40] 73 Fed. Reg. at 30225.

Administrator's Remand Order consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure ("FRCP") 62.1.[41]

Board Members Participating:

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

For the Board:

2/8/2024

X Clayton J. Nix

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

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

Enclosures:
Appendix A – Interim List of Potential Jurisdictional & Procedural Violations Under Review
Appendix B -- June 10, 2022 Board Letter to QRS Deferring Show Cause Order & Closure of Cases

cc: Dana Johnson, Palmetto GBA c/o National Government Services, Inc.
John Bloom, Noridian Healthcare Solutions
Geoff Pike, First Coast Service Options, Inc.
Wilson Leong, FSS
Jacqueline Vaughn, OAA

[41] FRCP 62.1 is entitled "Indicative Ruling on a Motion for Relief That is Barred by a Pending Appeal." While FRCP 62.1 is not directly applicable to the Board, the procedural developments in these cases are similar those addressed in FRCP 62.1 and the Board looked to it for guidance.

APPENDIX A

INTERIM LIST OF POTENTIAL JURISDICTIONAL, SUBSTANTIVE CLAIM, AND PROCEDURAL VIOLATIONS UNDER REVIEW[42]

The following summary of jurisdictional, substantive claim and procedural concerns and issues is preliminary and highlights the complexity of the jurisdictional review process.[43] This process is *exponentially* more complex when consolidated EJR requests are concurrently filed involving multiple group cases with 36 participants and when many of those cases are older cases (7+ years old).

The Board, through its ongoing review of jurisdiction, and other procedural issues, in these 8 group cases, has identified multiple, ***material*** jurisdictional issues and concerns that were not raised by FSS or the Medicare Contractors. The Board's review is based on the SoPs filed for these cases because, as explained at Board Rule 20.1.1 (Nov. 2021),[44] the SoPs are supposed to contain all relevant jurisdictional documentation for each participant in the group. The issues and concerns identified by the Board (thus far) include, but are not limited to, the following:

1. *Jurisdictional and Procedural Issues Raised in June 23, 2022 Scheduling Order*.— In its June 23, 2022 Scheduling Order, the Board raised some jurisdictional, claim-filing requirements and procedural issues and these remain open as the Board has not ruled on them yet.

2. *Participants That Did Not Properly Transfer Into the Group or Only Transferred a Portion of the Issue/Issues Covered By the Group*.— Four of the participants in these groups arrived by transfer from an individual appeal. For any participant that transfers into a group from an individual appeal, the Board must review whether the individual appeal properly included the issue the provider seeks to transfer. A provider can only transfer an issue that is properly existing in its individual appeal.[45] The Board expects it may identify participants with these types of jurisdictional transfer issues if it were to complete its jurisdictional review.

3. *Reviewing Scope of the EJR Request and Potential Improper Groups*.—In order for the Board to have jurisdiction over a group appeal, the group appeal must contain only one legal

---

[42] This listing is not exhaustive and only reflects preliminary findings and the Board has not yet completed or finalized its jurisdictional findings in these 36 group cases.

[43] 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. For example, whether an appeal was timely is not a jurisdictional requirement but rather is a claim filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013). *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*. Similarly, the Board notes that 42 C.F.R. §§ 405.1835(b) and 405.1837(c) address certain claim filing requirements.

[44] *See also* Board Rule 20.1 (Aug. 2018).

[45] The window to add issues to an individual appeal is limited by the regulation at 42 C.F.R. § 405.1835(e) as follows: "After filing a hearing request in accordance with paragraphs (a) and (b), or paragraphs (c) and (d), of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board only if – . . . . (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) or paragraph (c)(2), of this section." *See also* 42 C.F.R. §§ 405.1835(b), 1837(c), & Board Rule 8 for content and specificity requirements for issues being appealed.

question/issue.[46] Pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1837(a)(1), a group may only contain one legal issue. In pertinent part, § 405.1837(a)(1) states that "[a] provider . . . has a right to a Board hearing, as part of a group appeal with other providers, with respect to a final contractor or Secretary determination for the provider's cost reporting period, ***only if*** - . . . (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.[47] The Board is reviewing whether the Providers' consolidated EJR requests are ***improperly*** challenging *multiple* interpretations of law or regulation. In particular, the Board is reviewing whether the EJR request properly includes a challenge to the SSI eligibility codes used to identify the SSI days to be included in the numerator of the Medicare fraction (as embodied in PRRB Dec. No. 2017-D11[48]) in addition to the no-pay Part A days issue (as embodied in the *Empire* litigation decided before the Supreme Court[49]). If true, it raises ***immediate*** jurisdictional problems of whether the additional challenge(s) are *properly* part of the relevant groups[50] and, if true, requires determining: (1) whether each of the participants properly appealed additional issues[51] and, as relevant, whether it requested transfer of those additional issues to the group; (2) if a preliminary position paper was filed, whether the additional was properly briefed in the preliminary position paper in compliance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25[52]; and (3) whether the additional issues should be

---

[46] *See* 42 C.F.R. §§ 405.1842(a), 405.1842(f); 73 Fed. Reg. 30190, 30212 (May 23, 2008) (in response to comment that "the Board should have the authority to handle more than one question of fact or law in a group appeal" because "sometimes there is more than one disputed fact or question of law pertaining to a single item on the cost report" where "[a] common example of this is the [DSH] adjustment, which is determined by a combination of calculations, each of which may have more than one element in dispute", the Secretary affirmed that [t]he regulations at § 405.1837(a)(2) . . . specify that a group appeal involve a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group" and that "[w]hat constitutes an appropriate group appeal issue in a given case will be determined by the Board."). The Board further notes that 42 C.F.R. § 405.1839(b) (underline and bold emphasis added) states the following in relevant part:

> (b) *Group appeals*. (1) In order to satisfy the amount in controversy requirement under § 405.1837(a)(3) of this subpart for a Board hearing as a group appeal, 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.
> (2) *Aggregation of claims*. (i) For purposes of satisfying the amount in controversy requirement, group members are **not allowed to aggregate claims involving different issues**.
> (A) A group appeal must involve a **single** question of fact or **interpretation** of law, regulations, or CMS Ruling that is common to each provider (as described in § 405.1837(a)(2) of this subpart).

[47] (Emphasis added.)

[48] *Hall Render Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction v. Wisconsin Physicians Servs.*, PRRB Dec. No. 2017-D11 (Mar. 27, 2017).

[49] *Becerra v. Empire Health Found.*, 142 S. Ct. 2354 (2022), *reversing*, 958 F.3d 873 (9th Cir. 2020).

[50] This includes whether the group appeal request includes the additional issue and whether the final SoP filed in the relevant group establishes that the group meets the $50,000 AiC requirement for each of the additional issues. Per 42 C.F.R. § 405.1839(b), participants in a group are ***not*** permitted to aggregate claims involving different issues for purposes of meeting the $50,000 AiC requirement.

[51] Note that a proper appeal on an issue must include an AiC calculation for that issue. If the Providers were to claim that the group had multiple issues, then each participant would have a separate AiC calculation in the SoP *for* ***each*** *issue*. *See* 42 C.F.R. §§ 405.1839(b), 405.1837(c)(2)(iii). However, the Board's initial impressions are that each participant generally only has ***one*** AiC calculation behind Tab E in the relevant SoP.

[52] 42 C.F.R. § 405.1853(b)(2) and Board Rule 25 require the full briefing of each issue in a position paper filing. Consistent with this regulation and Board Rule 25, Board Rule 25.3 specifies that "[i]f the provider fails to brief an appealed issue in it is position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn."

bifurcated from the group per 42 C.F.R. § 405.1837(f)(2).[53] A critical aspect of the jurisdictional inquiry entails confirming that any potential bifurcation would not result in prohibited duplicate appeals by the same providers for the same issue and years. The Board has already flagged this issue in its letter dated July 22, 2022 and it was in the QRS' response to this inquiry that the Board learned of the litigation that QRS filed bypassing completion of the Board's administrative review process.

Notwithstanding the above jurisdictional issues and concerns, QRS made clear, with the June 10, 2022 filing of the Complaint in federal district court, that it was bypassing and abandoning the Board's jurisdictional review process (as discussed above).

[53] *See* 42 C.F.R. § 405.1837(a)(2) (stating providers have a right to participate in a group appeal only if "[t]he 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" (emphasis added)); 42 C.F.R. § 405.1837(f)(1) (stating "After the date of receipt by the Board of a group appeal hearing request under paragraph (c) of this section, a provider *may* ***not add*** *other questions* of fact or law *to the appeal*, regardless of whether the question is common to other members of the appeal (as described in § 405.1837(a)(2) and (g) of this subpart)."); 42 C.F.R. §§ 405.1835(b), 405.1837(c); Board Rules 7, 8, 12.2, 13, 16, 16.2.

APPENDIX B

June 10, 2022 Board Letter to QRS
Deferring Show Cause Order and Closure of Cases
Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii)
Due to QRS Filing in California Central District Court

(35 pages)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Scott Berends, Esq.
Federal Specialized Services
1701 S. Racing Avenue
Chicago, IL 60608-4058

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

RE: ***Deferring Show Cause Order & Closure of Cases***
Case No. 09-1903GC, *et al.* (*see* attached list of 80 group cases[1])

Dear Mr. Berends and Ravindran:

As the parties are aware, Quality Reimbursement Services, Inc. ("QRS"), the Providers' designated representative, filed a consolidated request for expedited judicial review ("EJR") on January 12, 2022 for the above-referenced 80 group cases involving, in the aggregate, over 950 participants.[2] On January 20, 2022, the Medicare Contractors' representative, Federal Specialized Services ("FSS"), requested an extension of time to review these 80 cases for jurisdictional issues due to the sheer size of these groups, the number of Medicare contractors involved and pending unresolved jurisdictional challenges filed in at least 8 of the group cases.[3] Shortly thereafter, on January 24, 2022, the Board issued a Notice of Stay and Scheduling Order ("Scheduling Order") to manage the jurisdictional review process for these 80 group cases and 950+ participants, assigning ongoing tasks to both parties and making known the Board's position that the 30-day period for responding to an EJR request does not begin until the Board finds jurisdiction pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842(b)(2). *Following the Board's Scheduling Order, the Providers were* ***silent*** *and* filed ***no objections*** *or requests for clarification with regard to the Scheduling Order*. On February 14, 2022, without notice to the Board or the opposing parties in these cases, QRS bypassed the ongoing jurisdictional review process by filing a lawsuit in the U.S.

[1] The Board has excluded Case No. 20-0162GC entitled "Hartford Health CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group" from the instant Scheduling Order because it was adjudicated by the Board and closed on March 17, 2022, several weeks prior to QRS' April 8, 2022 letter. Further, the Board added the optional group under Case No. 19-2515G entitled "QRS CY 2016 DSH Medicaid Fraction Dual Eligible Days Group" which was included in the EJR Request filed on February 16, 2022 that is identical to the one filed on January 20, 2022. *See* Board letter (Jan. 24, 2022) at n.26, n.27 for a more detailed explanation.

[2] *See supra* note 1.

[3] FSS' Response to Providers' Request for EJR (Jan. 20, 2022) identified the jurisdictional challenges as being pending and unresolved in the following 8 group cases:

- Case No. 18-1738GC (JC filed 10/14/21) because the providers improperly expanded the appeal request;
- Case No. 19-0014GC (JC filed 3/8/21) because several providers failed to include the group issue in their hearing request, failed to timely add the issue to their individual appeals and failed to properly transfer into the group and because the group providers improperly expanded their appeal request.
- Case No. 19-0164GC (filed 11/10/21) because: (1) the providers transferred the same issue to another group (Case No. 18-0037GC); and (2) the DSH – Medicaid Fraction/Dual Eligible Days issue was improperly/untimely added.
- Additional jurisdictional challenges have been filed in Case Nos. 14-1171G (filed 8/6/15), 14-1818G (filed 9/14/15), 14-3306G (filed 12/28/15), 14-3308G (filed 12/28/15) and 20-0244G (filed 6/24/21).

District Court for the Central District of California ("California Central District Court") seeking judicial review on the merits of its consolidated EJR request in these 80 cases. On March 14, 2022, FSS complied with the Board's Scheduling Order and timely filed the requisite responses. On April 8, 2022, ***roughly 2½ months after the Board's January 24, 2022 Scheduling Order***, QRS broke its silence and informed the Board and the Medicare Contractors of this lawsuit by filing the "Providers *Response* to PRRB's January 24, 2022 Ruling on FSS' Extension Request Relating to QRS' Combined EJR Request with respect to 80 Groups Case Nos. 09-1903, et at [*sic*]"[4] ("Providers' Response"). In its entirety, Providers' Response stated:

> In response to the Board letter dated January 24, 2022 in which the Board requested certain follow up action on the part of the Providers, the Providers respectfully note that they have filed a Federal complaint in the Central District of California based on the failure of the PRRB to render its EJR decision within 30 days. As such, the Providers consider that proceedings before the PRRB have been exhausted. Accordingly, the PRRB's previously established due dates no longer apply to the Providers.
>
> Should you have any questions, please contact the undersigned at [telephone number].

On April 18, 2022, FSS filed a request for dismissal of the Providers' cases for failure to comply with the Board's Scheduling Orders ("Request for Dismissal"). On April 24, 2022, the Board issued to the Providers an Order to Show Cause Why Dismissal Is Not Warranted ("Order to Show Cause") and the parties filed responses thereto.

As set forth in more detail below, the Board hereby takes the following actions:

1. Closes these 80 cases consistent with 42 C.F.R. § 405.1842(h)(3)(iii); and
2. Defers action on its Order to Show Cause, based on QRS' numerous, egregious, regulatory violations, until such time as there is an Administrator's Remand Order consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure ("FRCP") 62.1.[5]

Procedural Background

On January 12, 2022, QRS filed an EJR for the above 80 group cases.[6] *In the majority of these group cases*, QRS filed an electronic copy of the Schedule of Providers ("SoP"), with supporting

[4] (Emphasis added.)
[5] FRCP 62.1 is entitled "Indicative Ruling on a Motion for Relief That is Barred by a Pending Appeal." While FRCP 62.1 is not directly applicable to the Board, the procedural developments in these cases are similar those addressed in FRCP 62.1 and the Board looked to it for guidance,
[6] *See supra* note 1.

documentation, one or two days prior to the EJR request.[7] Per Board Rule 20.1.1 (Nov. 1, 2021), the SoP must "demonstrate[] that the Board has jurisdiction over ***each*** participant named in the group appeal."[8] Significantly, the overwhelming majority of these cases are *optional* groups and roughly 90 percent of the over 950 participants are in those *optional* groups. As explained at Board Rule 12.3.2 (Nov. 1, 2021), "[p]roviders not under common ownership or control may choose to join together to file an ***optional*** group appeal for a specific matter that is common to the providers for any fiscal year that ends in the same calendar year, but they are not required to do so."[9] In contrast, Board Rule 12.3.1 explains when a mandatory common issue related party ("CIRP") group appeal is required, "[p]roviders under common ownership or control that wish to appeal a specific matter that is common to the providers for fiscal years that end in the same calendar year ***must*** bring the appeal as a group appeal. See 42 C.F.R. § 405.1837(b)."[10]

On January 20, 2022, FSS requested a 60-day extension of time to review these 80 cases for jurisdictional issues "due to the sheer size of the groups, the recent closure of several of the groups and the number of [Medicare Contractors] involved."[11] FSS also noted that there were pending jurisdictional challenges in 8 of the 80 cases.[12] Finally, FSS noted that jurisdiction is paramount and maintained that its request was consistent with the intent of Board Rules 44.6 and 22 which give Medicare Contractors 60 days to review the final SoP (including the underlying jurisdictional documentation for each participant) and file jurisdictional challenges, as relevant, following receipt of the final SoP.

The January 24, 2022, Scheduling Order explained that, on March 25, 2020, the Board issued Alert 19 to notify affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." In Alert 19, the Board explained that the Board and CMS support staff temporarily adjusted their operations by maximizing telework for the near future.[13] The Scheduling Order further explained that, as the result of the surge in the Omicron variant of the COVID-19 virus, the skeletal Board staff that had returned to the office on a part-time basis, had resumed telework status.[14] While Alert 19 explained that, whenever possible, the Board planned to continue processing EJR requests within 30 days, the Board emphasized that it must have access to the jurisdictional documents to review and issue an EJR decisions. Accordingly, the Scheduling Order notified the parties in this case that it had stayed the 30-day period for responding to the EJR request for the above-captioned group appeals as follows:

---

[7] It appears that, in these situations, QRS was refiling an SoP previously filed.
[8] (Emphasis added.)
[9] (Emphasis added.)
[10] (Emphasis added.) Board Rule 12.3.2 is based on directive in 42 U.S.C. 1395oo(f)(1) and 42 C.F.R. 405.1837(b)(1)(i). In particular, this regulations states: "Two or more providers that are under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal."
[11] FSS' Response to Providers' Request for EJR (Jan. 20, 2022).
[12] *See supra* note 3.
[13] On January 14, 2022, the Secretary renewed the order finding that public health emergency exists as a result of COVID 19. *See* https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx.
[14] *See also infra* note 62.

> As you are aware, Board Rules require that Schedules of Providers ("SOPs") be filed in hard copy when, as is here, the group appeal has not been fully populated in OH CDMS. As the Board does not have access to the hard copy Schedules of Providers filed in the attached list of cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, *i.e.*, **whether "a provider of services may obtain a hearing under" the Board's governing statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); *see also* 42 C.F.R. § 405.1842(b)**. Accordingly, the Board: (1) will follow the standards set forth in the CMS regulations at 42 C.F.R. § 405.1801(d)(2) when calculating the Board's 30-day time period by excluding all days where the Board is not able to conduct its business in the usual manner; and (2) has stayed the 30-day period for responding to the EJR request for the above-captioned group appeals.[15]

In addition, the Scheduling Order set deadlines for each party to file and/or respond to any jurisdictional issues identified, and to upload any additional, relevant, documents or briefs to their respective cases in OH CDMS, to the extent that they were not already populated therein. Further, the Board requested that the record in these cases be supplemented with certain germane information from the individual appeals, from which participants had been transferred, to ensure the record before the Board was complete for purposes of the Board's jurisdictional review.[16] Finally, the Board noted that, per 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), and (e)(3)(ii), "jurisdiction is a prerequisite to consideration of an EJR request" and "this Scheduling Order necessarily affects the 30-day period for responding to the EJR request." In the footnote appended to this statement, the Board further explained that "A Board finding of jurisdiction is a ***prerequisite*** to any review of an EJR request pursuant to 42 C.F.R. § 405.1842 and the Board has the authority to request "[a]ll of the information and documents found necessary by the Board for issuing a[n EJR] decision[]" [i]ncluding documentation relating to jurisdiction. *See* 42 C.F.R. § 405.1842(e)(2)(ii) (referencing to the decision in subsection (f) which includes a decision on both jurisdiction and the EJR request)."[17]

---

[15] (Footnote omitted and bold and underline emphasis added.)

[16] Specifically, the Board stated: "The Board's preliminary review of the EJR request using its legacy docketing system, Case Tracker, shows that some of the participants transferred from individual appeals and that, in some cases, the relevant MAC had filed jurisdictional objections to the dual eligible days issue in the individual appeal and there were Provider responses. Further, there appears to be situations where the Board did not resolve that jurisdictional challenge. ***To ensure the record before it in these group cases is complete***, *the Board requests the parties to upload copies of these briefs and any relevant Board rulings to the Office of Hearings Case and Document Management System ("OH CDMS") in the appropriate group case* ***so that these documents may be considered as part of the Board's review of jurisdiction of the participants in these group cases***." Board letter (Jan. 24, 2022) (emphasis added).

[17] (Emphasis in original.)

Under Board Rule 44.3, if a party intends to respond to a motion, it must do so within 30 days, unless the Board imposes a different deadline. Significantly, QRS did not file any objection to FSS' request for an extension prior to the Rule 44.3 30-day time deadline. Nor did QRS file any objection to the Scheduling Order. QRS was simply silent.

On March 14, 2022, FSS complied with the Board's Scheduling Order and timely filed jurisdictional challenges in 15 distinct group cases. These challenges were different from, and in addition to, the 8 pending, unresolved, jurisdictional challenges that FSS noted in its initial January 20, 2022 response.[18]

On April 8, 2022, roughly 2½ months after the Board issued its Scheduling Order, QRS broke its silence to file the 4-sentence Providers Response[19] which, in whole, reads:

> In response to the Board letter dated January 24, 2022 in which the Board requested certain follow up action on the part of the Providers, the Providers respectfully note that they have filed a Federal complaint in the Central District of California based on the failure of the PRRB to render its EJR decision within 30 days. As such, the Providers consider that proceedings before the PRRB have been exhausted. Accordingly, the PRRB's previously established due dates no longer apply to the Providers.
>
> Should you have any questions, please contact the undersigned at [telephone number].

Providers' Response makes clear that the Providers are abandoning the Board's jurisdictional review process and are not complying with the Board's January 24, 2022 Scheduling Order by stating: "*the Providers consider that proceedings before the PRRB have been* ***exhausted*** [and] [a]ccordingly, the ***PRRB's previously established due dates no longer apply*** to the Providers."[20]

On April 18, 2022, FSS filed its Request for Dismissal wherein it requested the Board either: (1) dismiss these 80 cases for "failure to comply with Board rules and deadlines [in the January 24, 2022 Scheduling Order] and for, in essence, abandoning the issues before the Board" by filing a complaint in federal district court; or (2) "[i]n the alternative, . . . dismiss each of the cases for which the MACs have filed jurisdictional or substantive claim challenges."

---

[18] *See supra* note 3.

[19] Again, the Board notes that the caption for April 8, 2022 filing clearly notes it was intended as a response to the Board's Notice of Stay and Scheduling Order: "Providers Response to PRRB's January 24, 2022 Ruling on FSS' Extension Request Relating to QRS' Combined EJR Request with respect to 80 Groups Case Nos. 09-1903GC, et at (See Attached list)"

[20] Board Scheduling Order n.23 (Apr 21, 2022) (emphasis added).

In response to these filings, the Board issued an Order to Show Cause, on April 21, 2022, directing QRS to respond, no later than May 5, 2022, to FSS' Request for Dismissal and to Show Cause why the Board should not dismiss these 80 cases in their entirety based on:

- The Providers' failure to timely respond to the Medicare Contractor's Extension Request or the ensuing January 24, 2022 Board Scheduling Order to manage the Board's process for completing the requisite jurisdictional review.

- The Providers' abandonment of the Board's ongoing jurisdictional review process and refusal to comply with the Board's Scheduling Order for the management of that review process.

On May 5, 2022, QRS filed a response on behalf of the Providers urging the Board to not dismiss the cases because, "although it is the desire of the Providers to cooperate with the Board and the MAC, the Providers explain the basis for their commencement of an action in federal court, which the Providers continue to believe is legally appropriate, and why the Board should not dismiss these cases." QRS explains that it "did not respond to the Board's deadlines or to the MAC's filings because the Providers commenced an action in federal court and reasonably believed that further proceedings before the Board prohibited by regulation" and that they "notified the Board by letter dated April 8, 2022 that they had commenced an action in federal court." QRS contends that "[i]t was not until two weeks later when the Providers received the Board's April 21, 2022 letter that *the Providers became aware for the first time that the Board continued to believe that it retains responsibility over and would proceed with these cases*." In taking this position, the Providers readily recognize that they "are aware that there are other extenuating circumstances, such as COVID related staffing issues, which are hampering the Board's ability to process EJR requests."[21] However, "[w]hile sympathetic to those issues, the Providers believe that the statute's thirty-day deadline applies even if there are valid and compelling reasons why that deadline cannot be met." Finally, QRS asserts that "although the Providers have commenced an action in federal court, since the Board appears to believe that it retains authority over these cases, the Providers respond to the jurisdictional issues that Federal Specialized Services ("FSS") has raised."

Given the nature of QRS' response, and the arguments presented therein, the Board issued a Scheduling Order on May 6, 2022, directing that any response by FSS to QRS's filing must be filed no later than May 12, 2022. Accordingly, FSS responded on May 9, 2022 contending that:

1. The Providers' contention in its May 5, 2022 filing that the Board lacked the authority to allow the Medicare Contractors additional time to review and raise jurisdictional challenges was not timely and properly raised.

2. The Providers improperly waited nearly 2 months to advise the Board that such a complaint had been filed. The Providers' contention that CMS was responsible for advising the Board of a complaint's filing is countered by the fact that "there is no record that the summons was

[21] QRS letter dated May 5, 2022 filed in Case No. 09-1903GC, *et al*.

served" and that service did not occur until two months later on April 12, 2022 when an alias summons was issued in the case. Further, "when Providers finally notified the Board that a Complaint had been filed, they failed to set forth their basis for contending that such a complaint was procedurally proper; they failed to even identify the complaint they had filed.

3. The Providers failed to timely respond to any of the jurisdictional challenges raised by the Medicare Contractors.

4. After a lawsuit is filed, 42 C.F.R. § 405.1842(h)(3)(iii) does not prohibit further Board action to determine jurisdiction.[22]

Board Findings and Ruling:

The Board must decide what effect the Providers' filing of a lawsuit has on the proceedings before the Board in connection with the above-referenced 80 cases.

A. The 30-day Period For Responding to the Consolidated EJR Request Has Not Yet Begun and Bypassing the Completion of that Process Raises Fraud, Waste and Abuse Issues.

Parties to a Board appeal may request EJR pursuant to the provisions of 42 U.S.C. § 1395oo(f)(1) which states, in relevant part:

> Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. ***If a provider of services may obtain a hearing under subsection (a)*** and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). *The Board shall render such determination in writing within thirty days* ***after the Board receives the request and such accompanying documents and materials***, and the determination shall be considered a final decision and not subject to review by the Secretary.[23]

[22] 42 C.F.R. § 405.1842(h)(3)(iii) states, "If the lawsuit is filed before a final EJR decision is issued on the legal question, the Board may not conduct any further proceedings on the legal question or the matter at issue until the lawsuit is resolved."
[23] (Emphasis added).

To implement this statutory provision, the Secretary promulgated the regulation at 42 C.F.R. § 405.1842, setting forth the process for obtaining EJR, and the Board's obligations under the statute. As demonstrated by the following excerpts, 42 C.F.R. § 405.1842 makes clear that the 30-day clock for processing an EJR request does not begin until ***after*** the Board rules on jurisdiction:

> (a) *Basis and scope*. (1) This section implements provisions in section 1878(f)(1) of the Act that give **a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter** (as described in § 405.1840 of this subpart), and the Board determines it lacks the authority to decide the legal question (as described in § 405.1867 of this subpart, which explains the scope of the Board's legal authority).
>
> (2) A provider may request a Board decision that the provider is entitled to seek EJR or the Board may consider issuing a decision on its own motion. **Each EJR decision by the Board must include a specific jurisdictional finding on the matter(s) at issue**, and, where the Board determines that it does have jurisdiction on the matter(s) at issue, a separate determination of the Board's authority to decide the legal question(s).
>
> ****
>
> (4) **The provider has a right to seek EJR** of the legal question under section 1878(f)(1) of the Act ***only if***—
>
> (i) **The final EJR decision of the Board or the Administrator, as applicable, includes a finding of Board jurisdiction over the specific matter at issue a**nd a determination by the Board that it has no authority to decide the relevant legal question; or
>
> (ii) The Board fails to make a determination of its authority to decide the legal **question no later than 30 days after finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete**.
>
> (b) *General*—(1) *Prerequisite of Board jurisdiction*. The Board (or the Administrator) **must find that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question**.

> (2) *Initiating EJR procedures*. A provider or group of providers may request the Board to grant EJR of a specific matter or matters under appeal . . . . Under paragraphs (d) and (e) of this section, **a provider may request** a determination of the Board's authority to decide a legal question, but **the 30-day period for the Board to make a determination under section 1878(f)(1) of the Act** [*i.e.*, 42 U.S.C. § 1395oo(f)(1)] **does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete**.[24]

Clearly, when implementing 42 U.S.C. § 1395oo(f)(1) through 42 C.F.R. § 405.1842, the Secretary recognized that the 30-day period "does not begin to run ***until the Board finds jurisdiction*** to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete."[25] Moreover, the Board is bound by this regulation because, as stated in 42 C.F.R. § 405.1867, "[i]n exercising its authority to conduct proceedings under this subpart, *the Board must comply with all* the provisions of Title XVIII of the Act *and* ***regulations issued thereunder*** . . . ." Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

> Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.[26]

Thus, it is clear that the 30-day clock does not start until ***after*** the Board determines that it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) underlying an EJR request. Note that the Board's use of the term "stay" (as used in this

---

[24] (Emphasis added).
[25] 42 C.F.R. § 405.1842(b)(2) (emphasis added). *See also* 69 Fed. Reg. 35716, 35730 (June 25, 2004) (proposed rule explaining: "In proposed § 405.1842(b), we would set forth an overview of the EJR process. We believe that an overview would be helpful given the complexity of the process. In § 405.1842(b)(l), ***we would emphasize that a Board finding that it has jurisdiction*** *over the specific matter at issue* ***is a prerequisite*** *for its determination of its authority to decide the legal question*, and for the ensuing stages of the EJR process. Section 1878(f)(1) of the Act states that a provider may file a request for EJR '[i]f [such] provider of services may obtain a hearing under subsection (a) [which sets forth the jurisdictional requirements for obtaining a Board hearing].' In § 405.1842(b)(2) we would state that the EJR procedures may be initiated in two ways. First, a provider or group of providers may request the Board to grant EJR, or, second, the Board may consider on its own motion whether to grant EJR. We would also state in paragraph (b)(2), ***consistent with*** *the requirement that a Board finding of jurisdiction is a prerequisite of both the provider's ability to obtain EJR and the Board's authority to issue an EJR Decision*, that ***the 30-day time limit*** specified in section 1878(f)(l) of the Act for the Board to act on a provider's complete request ***does not begin to run until the Board has found jurisdiction*** on the specific matter at issue." (emphasis added)).
[26] (Emphasis added.)

and prior similar situations) in relation to the 30-day period for responding to the parties' EJR requests, was an inartful use of that term because the Board's intent was to simply notify the parties that the Board had not yet finished its jurisdictional review of the parties' EJR requests and, as such, the 30-day period for the review of the EJR requests had not yet commenced.

The Board notes that the Secretary had a sound basis for issuing 42 C.F.R. § 405.1842(b)(2). The statute itself states that a provider may be authorized to request EJR "***if*** [it] ***may obtain a hearing under subsection (a). . . .***"[27] Thus, as the Court in *Alexandria Hospital v. Bowen* ("*Alexandria*") noted, "the statute itself suggests that an EJR request need not be considered before the Board determines it has jurisdiction over an appeal. Moreover, the legislative history makes clear that in enacting the EJR provision, Congress sought solely to expedite resolution of the *legal* controversies in Medicare reimbursement appeals."[28] The Court in *Alexandria* continued, stating:

> Nor will the hospitals be heard to argue that the filing of an EJR request requires the PRRB to determine its jurisdiction over an appeal *and* respond to the EJR request within 30 days. Such an argument confuses what are in reality two separate analyses: jurisdiction and EJR. *The jurisdictional analysis determines whether the PRRB may consider a provider's appeal*. The EJR inquiry, on the other hand, determines whether a party properly before the PRRB raises issues which must be resolved before a court rather than the Board. *The language of the statute supports this distinction.* EJR requests relate to the authority of the PRRB to decide questions of law, not whether an appeal is properly before them. While Congress has clearly imposed a 30-day limit on the PRRB's evaluation of EJR requests, no such limits have been placed on the PRRB's evaluation of its jurisdiction. . . .
>
> The court is also unconvinced that Congress meant to require evaluation of EJR requests within a 30-day time frame when the PRRB has not made a jurisdictional determination. It makes no sense to require the PRRB to evaluate an EJR request they might never reach if the appeal is not properly before the Board. *Thus, the hospitals' argument that the PRRB absolutely must make an EJR determination within 30 days of document receipt is* ***without merit***.[29]

---

[27] 42 U.S.C. § 1395oo(f)(1) (emphasis added).
[28] *See* H.R. Rep. No. 96–1167, *reprinted in* 1980 U.S. Code Cong. & Ad. News at 5757; *Alexandria Hosp. v. Bowen*, 631 F. Supp. 1237, 1244 (W.D. Va. 1986); *San Francisco General Hosp. v. Shalala,* No. C 98-00916, 1999 WL 717830 (N.D. Cal. Sept. 8, 1999); *Total Care, Inc. v. Sullivan,* 754 F. Supp. 1097 (W.D. N.C. 1991); *Abington Mem'l Hosp. v. Bowen,* Civ. A No. 86-7262, 1988 WL 71367 (E.D. Pa. July 1, 1988); *Good Samaritan Hosp. v. Heckler*, No. CV84-L-459, 1986 WL 68497 (D. Neb. June 27, 1986).
[29] *Alexandria Hosp. v. Bowen*, 631 F. Supp. at 1244.

The *Alexandria* Court's conclusions are also supported by the practical considerations involved in the EJR process. If EJR requests were permitted to supersede jurisdictional determinations, there would be only two logical outcomes. The first is that jurisdictional determinations need never be made in cases where EJR requests are filed before a jurisdictional determination is reached by the Board. This would result in fraud, waste and abuse concerns if parties, unable to meet the Board's jurisdictional requirements, would still able to prevail in federal court, merely by filing an EJR request. The second conclusion is that federal trial courts would be forced to resolve jurisdictional disputes.[30] Not only are the federal trial courts ill-suited for making such determinations, it is a task assigned to the Board, *by statute*.

Significantly, in these 80 group cases, with over 950 participants, the Board has not yet completed its jurisdictional review to confirm whether it has jurisdiction to hear all of the providers' disputes raised in the EJR request. Having sufficient time to complete the jurisdictional and substantive claim review[31] process is important to ensure that the groups, and all of the underlying providers, are properly before the Board both generally and for the issue(s) raised in the EJR request. Further, the jurisdictional and substantive claim review process ensures that the groups, and underlying providers, have complied with the applicable Board regulations and rules (*e.g.*, have not previously withdrawn or been dismissed without being reinstated; are not pursuing a prohibited duplicate appeal of the same issue for the same year; and have complied with the mandatory CIRP group rules). Without a proper jurisdictional review, fraud, waste and abuse concerns could arise. Indeed, these concerns are very real and evident in these 80 group cases.

In compliance with the Board's January 24, 2022 Scheduling Order, the Medicare Contractors began submitting Jurisdictional Challenges in their respective cases. On March 14, 2022, FSS timely filed a comprehensive response noting that Jurisdictional Challenges and/or Substantive Claim Challenges had been filed in 15 of the 80 group cases encompassed in the instant EJR request. These challenges as well as separate challenges or jurisdictional issued raised by the Medicare Contractors directly (both prior to and after the consolidated EJR request was filed) include, but are not limited to:

- Jurisdictional challenges claiming that, pursuant to 42 C.F.R. § 405.1889(b), certain providers had no right to appeal a revised NPR for the group issue. Cases affected include Case Nos. 13-3191GC, 13-1440G, 13-2678G, 13-2693G; 14-1174G; 15-1067G; 15-2385G, 20-0250G, 20-0244G.

- Jurisdictional challenges identifying certain participants may not have been validly transferred from an individual appeal into the relevant group because the issue that the participant sought to transfer was not properly part of the individual appeal (*i.e.*, was

[30] It is hard to see federal courts deciding jurisdictional issues, including determining whether a case or provider: (a) has been previously withdrawn or dismissed without being reinstated; (b) is pursuing a prohibited duplicate appeal of the same issue for the same year; or (c) has complied with the mandatory CIRP group rules.
[31] As stated in Board Rule 44.5, "[t]he Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

neither properly part of the appeal request nor properly added pursuant to 42 C.F.R. §§ 405.1835(a)-(b), (e)). In some situations, the Medicare Contractor has suggested that the transferred issue is narrower than the group issue and, as such, that there has been an improper attempt to expand the issue from the individual appeal. Cases affected include Case No. 13-3191GC, 13-2678G, 15-2385G, 18-1738G, 19-0014GC, 19-0164GC.

- Jurisdictional challenges arguing that certain providers should be dismissed because they were already a participant for the same issue and year in another appeal. Cases affected include Case Nos. 15-0018G, 15-3031G, 15-3039G and 19-0164GC.

- Jurisdictional challenge claiming that certain providers should be dismissed because they appealed prematurely under 42 C.F.R. § 405.1835(c) for failure to timely issue a determination. Cases affected include 15-0018G and 15-1419G.

- A jurisdictional challenge that Case No. 15-1067G is not valid because the group failed to meet the minimum $50,000 amount in controversy as documented in the SoP and supporting documents filed for this group.

- A jurisdictional challenge in Case No. 15-2385G alleging that there is no documentation establishing that a provider was properly transferred into the group.

- Jurisdictional challenges identifying multiple providers that were ***improperly*** listed in the SoP after they were ***previously*** withdrawn by QRS, dismissed by the Board or its transfer to the group was denied. Cases affected include Case Nos. 13-2678G, 13-2693G, 13-1440G, 14-1174G, 15-1419G, 15-3031GC, and 15-3039G.[32]

- Jurisdictional challenges claiming that, because certain providers are commonly owned or controlled, they could be required to be part of a mandatory CIRP group. Accordingly, they may not be a participant in the relevant optional group and could be subject to dismissal. Cases affected include Case Nos. 15-1419G, 15-3031G, 18-1259G, 18-1260G.[33]

- Jurisdictional challenges raising questions whether QRS was an authorized representative of certain participants. Cases affected include Case Nos. 13-2678G, 13-2693G, 15-2385G.

- Jurisdictional challenges in Case No. 16-1142G, 18-1259G, and 18-1260G averring that the determination at issue for a participant was not included as required by 42 C.F.R. § 405.1835(b) and should be reviewed for dismissal.

[32] Most of the challenges for the withdrawn/dismissed participants are raised through exhibits attached to the jurisdictional challenges showing correspondence either from QRS withdrawing the participant or from the Board dismissing the participant and/or denying transfer to the relevant group.

[33] In one situation, the Medicare Contractor has identified a CIRP group for the same issue and year in which it believes the provider is a participant and, if so, that duplication would be a clear violation of the mandatory CIRP regulation and Board Rule 4.6 prohibiting duplicate appeals. In another, the Medicare Contractor identified 2 CIRP providers participating in the same *optional* group with an aggregate amount in controversy in excess of $50,000, which if true would violate the mandatory CIRP regulation.

- Jurisdictional issues noted in Cases No. 20-0248, 20-0250G, and 20-0411GC regarding certain providers that failed to properly establish an individual appeal prior to transferring to the group because they failed to *timely* file their individual appeal within the period allowed by 42 C.F.R. § 405.1835(a)(3).

- Jurisdictional challenges filed in Case Nos. 14-1818G, 14-3306G, 14-3308G allege that certain providers did not include a claim for the item on their cost report and did not identify the item as a self-disallowed cost by identifying the issue as a protested amount on their cost report.

- A substantive claim challenge[34] was filed for Case No. 19-2513 claiming that none of the providers included an appropriate claim for the appealed item in dispute as required under 42 C.F.R. § 413.24(j).

In addition, the Board through its ongoing review of jurisdiction, and other procedural issues, in these 80 group cases, has identified ***numerous, material,*** jurisdictional issues and concerns that were not raised by FSS or the Medicare Contractors. The issues and concerns identified by the Board include, but are not limited to, the following.

1. *Prohibited Duplicate Appeals*

   There are violations of Board Rule 4.6 prohibiting duplicate appeals. For example, the participants in Case No. 09-1903GC (BHCS 07 DSH Dual Eligible Days) are duplicative of the participants, and the cost reporting periods, at issue in Case Nos. 13-3896GC and 13-3938GC.

2. *Providers With No Appeal Rights*

   There are additional providers that, pursuant to 42 C.F.R. §405.1889(b), had no right to appeal a revised NPR for the group issue. Other examples outside of those identified by the Medicare Contractors include Case Nos. 20-0248G and 20-0250G.

3. *Improper Pursuit of Previously Withdrawn/Dismissed Participants in Excess of $1 million*

   There are a significant number of participants in these 80 groups for whom QRS is ***improperly*** pursuing reimbursement by including them on the Schedule of Providers even though they were either ***previously withdrawn by QRS*** from the relevant group case, the Board denied the transfer to the group appeal ***or*** the Board dismissed them. Although the Board has not completed its review, the following examples from only 8 of the 80 cases alone demonstrate that QRS is ***improperly*** pursuing reimbursement ***in excess of $1 million.***

[34] *See supra* note 31 (discussing what the Board's use of the term "substantive claim challenge" means).

Such action on the part of QRS raises significant fraud and abuse concerns,[35] and the Board takes administrative notice that this is not an isolated concern. Fraud and abuse concerns naturally arise in instances where a provider (or a provider representative) fails to follow Board Rules and the Board's governing regulations[36] by: (a) pursuing prohibited duplicate reimbursement claims for the same issue and year in multiple cases; or (b) pursuing reimbursement for issues that were previously formally withdrawn, or dismissed, and have not been reinstated by the Board. *To this end, a group representative has a responsibility to track and manage its cases and ensure due diligence is exercised* ***prior to*** *making filings.* Recent examples of group cases in which the Board has identified that QRS has improperly included previously dismissed or withdrawn providers on final SoPs without identifying those prior dismissals/withdrawals; ***or*** prior group cases in which withdrawals were ***required*** under settlement with the government but were not withdrawn, even after notification was sent to QRS separately by the relevant Medicare contractor or FSS

[35] Based on its preliminary review of just some of these cases, the Board fully expects to identify a significant number of other situations where QRS failed to remove withdrawn/dismissed providers from the SoPs, particularly in light of the age of the SoPs that QRS refiled and is relying on for its consolidated EJR request (*e.g.*, relying on 9+ year old SoPs in Case Nos. 13-3942G and 13-3944G where there are 106 participants in the aggregate). Indeed, the Medicare Contractors have already identified some of these other situations. *See supra* note 32 and accompanying text. Further, in its May 5, 2022 response to the Board's Show Cause Order, QRS sets forth in Exhibit 4 a listing of the 14 previously withdrawn/dismissed providers that the Medicare Contractors had identified *with an AIC in the aggregate of $1,054,115.* Seven of these 14 (with an aggregate AiC of $476,115) overlap with the Board's preliminary listing, *infra*, of previously withdrawn/dismissed providers:

- Case No. 13-2678G – #22 Leesburg RMC and #27 Union General Hospital; and
- Case No. 13-2693G – #26 Wuesthoff MC;
- Case No. 14-1174GC – #19 Shands Jacksonville Medical Center, #23 Leesburg Regional Medical Center, #28 Union General Hospital, and #39 MedCenter One Inc.

The ones not on the Board's list have an aggregate AiC of $578,000 and include:

- Case No. 13-2678G – #38 St. Alexius MC and #39 Bismarck MedCenter One;
- Case No. 15-0018GC – #4 Cox Medical Center;
- Case No. 15-1419G – #1 Lawrence & Memorial Hospital on SoP-A and #21 FF Thompson Hospital on SoP-B;
- Case No. 15-3031G – #26 Wilkes Regional MC; and
- Case No. 15-3039G – #25 Wilkes Regional MC.

Accordingly, the AiC of Board's preliminary listing of previously withdrawn/dismissed participants would increase from $1,038,115 to ***$1,616,115*** if these additional 7 are included. The Board is confident that it would identify additional instances if it were to complete its jurisdictional review process (*e.g.*, the Medicare Contractors identified Case Nos 13-1440G (C-4) and 14-1171G as having previously withdrawn/dismissed providers but those cases are ***not*** on QRS' list of 14). The Board listing, plus the Medicare Contractors listing, demonstrates the hollowness of QRS' offer to simply withdraw the 14 Providers the Medicare Contractors identified (roughly 30% of what has thus far been identified this issue). This is more than a mere oversight, as QRS clearly failed to exercise any, much less due, diligence, when it resubmitted stale SoPs concurrent with the consolidated EJR request.

[36] *See, e.g.*, 42 U.S.C. § 3729 (False Claims Act).

include: Case Nos. 10-0924GC,[37] 12-0281G,[38] 13-3075,[39] 13-3928G, 13-3941G,[40] 14-4385GC, 14-4386GC,[41] 14-4171GC, 14-4172GC,[42] 15-0020G, 15-1423G,[43] 15-0585GC, 15-0587GC,[44] 15-3484GC,[45] 15-1642GC, 15-1643GC, 15-1644GC, 15-1648GC, 15-2460GC, 16-1345GC, 16-1348GC, 16-1349GC,[46] 17-0568GC, and 19-2376GC. [47] These examples highlight, *at a minimum*, QRS' reckless disregard for its

---

[37] As part of an EJR determination dated August 2, 2019, the Board notified QRS that it had *improperly* included Participant #1 on the SoP because it had filed a void transfer request to transfer from a case which the Board had closed more than 3 years earlier -- Case No. 08-1716.

[38] As part of an EJR determination dated April 12, 2019, the Board notified QRS that it had "*improperly"* included Participant #9 on the SoP because the Board previously issued a determination denying jurisdiction over the Provider and its request to transfer to the respective group appeal.

[39] As part of an EJR determination dated April 4, 2019, the Board notified QRS that it had "*improperly"* included a Provider on the SoP for Case No. 13-3075GC because, on October 24, 201**3**, the Board had previously denied the request to transfer because the Provider did not timely appeal the issue for which transfer was requested.

[40] As part of an EJR determination dated April 8, 2019, the Board notified QRS that it had "*improperly"* included Rapid City Regional Hospital as a participant in the SoPs for Case Nos 13-3928G and 13-3941G because the Board previously had issued a determination denying jurisdiction over the Provider and its request to transfer to the respective group appeals.

[41] As part of an EJR determination dated June 24, 2019, the Board notified QRS that the SoP for Case Nos. 14-4385GC and 14-4386GC had failed to comply with Board rule by "*improperly*" including Scottsdale Osborn Medical Center because the Board had previously issued a determination denying jurisdiction over the Provider and its request to transfer to the respective group appeals.

[42] As part of an EJR determination dated September 30, 2021, the Board admonished QRS for "*improperly*" including Mercy Hospital Springfield on the SoP for Case No. 14-4171GC and 14-4172GC because the Board had issued a jurisdiction determination on March 25, 201**5** dismissing the dual eligible days issue as untimely added to Case No. 14-0460 and denying transfer from Case No. 14-0460 to the respective group appeals. The Board reminded QRS that it has a responsibility to track and manage its cases and ensure it exercises due diligence prior to making filings.

[43] As part of an EJR determination dated April 11, 2019, the Board notified QRS that it had "*improperly*" included Lawrence & Memorial Hospital on the SoP for Case No. 15-0020G and 15-1423G because the Board previously issued a determination dated November 7, 2016 (as modified by letter dated December 12, 201**6**) denying jurisdiction over the Provider and its request to transfer to the respective group appeals.

[44] As part of an EJR determination dated April 4, 2019, the Board notified QRS that it had "*improperly*" included 3 different providers on both the SoP Case Nos. 14-0585GC and 15-0587GC because, by letters dated May 14, 2015, July 9, 2015, November 17, 2015, the Board had denied transfers of those 3 providers to both Case Nos. 14-0585GC and 15-0587GC.

[45] As part of an EJR determination dated April 12, 2019, the Board notified QRS that it had "*improperly*" included a provider on the SoP even though the Board had denied jurisdiction in the individual appeal and denied transfer therefrom on February 23, 201**6** and, *following a request for reconsideration*, ***upheld*** that denial by letter dated June 17, 201**6**.

[46] QRS failed to withdraw a provider from Case Nos. 15-1642GC, 15-1643GC, 15-1644GC, 15-1648GC, 15-2460GC, 16-1345GC, 16-1348GC, and 16-1349GC even though: (1) the Bankruptcy Settlement Agreement entered into between the Provider and the CMS in June 2021 required within 30 days of the Bankruptcy Settlement Agreement's effectuation to "withdraw their participation in PRRB Appeals . . . or appeals pending in any venue or jurisdiction"; (2) On September 1, 2021 ,the Medicare Contractor notified QRS by email of its obligation to withdraw per the agreement; and (3) on September 17, 2021, the Medicare Contractor filed a Request for Dismissal of that provider from these cases based on QRS' in action. Notwithstanding, QRS took no action and, in particular, did not respond within the 30 days allotted under Board Rule 44.3 and, accordingly, the Board dismissed the provider and reprimanded QRS for its failure to comply with the Bankruptcy Settlement Agreement.

[47] In a Board determination dated August 12, 2020 on a Medicare Contractor challenge to certain issue transfers, the Board reopened Case No. 17-0568 to dismiss 2 providers that had *improperly* transferred from 10+ month ***closed*** cases, and reopened and rescinded the EJR determination for Case No. 17-0568GC in order to effectuate the void/invalid

basic responsibilities and due diligence as a representative appearing before the Board. As a representative with more than 1,500 open cases (of which there are more than 1,000 CIRP groups and 130 optional groups), QRS should be intimately familiar with the need to track and account for withdrawals and dismissals in its filings of SoPs with the Board[48] as well as Board Rule 47 addressing how a dismissed or withdrawn provider may be reinstated to an appeal.[49]

Especially egregious examples of QRS's failure to competently fulfil its responsibilities as a Provider Representative *in 8 of the instant 80 group cases* include:

a. Case No. 13-1419G – On January10, 2022, 2 days prior to filing its EJR request, QRS refiled what it identified as its original SoP dated June 4, 2014.[50] However, nearly 6 years after filing the original SoP, and nearly 2 years before refiling it as part of its EJR request, QRS *filed* ***in OH CDMS***[51] its withdrawal of Participant #11, St. Francis North Hospital (Prov. No. 19-0197, FYE 6/30/2006, amount in controversy ("AiC") $330,000) on February 25, 2020. Under Board Rules, withdrawals are self-effectuating.[52] Despite its withdrawal, QRS has continued to improperly include St. Francis North Hospital on the Final Schedule of Providers and pursue reimbursement.

---

transfers and dismissals. Further, the Board dismissed those same two providers from Case No. 19-2376GC as it had bifurcated from 17-0568GC and their participation in Case No. 19-2376GC depended on the validity of was dependent on that bifurcation. Finally, the Board admonished QRS, as the Group Representative (as well as the Representative in the individual cases) for submitting transfer requests from these individual appeals to Case No. 17-0568GC that they should have known were both invalid and void since the individual cases had been closed for over ten months when the transfer requests were made. The Board reminded them that as representatives they have the responsibility to track and manage their cases and ensure they exercise due diligence prior to making filings.

[48] The Board has identified one SoP where QRS noted withdrawals. The SoP for Case No. 15-0018G that is attached to the January 12, 2022 consolidated EJR request shows an example of an SoP where QRS *correctly* noted 2 separate providers that were previously withdrawn – Participant #3, Prov. No. 19-0125, on SoP-A and Participant #20, Prov. No. 33-0074, on SoP-B. Similarly, the cover letter to the SoP filed in Case No. 14-2217GC includes the withdrawal of 2 participants, Prov. Nos. 340158 and 34-0183, and neither of these withdrawn participants were included on the attached SoP.

[49] For example, QRS filed an *amicus curiae* brief in support of the hospitals position in the case, *Baptist Memorial Hospital-Golden Triangle v. Sebelius*, 566 F.3d 226 (D.C. Cir. 2009) ("*Baptist*"). In *Baptist*, the D.C. Circuit found the following: "Notwithstanding the clear directions in the [PRRB] Instructions, the hospitals *gamely* argue that they did not need to follow the Instructions to reinstate a previously **dismissed** appeal. . . . The hospitals cannot so easily evade the plain meaning of the Instructions. The relevant reinstatement provision quite clearly explains how to reinstate appeals for failure to file a timely position paper and lists certain requirements for doing so—including that the party "explain in detail" its reason for non-compliance." (Emphasis added.)

[50] The cover letter transmitting the SoP with supporting jurisdictional documentation is dated June 26, 2004 and the attached SoP lists the "date prepared" as June 4, 2014. Further, the caption for the filing in OH CDMS identifies the filing as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the 700+ pages of attachments.

[51] The Board's electronic filing system is known as the Office of Hearings Case and Document Management System ("OH CDMS") and was launched on a voluntary basis in August 2018. The Board implemented mandatory electronic filing on November 1, 2021. The OH CDMS records readily available to the parties for Case No. 13-1419G show that Philip Payne of QRS filed the request for withdrawal on February 25, 2020 at 3:04 pm.

[52] *See* Board Rule 46 (stating "NOTE: A provider's request for withdrawal is self-effectuating and does not require any action by the Board once it is filed. Notwithstanding, the Board or Board Staff generally will issue a notice

b. Case No. 13-1440G – On January 10, 2022, 2 days prior to filing its EJR request, QRS refiled what is identified as its original SoP dated June 4, 2014.[53] However, by letter dated October 16, 2017, the Board issued its decision to QRS denying the transfer of Participant #14, Cape Fear Valley Medical Center (Prov. No. 34-0028, FYE 9/30/2006, AiC $38,000) from Case No. 13-3632 to Case No. 13-1440G. Notwithstanding the denial, QRS has continued to improperly pursue reimbursement for that provider on the Final SoP submitted with the instant EJR Request and failed to include the Board's dismissal in the documentation attached to that Schedule of Providers.

c. Case No. 13-2678G – On January 11, 2022, one day prior to filing its EJR request, QRS refiled what it identified as its original SoP dated October 27, 2014.[54] However, QRS failed to update the SoP to reflect the following dismissals and withdrawals that occurred subsequent to the original 2014 filing. Furthermore, QRS continues to pursue reimbursement on behalf of these Providers *after* they had been removed from Case No. 13-2678G.

   i. On April 29, 2015, QRS withdrew Participant #22, Leesburg Regional Medical Center (Prov. No. 10-0084, FYE 6/30/2007, AiC $55,115).

   ii. On May 17, 2016, QRS withdrew Participant #18 Shands Jacksonville Medical Center (Prov. No. 10-0001, FYE 6/30/2007, AiC $24,000) following a Board request dated May 7, 2016 for QRS to provide a copy of the missing letter of authorization from the Provider.

   iii. On April 15, 2015, the Board notified QRS that, in connection with Participant #27 Union General Hospital (Prov. No. 11-0051, FYE 4/30/2007, AiC $22,000) the Board was dismissing the DSH Dual Eligible Days (Medicaid and SSI Fraction), and other issues in Case No 13-1904 and denying transfer of that issue to 13-2678G.

d. Case No. 13-2693G – On January 11, 2022, one day prior to filing its EJR request, QRS refiled roughly 4/5 of its original SoP, dated October 27, 2014,[55] and the

---

acknowledging the withdrawal when it results in the closure of a case. The Board does not issue a similar notice when the withdrawal does not result in the closure of the case.").

[53] The cover letter transmitting the SoP with supporting jurisdictional documentation is dated June 26, 2004 and the attached the SoP lists the "date prepared" as June 4, 2014. Further, the caption for the filing in OH CDMS identifies the filing as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the 700+ pages of attachments.

[54] The cover letter transmitting the SoP with supporting jurisdictional documentation is dated October 28, 2014 and the attached SoP lists the "date prepared" as October 27, 2014. Further, the caption for the filing in OH CDMS identifies the filing as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the roughly 1950 pages of attachments.

[55] The cover letter transmitting the SoP with supporting jurisdictional documentation is dated October 28, 2014 and the attached SoP lists the "date prepared" as October 27, 2014. Further, the caption for the filing in OH CDMS identifies the filing as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the 2130+ pages of attachments.

remaining 1/5 of that document on January 19, 2022, one week after filing its EJR request.[56] However, in December 2017, the Board notified QRS of its decision to deny transfer of Wuesthoff Memorial Hospital (Prov. No. 10-0092, FYE 9/30/2008) from Case No. 13-2106 to Case No. 13-2693G because the revised NPR at issue did not adjust the issue for which transfer was requested. Notwithstanding, QRS has continued to improperly pursue reimbursement for the Provider as Participant #26 on the SoP with an AiC of $115,000.

e. Case Nos. 13-3942G and 13-3944G – On January 11, 2022, one day prior to filing its EJR request, QRS refiled what it identified as its original SoPs for Case Nos. 13-3942G and 13-3944G which are each ***dated December 2, 2012***.[57] However, on May 24, 2017, the Board notified QRS of its decision to deny the transfer of Rapid City Regional Hospital (Prov. No. 43-0077, FYE 6/30/2009) from Case No. 14-1297 to Case Nos. 13-3942G and 13-3944G because the Provider did not timely file its individual appeal request. Notwithstanding, QRS continues to improperly pursue reimbursement for the Provider as Participant #47 on the SoP for Case No. 13-3942G with an AiC of $21,000 and as Participant #44 on the SoP for Case No. 13-3944G with an AiC of $105,000.

f. Case No. 14-1816G—On January 11, 2022, one day prior to filing its EJR request, QRS refiled what it identified as its original SoPs for Case No. 14-1816G which is dated April 7, 2015.[58] However, on November 18, 2015, the Board notified QRS of its decision to deny the transfer of Larkin Community Hospital from Case No. 14-3904 because the Provider's original individual appeal request did not include the SSI fraction dual eligible days issue (nor was it timely added to the case). Notwithstanding, QRS continues to improperly pursue reimbursement for the Provider as Participant #8 on the SoP with an AiC of $44,000.

g. Case No. 14-1174G – On January 11, 2022, one day prior to filing its EJR request, QRS refiled its original SoP, dated March 20, 2015.[59] However, QRS failed to update

[56] As the SoP with supporting documentation and cover letter consists of 2137 pages, QRS divided the filing into 5 parts and uploaded parts 1, 2, 4 and 5 on January 11, 2022 and the missing part 3 on January 19, 2022, a week after it had filed the consolidated EJR request on January 12, 2022.

[57] While the cover letters transmitting the SoPs with supporting jurisdictional documentation for Case Nos. 13-3942G and 13-3944G are dated December 30, 2014 and December 26, 2014 respectively, each of the attached SoPs list the "date prepared" as December 2, 2012. Further, the caption for the filing in OH CDMS identifies these filings as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the aggregate roughly 3900 pages of attachments to these SoPs (1980+ pages for Case No. 13-3942G and 1900+ pages for Case No. 13-3944G).

[58] The cover letter transmitting the SoP with supporting jurisdictional documentation is dated April 28, 2015 and the attached SoP lists the "date prepared" as April 7, 2015. Further, the caption for the filing in OH CDMS identifies the filing as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the 863 pages of attachments.

[59] The cover letter transmitting the SoP with supporting jurisdictional documentation is dated March 31, 2015 and the attached SoP lists the "date prepared" as March 20, 2015. Further, the caption for the filing in OH CDMS identifies the filing as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the 2250 pages of attachments.

the SoP to reflect the following dismissals and withdrawals that occurred subsequent to the original 2015 filing and, as such, is improperly pursing reimbursement on behalf of these providers.

i. By letter dated April 7, 2015, the Board notified QRS that the Board was dismissing Case No. 13-2753 for Bismarck MedCenter One (Prov. No. 35-0015, FYE 12/31/2007) in its entirety and denied transfer of the DSH SSI Fraction/Dual Eligible days issue to Case No. 14-1174G. QRS has continued to improperly pursue reimbursement for the Provider as Participant #39 on the SoP with an AiC of $50,000.

ii. By letter dated April 15, 2015, the Board notified QRS that the Board was dismissing all issues except the rural floor budget neutrality adjustment ("RFBNA") issue in Case No. 13-1904 for Union General Hospital (Prov. No. 11-0051, FYE 4/30/2007) because QRS *only* obtained authorization to act on behalf of the Provider for the RFBNA issue. Accordingly, the Board denied the transfer of the Dual Eligible Days (Medicaid & SSI fractions) issue from Case No. 13-1904 to Case No. 14-1174G. However, QRS has continued to improperly pursue reimbursement for the Provider as Participant #28 on the SoP with an AiC of $10,000.

iii. On April 29, 2015, QRS filed its request to withdraw Leesburg Regional Medical Center (Prov. No. 10-0084, FYE 6/30/2007) from Case No. 14-1174G (among others). Despite its withdrawal, QRS continues to improperly pursue reimbursement for the Provider as Participant #23 on the SoP with an AiC of $138,000.

iv. On May 17, 2016, QRS filed its request to withdraw Shands Jacksonville (Prov. No. 10-0001, FYE 6/30/2007) from Case No. 14-1174G (among others). Despite this withdrawal, QRS has continued to improperly pursue reimbursement for the Provider as Participant #19 on the SoP with an AiC of $86,000.

4. Prohibited Participation of CIRP Providers in Optional Groups

There are additional violations, or potential violations, of the mandatory CIRP group requirements at 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R § 405.1837(b)(1). For example, on March 17, 2022 (several weeks prior to QRS' April 8, 2022 letter), the Board issued a request for additional information in two *optional* group cases (Case Nos. 19-2513G and 19-2515G), identifying potential CIRP compliance issues and QRS submitted a partial response.[60] The Board has a similar open inquiry from January 2021 on the participation of Deaconess Medical Center in Case No. 17-1412G notwithstanding the fact that the provider is part of Empire Health and Empire Health has an open CIRP group for the same issue and year under Case No. 17-0554GC. Upon further review, the Board would issue similar

[60] The mandatory CIRP regulation applies to commonly owned ***or*** *controlled* providers. QRS' response failed to address one provider and, for 2 providers, the response did not adequately address whether there was "control" (*e.g.*, control of the provider through a management agreement).

development letters for CIRP issues identified in other groups, including Case Nos. 13-1419G, 13-3942G, 13-3944G 15-0018G, 15-1419G, 15-3039G, and 16-1750.

5. *Unauthorized Representation of Participants*

   The Board has identified multiple situations where QRS failed to obtain proper authorization from the provider to be a participant in the relevant group. In these situations, the Board has dismissed the provider from the group. For example, in Case No. 13-1419G, QRS failed to provide documentation of proper authorization from Participant #2, Pacifica Hospital of the Valley ($13,000 AiC). Board Rule 5.4 (Mar. 2013) specifies that "[t]he letter designating the representative must be on the Provider's letterhead and be signed by an owner or officer of the Provider" and "must reflect the Provider's fiscal year under appeal." Contrary to Board Rule 5.4, the authorization letter is not on hospital letterhead and does not identify the organization to which the signatory belongs.

6. *Participants That Did Not Properly Transfer Into the Group or Only Transferred a Portion of the Issue/Issues Covered By the Group*.— The majority of the 950+ participants in these groups arrived by transfer from an individual appeal. For any participant that transfers into a group from an individual appeal, the Board must review whether the individual appeal properly included the issue the provider seeks to transfer. A provider can only transfer an issue that is properly existing in its individual appeal.[61] The Medicare Contractors, as discussed *infra*, have already identified issues with some transfers and the Board expects it would identify additional issues if it were to complete its jurisdictional review.

7. *Participants that Fail to Have Both Issues Covered by the EJR Request*.— The EJR request pertains to the DSH adjustment calculation and covers two separate issues where one pertains to the SSI fraction and the other to the Medicaid fraction as used in that calculation. Thus, for each year, a participant tends to be in two groups – one for the SSI fraction issue and one for Medicaid fraction issue. The Board is aware that some providers are participants in only one of the fraction groups (*e.g.*, a participant in the SSI fraction group but not the Medicaid fraction group or vice versa). In those instances, the Board must assess whether the provider can remain in the group and, if so, to what extent the EJR applies.

Notwithstanding the above jurisdictional issues and concerns, QRS made clear, in its April 8, 2022 filing, that it had abandoned the Board's jurisdictional review process as discussed above. QRS reinforced its intent in the Providers' response to the Board's Order to Show Cause, as shown by the following excerpts:

[61] The Board notes that the window in which issues can be added to an individual appeal is limited by regulation at 42 C.F.R. § 405.1835(e) which states in pertinent part: "After filing a hearing request in accordance with paragraphs (a) and (b), or paragraphs (c) and (d), of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board only if – . . . . (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) or paragraph (c)(2), of this section." *See also* 42 C.F.R. § 405.1835(b) and Board Rule 8 for content and specificity requirements for issues being appealed.

- "The Board, however, failed to render its decision within the thirty-day period. Instead, partly at the request of FSS, the Board informed the Providers that the Board required an additional sixty days to review jurisdictional documents.[1]"

- Footnote 1, appended to the above quote, reads: "*The Providers are aware that there are other* ***extenuating circumstances***, such as COVID related staffing issues which are hampering the Board's ability to process EJR requests. While certainly sympathetic to those issues, the Providers believe that the statute's thirty-day deadline applies even if there are valid and compelling reasons why that deadline cannot be met. The Providers' filing of their EJR complaint, therefore, should not be viewed as casting aspersions on the pace with which the Board is addressing these issues in any way. It simply reflects the objective fact that a decision was not issued within thirty days."[62]

While QRS' April 8, notice did not provide the case number assigned to the Complaint the Providers filed in federal court, PACER (the federal courts' filing system) verifies that the Providers' Complaint, relevant to this decision, was filed in federal district court on February 14, 2022. However, QRS waited nearly two months (54 days) to notify the Board, FSS and the Medicare contractors of the Complaint and its position that the Board proceedings were otherwise

[62] Provider's Response to FSS' Request for Dismissal at n.1 (May 5, 2022). In this situation, it is unrealistic and naive for QRS to expect the Board to complete the prerequisite jurisdictional review process, as well as a review of the EJR request, itself within 30 days. The unreasonableness of QRS' position is highlighted by the following facts:

- The consolidated request consists of 80 cases involving over 950 participants;
- The SoPs with supporting documentation involve tens of thousands of documents. For example, the 8 cases identified as improperly listing previously dismissed/withdrawn participants (Case Nos. 13-1419G, 13-1440G, 13-2678G, 13-2693G, 13-3942G, 13-3944G, 14-1174G, and 14-1816G) involve, in the aggregate, nearly 12,500 pages of attachments which averages to roughly 40 pages per participant (12,473 pages/315 participants). Projecting that to the 950+, the Board estimates that the SoPs for these 80 cases involve over 37,000 pages of documentation related to jurisdiction.
- The majority of the cases at issue are legacy cases and were not filed initially in OH CDMS. As a result, the jurisdictional documentation was filed in hard copy.
- The Agency, including the Board has been in maximum telework status since March 2020 with limited and, at times, no access to hard copy files and filings. Indeed, during the 30 days immediately following the filing of the January 12, 2022 consolidated EJR request, the Baltimore/DC metro area was experiencing the effects of the surge in COVID-19 cases due to the Omicron variant and the Agency remained in maximum telework status and no staff members were in the Board's offices until mid-February 2022 when certain skeletal staff members began coming into the Board's offices. The Agency only lifted that status on May 23, 2022.
- Review and navigation of scanned PDF copies of SoPs is exponentially more time consuming that review of a hard copy SoP that is tabbed and documents can be accessed both horizontally and vertically. As set forth in Board Rule 21, the SoP is organized by participant (Tab 1 is participant 1, Tab 2 is participant 2, etc.) and each participant's jurisdictional documents are organized by Tabs A through H. An example of horizontal access is reviewing the jurisdictional documentation provider by provider. An example of horizontal access is solely looking at the representation letter housed behind Tab H of each provider and this type of access is important for purposes of consistency and quality control. As the PDF documents upload here do not have bookmarks, vertical navigation is not an immediate resource. Some of the optional groups are very large making navigation of an SoP, such as flipping between providers, very challenging. For example, Case No. 13-2693G involves 54 participants and the SoP is spread across 5 pdf documents containing 2137 pages, in the aggregate (and, again, contains no bookmarks to facilitate navigation).

"exhausted"/done.[63] This delay caused significant waste of the Board's limited resources, as well as those of FSS and the Medicare contractors servicing the 950+ participants in the 80 group cases.[64] More concerning is QRS' attempt to undermine, and bypass, the Board's regulatory and statutory duty to conduct a complete and thorough jurisdictional review process for all of the participants in these cases. QRS essentially self-declared that all 950+ participants in these groups have a right to pursue EJR in federal district court (regardless of whether the Board has jurisdiction over such providers, including instances of previously dismissed or withdrawn providers). If the Providers were successful on the merits of their claims in federal court, then bypassing the Board's jurisdictional review process could result in millions of dollars being improperly paid.[65]

Accordingly, based on QRS' failure to comply with the Board's filing deadline set forth in its Scheduling Order, the Board exercised its authority under 42 C.F.R. § 405.1869(b)(2) and required QRS to show cause why the Board should not dismiss the appeals in the attached listing based on:

- QRS' failure to timely respond to the Medicare Contractor's Extension Request or the Board's ensuing Scheduling Order to manage the Board's process for completing the requisite jurisdictional review.

- QRS' abandonment of the Board's ongoing jurisdictional review process, and refusal to comply with the Board's Scheduling Order for the management of that review process.

B. Board Deferment of its Order to Show Cause Why Dismissal is Not Appropriate

42 C.F.R. § 405.1842(h)(3) addresses how Provider lawsuits relating to an EJR request affect Board proceedings:

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

[63] While the notice identified the jurisdiction in which the lawsuit was filed, it did not include either a copy of the complaint, the date the lawsuit was filed, or the case number established for the lawsuit.
[64] The Board takes administrative notice that it has a very large docket of pending cases (9485 as of April 1, 2022) and is processing many EJR requests involving multiple thousands of participants. As of April 8, 2022, ***in addition to*** *the 80 cases covered in this notice*, the Board had 253 cases with EJR requests pending of which 130 were filed by QRS. On or after April 8, 2022, EJR requests were filed for an additional 207 cases of which 154 were filed by QRS. As these cases were primarily group cases, they involved thousands of participants in the aggregate.
[65] As explained *supra*, a partial review of just 8, of the 80, group cases being pursued as part of the ongoing lawsuit reveals previously withdrawn/dismissed participants accounting for approximately $1 million in controversy on the related SoPs.

****

> (iii) *If the lawsuit is filed before a final EJR request is issued on the legal question*, ***the Board may not conduct any further proceedings*** on the legal question or the matter at issue until the lawsuit is resolved.[66]

The Board initially suggested, in its letter dated April 21, 2022, that the clause "proceedings on the legal question or matter at issue" in § 405.1842(h)(3)(iii) only addressed proceedings "on the substance of the EJR request and does not address pre-requisite jurisdiction or other procedural issues that may arise in an appeal or proceedings before the Board." However, upon further reflection, the Board agrees that this regulation ***bars any further Board proceedings*** in these 80 group cases, including proceedings on pre-requisite jurisdictional issues or other procedural issues. Consistent with FRCP 62.1, the Board issues this ruling on a Motion for Relief that is barred by a pending appeal and, as explained below, is deferring consideration of its Order to Show Cause until, or if, the Administrator remands these cases back to the Board.

In response to the Board's April 21, 2022 Order to Show Cause, QRS asserted that it "did not respond to the Board's deadlines or to the MAC's filings because the Providers commenced an action in federal court and *reasonably believed that further proceedings before the Board prohibited by regulation*."[67] QRS then stated that it "notified the Board by letter dated April 8, 2022 that [the Providers] had commenced an action in federal court" and that "[i]t was not until two weeks later when the Providers received the Board's April 21, 2022 letter that the Providers became aware for the first time that the Board continued to believe that it retains responsibility over and would proceed with these cases." QRS further stated that, based on § 405.1842(h)(3)(i), it "presumed that the Office of the Attorney Advisor within CMS would promptly notify the Board of the suit" and "regret that apparently this did not happen, and we apologize for not doing more to proactively notify the Board regarding the filing of the complaint ourselves."

FSS in its May 5, 2022 response, suggested that QRS' response was disingenuous in presuming that the CMS Office of Attorney Advisor would promptly notify the Board of the Providers' lawsuit, filed by QRS, because QRS had failed to properly serve the Secretary until April 12, 2022 with an alias summons:

> Though Providers filed their Complaint on February 14, 2022, they waited until April 8, 2022 (nearly two months later) to advise the Board that such a complaint had been filed. Providers contend that CMS was responsible for advising the Board of a complaint's filing but there is no record that the summons was served and on April 12, 2022, an alias summons was issued in the case. Such a summons would not be necessary if Providers had effected service in the first instance. Again, when Providers finally notified the Board that a

[66] (Emphasis added.)
[67] (Emphasis added.)

> Complaint had been filed, they failed to set forth their basis for contending that such a complaint was procedurally proper; they failed to even identify the complaint they had filed. Providers, likewise, failed to timely respond to any of the jurisdictional challenges raised by the MAC.

The Board subsequently reviewed the preambles to the proposed rule, dated June 5, 2004,[68] and the May 23, 2008 final rule[69] that promulgated the regulation at 42 C.F.R. § 405.1842(h)(3)(iii). The preamble to the proposed rule described this regulation as follows:

> Proposed § 405.1842(h)(3) would specify the effect that a provider lawsuit would have on the Board's ability to conduct further proceeding on the legal matter at issue. In general, if a provider files a lawsuit on the same legal issue for the same cost year that is currently pending before the Board - that is, the provider goes into court without waiting for a final administrative decision on EJR, we would seek to have the lawsuit dismissed, and we would prohibit the Board from conducting further proceedings on that issue until the lawsuit is resolved.[70]

The final rule includes additional guidance on § 405.1842(h)(3):

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

[68] 69 Fed. Reg. 35716 (June 25, 2004).
[69] 73 Fed. Reg. 30190 (May 23, 2008).
[70] 69 Fed. Reg. at 3572

> intermediary to spend its limited resources to spend time on a Board appeal if the provider has filed a complaint that involves a legal matter that is relevant to a legal issue in the Board appeal. If the court properly has jurisdiction over the appeal, the decision, that it or a higher court renders, may resolve the issue or issues in the Board case, or otherwise inform the Board in reaching a decision, or affect the parties' decision as to whether they should attempt to settle the Board case. On the other hand, where the basis for the court's jurisdiction is defective (which we believe would most likely be the situation when a provider attempts to file a complaint based on a legal issue related to an appeal still pending before the Board), a contrary rule would not discourage providers from filing improper appeals with the court. We believe our proposal to be in line with the general rule practiced by courts that an appeal to a higher court deprives the lower court of jurisdiction to conduct further proceedings until the appeal is resolved by the higher court.[71]

Based on the above explanation regarding the intent and purpose for 42 C.F.R. § 405.1842(h)(3)(iii), the Board finds that QRS' filing of the Complaint in the California Central District Court prohibits the Board from conducting any further proceedings on the EJR request for the cases as filed above, including any proceedings related to the prerequisite jurisdiction.

In so ruling, the Board notes that QRS created the confusion surrounding the status of these cases at the Board. QRS readily admits that, once it filed the Complaint in federal district court on February 14, 2022, they "*reasonably believed that further proceedings before the Board were prohibited by regulation*"[72] and stated that they did not notify the Board of that filing because, based on § 405.1842(h)(3)(i), they "presumed that the Office of the Attorney Advisor within CMS would promptly notify the Board of the suit." However, the Board finds QRS' reliance on § 405.1842(h)(3)(i) to be misplaced and not made in good faith. Namely, it ignores both the Board's ruling in its January 24, 2022 Scheduling Order and the Providers' obligations under Board Rules. Pursuant to Board Rule 1.3 (Nov. 1, 2022),[73] QRS had a duty to communicate early and in good faith with the Board and the opposing party (in that regard the Secretary is not a party per 42 C.F.R. § 405.1843(b)):

---

[71] 73 Fed. Reg at 30214-15.
[72] (Emphasis added.)
[73] The recent changes to the Rules (effective Nov. 1, 2021) were first published in June 16, 2021 and, in advance of their effective date, invited comments from all interested individuals, providers, government contractors and other organization to be submitted by July 30, 2021. Subsequently on September 30, 2021, based on its review of that feedback, the Board then published further revisions to the Rules (effective Nov. 1, 2021). *See* Board Order No. 1 (available at: https://www.cms.gov/files/document/revised-prrb-rules-v-30-cover-order-1-superseded-v-31.pdf); Board Alerts 21 and 22 (available at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Alerts); Board Order No. 2 (https://www.cms.gov/files/document/current-prrb-rules-v-31-cover-order-2-november-1-2021.pdf).

> **1.3 Good Faith Expectations**
>
> In accordance with the regulations, the Board expects the parties to an appeal to communicate early, act in good faith, and attempt to negotiate a resolution to areas of misunderstanding and differences. The duty to communicate early and act in good faith applies to dealings with the opposing party, the Board, and/or any relevant nonparty.

Similarly, pursuant to Board Rule 5.2 (Nov. 1, 2021), QRS, as the Providers' representative, is responsible for being familiar with, and following, Board rules and procedures and governing regulations (including 42 C.F.R. § 405.1842(b)(2)), and timely responding to correspondence or requests from the Board or the opposing party:

> **5.2 Responsibilities**
>
> *The case representative is responsible for being familiar with the following rules and procedures* for litigating before the Board:
>
> - The Board's governing statute at 42 U.S.C. § 1395oo;
> - *The Board's governing regulations at 42 C.F.R. Part 405, Subpart R*; and
> - *These Rules*, which include any relevant Orders posted at https://www.cms.gov/Regulations-and-Guidance/ReviewBoards/PRRBReview/PRRB-Instructions (see Rule 1.1).
>
> Further, *the case representative is responsible for*:
>
> - Ensuring his or her contact information is current with the Board, including a current email address and phone number;
> - Meeting the Board's deadlines; and
> - *Responding timely to correspondence or requests from the Board or the opposing party*.
>
> Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.[74]

[74] (Italics emphasis added.) *See also, Baptist Mem'l Hosp.-Golden Triangle v. Sebelius*, 566 F.3d 226, 227 (D.C. Cir. 2009) wherein the Circuit Court affirmed the District Court's granting of summary judgment to the Secretary because the Providers failed to follow Board Rules, stating, "The court therefore granted summary judgment to the Board.

In response to the Board's April 24, 2022 Order to Show Cause, QRS asserted that "any theory of wholesale abandonment of so many appeals because the Providers decided to pursue those appeals in Federal court under a good faith understanding of the statute's requirement that the Board decides EJR requests within thirty days, and our good faith understanding that the filing of such a complaint halts further action before the Board, would be mistaken." Further, in its response, QRS is quick to assert that 42 U.S.C. § 1395oo(f)(1) obligated the Board (and the Medicare Contractors) to process its EJR request, ***and*** complete its jurisdictional review of those 80 group cases and the underlying 950+ participants, within 30 days of its filing the EJR request (*i.e.*, by Friday February 11, 2022). However, QRS' reliance on this position glosses over the record, and ignores how its silence interfered with the speedy, orderly and fair conduct of the Board proceedings (both in these cases and others) and prejudiced the opposing parties. Indeed, the following inaction on QRS' part belies its claim in the April 8, 2022 notice to the Board that "proceedings before the PRRB have been exhausted":

1. QRS did not notify the Board, FSS, or the Medicare Contractors, of its opposition to FSS' January 20, 2022 motion to extend the Medicare Contractor's time to file jurisdictional challenges until May 5, 2022, more than 3 months after that motion was filed.[75] Indeed, the tardiness of QRS' opposition is highlighted by the fact that it did not make its opposition known until after that extended deadline had passed by more than 50 days. QRS' failure to file notice with the Board, and serve FSS and/or the Medicare Contractors (*i.e.*, the opposing parties), of its opposition to FSS' request, violates QRS' obligations under Board Rules 1.3, 5.2, and 44.

2. QRS did not notify the Board of its objection to the Board's January 24, 2022 ruling on the extension, and the associated Scheduling Order, until May 5, 2022, more than 3 months after the fact. QRS' failure to file and preserve its objection to the Board's January 24, 2022 ruling and Scheduling Order violates QRS' obligations under Board Rules 1.3, 5.2, and 44 and deprived the Board of an opportunity to consider its ruling and Scheduling Order and, if necessary, correct or clarify that ruling and/or Scheduling Order.[76] The tardiness of QRS' opposition is again highlighted by the fact that it failed to make its opposition known until well after the extended deadline they complain of had passed.

Because the Board's procedural rules mean what they say and say what they mean, and because the hospitals did not follow them, we affirm."

[75] QRS' April 8, 2022 filing was 3 sentences long and did not provide this notice.

[76] While the Board is not bound by the FRCP, the Board refers to them for guidance and notes that the principles of FRCP 46 are similar. FRCP 46 applies to trial-like proceedings and "requires that a party seeking to preserve an objection to the court's ruling must 'make know to the court the action which the party desires the court to take or the party's objection to the action of the court and the grounds therefor.'" *Beach Aircraft Crop. v. Rainey*, 488 U.S. 163 (1988). *See also Cain v. J.P. Productions*, 11 Fed. Appx 714 (9th Cir. 2001). Similarly, the purpose behind Rule 46 is also relevant: "As pointed out in the discussions of Rule 46, the function of an exception was to bring pointedly to the attention of the trial judge the importance of the ruling from the standpoint of the lawyer and to give the trial judge an opportunity to make further reflection regarding his ruling. Proceedings of Institute, Washington, D.C., 1938, p. 87. In justifying the rule it was stated 'the exception is no longer necessary, if you have made your point clear to the court below.' Proceedings of Institute, Cleveland, 1938, p. 312. 'But of course it is necessary that a man should not spring a trap on the court * * *, so the rule requires him to disclose the grounds of his objections fully to the court.' Proceedings of Institute, Washington, D.C., 1938, p. 145; see also p. 87." *Bucy v. Nevada Const. Co.*, 125 F.3d 213, 218 (9th Cir. 1942).

3. On January 24, 2022, the Board made its position as to how the 30-day period to respond to the EJR request at issue, based on 42 U.S.C. § 1395oo(f), 42 C.F.R. §§ 405.1842(b)(2), 405.1801(d)(2)[77] and Board Alert 19, known to the parties in these cases. Specifically, the Board notified the parties that the Board had the authority to stay the start of the 30-day period since 42 C.F.R. § 405.1842(b)(2) specifies jurisdiction is a prerequisite to Board consideration of an EJR request. Because the Board was not operating normally – as evidenced by the fact that, during January 2022, all CMS offices (including the Board's) were closed to employees due to the surge of the COVID-19 Omicron variant. To that end, the Board issued its Scheduling Order to memorialize and effectuate the necessity to stay the jurisdictional review process and delay the start of the 30-day period to review the EJR request. QRS failed to notify the Board of its objection to the Board's January 24, 2022 Scheduling Order until May 5, 2022. QRS' failure to timely file, and preserve, that objection violates Board Rules 1.3, 5.2 and 44. QRS' delay also interfered with the speedy, orderly and fair conduct of the Board proceedings and prejudiced the Board by depriving it of an opportunity to reconsider its ruling and, if necessary, correct or clarify it,[78] or take other actions, ***prior to*** Friday, February 11, 2022 (*i.e.*, prior to the end of the alleged 30-day deadline from January 12, 2022). QRS' delay allowed the 30-day EJR review deadline, as alleged by QRS to be established in 42 U.S.C. § 1395oo(f)(1) (that QRS now alleges the Board missed), to pass, and, under QRS' strained interpretation that ignores the Secretary's regulations, permitted federal litigation to be pursued.[79]

4. In its January 24, 2022 Scheduling Order, the Board set forth its process for conducting jurisdictional review. In addition to specifying time for the Medicare Contractors to file jurisdictional challenges and the Providers to respond to those challenges, the Board included the following directive to the parties to supplement the record in these group cases "*to ensure the record before it in these group cases is* ***complete***"[80]:

> The Board's preliminary review of the EJR request using its legacy docketing system, Case Tracker, shows that some of the participants transferred from individual appeals and that, in some cases, the relevant MAC had filed jurisdictional objections to the dual eligible days issue in the individual appeal and there were Provider responses. Further, there appears to be situations where the Board did not resolve that jurisdictional challenge. ***To ensure the record before it in these group cases is complete***, *the Board requests the parties to upload copies of these briefs and any relevant Board*

[77] The Board's Notice was clear that a Board finding of jurisdiction is a prerequisite to any review of an EJR request citing to 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), (e)(3)(ii).
[78] For example, the Board could have explained how reliance solely on 42 U.S.C. § 1395oo(f)(1) would be misplaced given the Secretary's implementation of that statute at 42 C.F.R. § 405.1842 (including in particular § 405.1842(b)(2)) as promulgated in the May 23, 2008 final rule and the Secretary's explanation of that regulation in the June 5, 2004 proposed rule. *See supra* notes 70 and 71 and accompanying text.
[79] *See supra* note 76 (discussing how the FRCP supports the Board's position).
[80] (Emphasis added.)

> *rulings to the Office of Hearings Case and Document Management System ("OH CDMS") in the appropriate group case so that these documents may be considered as part of the Board's review of jurisdiction of the participants in these group cases.*

QRS blatantly disregarded, and failed to address the Board's directive, to supplement the record relative to jurisdiction.[81] *As the overwhelming majority of the 80 group cases* involved participants that transferred from individual cases formed under the legacy docketing system, the Board's directive applied to the great majority of the 80 group cases. The Board agrees with FSS' statement, in its April 18, 2022 Request for Dismissal, that "the Board's Orders are not aspirational and the Providers' basis for disregarding them is unsupported (and unsupportable) by either law or fact."

5. QRS' failure to promptly notify the Board that it had filed the lawsuit in the California Central District Court violates Board Rule 1.3, and prevented the Board and the Medicare Contractors from understanding the nature of QRS' position relative to the 30-day period specified in 42 U.S.C. § 1395oo(f)(1). This occurred, despite the fact that, at that point in time, QRS claimed to "reasonably believe[] that further proceedings before the Board were prohibited by [the] regulation" at 42 C.F.R. § 405.1842(h)(3)(iii). QRS points to the statement in 42 C.F.R. § 405.1842(h)(3)(i) that "the Office of the Attorney Advisor must promptly provide the Board with written notice of the lawsuit and copy of the compliant." QRS further contends that it "presumed that the Office of the Attorney Advisor within CMS would promptly notify the Board of the suit." However, that does not mean that QRS did not have an affirmative obligation to *promptly* notify the Board of the lawsuit, and a further specific obligation to notify the Board of the lawsuit based on the circumstances of the Board proceedings. The following circumstances make it clear that QRS had an affirmative obligation to notify the Board of the Complaint being filed, and that QRS should have been aware of that affirmative obligation:

    a. The Board, in its Scheduling Order, made clear its position that the 30-day period for responding to the EJR request had not yet commenced. Further, the Scheduling Order directed both parties to submit certain jurisdictional related information, over a 90-day time frame, relevant to these 80 group cases and the underlying 950+ participants.

    b. Both the Board and the Medicare Contractors were acting in reliance on the authority of that Scheduling Order.

[81] The Board notes that the Medicare Contractors *did respond* to this portion of the Scheduling Order and *did file* copies of pending/unresolved jurisdictional challenges in individual appeals that impact participants in these 80 group cases. Indeed, the Board believes that it was as a result of this directive that the Medicare Contractors identified previously withdrawn/dismissed providers where challenges in individual appeals had been resolved through dismissal/withdrawal and denial of transfers. *See supra* note 32 and accompanying text.

c. QRS' position is dependent upon promptly effectuating service on the Secretary, and FSS contends that this service was not actually effectuated until on April 12, 2022, more than two months later, when an alias summons was issued.[82]

These circumstances make clear that QRS had a duty, pursuant to Board Rule 1.3, "to communicate early and act in good faith [with regard] [] to dealings with the opposing party, the Board, and/or any relevant nonparty."[83] Indeed, QRS' failure to comply with Board Rule 1.3, by promptly notifying the Board, FSS and the Medicare Contractors of the lawsuit on or about February 14, 2022, prejudiced the Board, FSS and the Medicare Contractors in other matters. Specifically, it interfered with the speedy, orderly and fair conduct of the Board proceedings (on these and other cases) and deprived both the Board, and the Medicare Contractors, of the opportunity to decide whether to delay, or cease, work on the 80 group cases and the underlying 950+ participants in favor of other time-sensitive work such as ***other*** EJR requests filed by QRS and other representatives. Indeed, QRS' two-month delay in notifying the Board, and the opposing parties, of the lawsuit filed in the California Central District Court raises concerns about potential prejudicial sandbagging by QRS to benefit subsequent EJR requests that QRS filed on behalf of other providers between January 24, 2022 and April 8, 2022 (*i.e.*, the date QRS gave notification).[84] In this regard, the Board notes that QRS filed EJR requests covering 36 cases with more than 640 participants in the aggregate,[85] of which the overwhelming majority (*i.e.*, greater than 80 percent of the 640+ participants) is associated with a consolidated EJR request filed on

---

[82] FSS letter dated May 9, 2022 (stating: "Though Providers filed their Complaint on February 14, 2022, they waited until April 8, 2022 (nearly two months later) to advise the Board that such a complaint had been filed. Providers contend that CMS was responsible for advising the Board of a complaint's filing but there is no record that the summons was served and on April 12, 2022, an alias summons was issued in the case. Such a summons would not be necessary if Providers had effected service in the first instance. Again, when Providers finally notified the Board that a Complaint had been filed, they failed to set forth their basis for contending that such a complaint was procedurally proper; they failed to even identify the complaint they had filed. Providers, likewise, failed to timely respond to any of the jurisdictional challenges raised by the MAC.").

[83] It is disingenuous for QRS to suggest in hindsight in its May 5, 2022 response to the Board's April 24, 2022 Order to Show Cause that "[t]he Providers did not respond to the Board's deadlines or to the MAC's filings because [on February 14, 2022] the Providers commenced an action in federal court and reasonably believed that further proceedings before the Board prohibited by regulation" and that "[t]he Providers notified the Board by letter dated April 8, 2022 that they had commenced an action in federal court" but "[i]t was not until two weeks later when the Providers received the Board's April 21, 2022 letter that the Providers became aware for the first time that the Board continued to believe that it retains responsibility over and would proceed with these cases." The Board made its position known in its January 24, 2022 Notice of Stay and Scheduling Order and to the extent QRS had any doubts it had an obligation to seek clarification from the Board. Again, the Board's January 24, 2022 Notice of Stay and Scheduling Order was not aspirational and the Providers' basis for disregarding it is unsupported (and unsupportable) by either law or fact.

[84] *See Fink v. Gomez*, 239 F.3d 989 (9th Cir. 2001) ("[T]he cases discussed above make clear that sanctions are available if the court specifically finds bad faith or conduct tantamount to bad faith. Sanctions are available for a variety of types of willful actions, including recklessness when combined with an additional factor such as frivolousness, harassment, or an improper purpose. Therefore, we hold that an attorney's reckless misstatements of law and fact, when coupled with an improper purpose, such as an attempt to influence or manipulate proceedings in one case in order to gain tactical advantage in another case, are sanctionable under a court's inherent power.").

[85] On February 11, 2022, QRS filed a consolidated EJR request covering 10 group cases with 46 participants, in the aggregate. On February 27, 2022, QRS filed a consolidated EJR request covering 12 group cases with roughly 520 participants, in the aggregate. On March 9, 2022, QRS filed a consolidated EJR request covering 14 group cases with 76 participants, in the aggregate.

February 17, 2022[86] just days after the February 14, 2022 lawsuit was filed.[87] To this point, it is the Board's understanding that, ***prior to*** *the April 8, 2022 notice*, QRS filed an Amended Complaint on March 30, 2022 incorporating these other EJR requests into the lawsuit pending in the California Central District Court (or into new sister lawsuits filed therein).[88] Moreover, it is the Board's understanding that another representative, Healthcare Reimbursement Services, Inc. ("HRS") contemporaneously filed consolidated EJR requests covering 120 group cases with 569 participants in the aggregate,[89] and has joined QRS in lawsuits filed in the California Central District Court, including the one involved with the instant 80 group cases.[90]

As part of its April 8, 2022 notice to the Board, QRS clearly stated that it was abandoning the Board's jurisdictional review process and not complying with the Board's January 24, 2022 Scheduling Order when they stated in their April 8, 2022 filing: "*the Providers consider that proceedings before the PRRB have been* ***exhausted***[and] [a]ccordingly, the ***PRRB's previously established due dates no longer apply*** to the Providers."[91] Further, it is clear the Providers are pursuing the merits of their cases as part of the lawsuit. Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii), the Board is prohibited from further proceedings in these cases. Therefore, the Board must close these cases.[92]

However, the Board cannot permit QRS' reckless disregard for its ***basic*** responsibilities and due diligence, as a representative appearing before the Board (including but not limited to failure to track and account for withdrawn/dismissed providers), its abandonment of the jurisdictional review process, and its disregard for the Board's authority, orders and process, to remain unanswered. Accordingly, if these cases are remanded, the Board will complete its jurisdictional review and weigh the severity of QRS' violations of, and failure to comply with, Board Rules, regulations and Orders, the prejudice to the Board and the opposing parties, and the interference with the speedy, orderly and fair conduct of the Board proceedings (regarding both these cases and others), and the

---

[86] The January 17, 2022 consolidated EJR request covers 12 cases: Case Nos. 13-2324GC, 13-2328GC, 14-1072GC, 14-1073GC, 15-0580GC, 15-0586GC, 15-1622GC, 15-1624GC, 16-0678GC, 16-0679GC, 17-0575GC, and 17-0577GC.
[87] QRS waited until May 19, 2022 to file notice to the Board and the opposing parties that it had filed a lawsuit covering the 12 group cases covered by the February 17, 2022 consolidated EJR request.
[88] The Board will be addressing the status of these other cases under separate cover shortly.
[89] On December 29, 2021, HRS filed a consolidated EJR request covering 63 group cases with 255 participants, in the aggregate. On January 17, 2022, HRS filed a consolidated EJR request covering 40 cases with 200 participants, in the aggregate. On February 27, 2022, HRS filed a consolidated EJR request covering 17 group cases with 114 participants, in the aggregate.
[90] The Board will be addressing the status of these other cases under separate cover shortly.
[91] Board Scheduling Order at n.23 (Apr 21, 2022) (emphasis added).
[92] As noted in 42 C.F.R. § 405.1837(a), a group appeal may only have "a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." Similarly, as explained at 42 C.F.R. § 405.1842(d), "[a] provider (or, in the case of a group appeal, a group of providers) may request a determination by the Board that it lacks the authority to decide a legal question relevant to a specific matter at issue in an appeal." Accordingly, the Board must assume there are no other issues, particularly since: (1) the existence of other issues would necessarily mean that the Board would not have jurisdiction over the group until that defect was cured; and (2) the Providers did not identify any concurrent issues with the filing of the consolidated EJR request but rather claimed therein that the Board had jurisdiction over the groups.

effect on the operations of the Board, when determining what, if any, remedial actions will be taken. Examples of available remedial actions that the Board may consider include, but are not limited to:

1. Dismissal of the 80 group cases and all underlying participants.
2. Dismissal of any group case in which the Board identifies any jurisdictional or material procedural errors occurred, whether by one participant or more.
3. Dismissal of any participant for which there is an open jurisdictional challenge regardless of the merit of such challenge.

These potential actions are well within the Board's authority pursuant to 42 C.F.R. § 405.1868(a)-(b),[93] as confirmed in the preamble to the May 23, 2008 final rule:

> Most of the comments we received on this subject came from providers, and reflect a perceived disparate treatment by the Board when a provider, rather than an intermediary, fails to follow a procedural rule or timeframe set by the Board. We proposed two possible actions by the Board, one applicable to a provider and the other applicable to an intermediary. That is, the worst case scenario for a provider would be a dismissal of the appeal by the Board, while the harshest remedy for an intermediary would be the issuance of a decision by the Board based on the written record established at the point of the intermediary's violation. However, we note that, because providers are the proponents of a case, they are responsible for moving the case forward by meeting all deadlines. Additionally, at section 1878(e) of the Act, the Congress has given the Board authority to make rules and establish procedures to carry out its function. Moreover, we note that the Board will have broad discretion to weigh the particular facts at hand in order to decide whether or not an offense merits remedial action.
>
> ****
>
> Again, we are clarifying that the proposed rule did not identify a complete listing of all potential Board sanctions. The Board has the

[93] 42 C.F.R. § 405.1868 states:

(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.

(Emphasis added.)

> authority to take appropriate action against either party for procedural violations, but appropriate action does not necessarily mean a dismissal or the early issuance of a decision by the Board. We believe that these provisions will alert both parties that the Board has a mechanism in place to effectively stop a delaying tactic, or to redress other procedural violations. As a result, the parties should be less inclined to ignore procedural requirements and, accordingly, be more motivated to meet the deadlines set by the Board.[94]

* * * * *

In summary, 42 C.F.R. § 405.1842(h)(iii) bars the Board from conducting any further proceedings, because the Providers are pursuing the merits of their appealed issue in the California Central District Court, and there are no remaining issues beyond the EJR request.[95] Accordingly, the Board hereby closes these cases and removes them from the Board's docket. No further proceedings will occur, except upon remand from the Administrator, pursuant to 42 C.F.R. 405.1877(g)(2).

Board Members Participating:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

6/10/2022

X Clayton J. Nix

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

Enclosures: List of Groups

cc: Bill Tisdale, Novitas Solutions
Judith Cummings, CGS
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators
Danielle Decker, NGS
Pamela VanArsdale, NGS
Cecile Huggins, Palmetto GBA
Byron Lamprecht, WPS
Wilson Leong, FSS
Jacqueline Vaughn, OAA

[94] 73 Fed. Reg. at 30225.
[95] *See supra* note 92.

LIST OF 80 GROUP CASES

09-1903GC	BHCS 07 DSH Dual Eligible Days
13-1419G	QRS 2006 DSH SSI Fraction Denominator/Dual Eligible Group
13-1440G	QRS 2006 DSH Medicaid Fraction/Dual Eligible Group
13-1720GC	Scott & White 2008 Medicaid Fraction Dual Elig Days CIRP Group
13-1722GC	Scott & White 2008 DSH SSI Fraction Dual Elig Days CIRP Group
13-2678G	QRS 2007 DSH Medicaid Fraction Dual Eligible Days Group (2)
13-2693G	QRS 2008 DSH Medicaid Fraction Dual Eligible Days Group
13-2901GC	QRS BJC 2007 DSH SSI Fraction Dual Eligible Days CIRP Group
13-2903GC	QRS Novant 2007 SSI Fraction Dual Eligible Days CIRP Group
13-2904GC	QRS Novant 2007 Medicaid Fraction Dual Eligible Days CIRP Group
13-3061GC	QRS WFHC 2009 Medicaid Fraction Dual Eligible CIRP Group
13-3191GC	QRS Novant 2006 DSH Dual Eligible Days
13-3942G	QRS 2009 DSH Medicaid Fraction/Dual Eligible Days Group
13-3944G	QRS 2009 DSH SSI Fraction/Dual Eligible Days Group
14-1171G	QRS 2008 DSH SSI Fraction Dual Eligible Days Group
14-1174G	QRS 2007 DSH SSI Fraction Dual Eligible Days Group
14-1816G	QRS 2010 DSH SSI Fraction Dual Eligible Days Group
14-1818G	QRS 2010 DSH Medicaid Fraction Dual Eligible Days Group
14-2217GC	QRS Novant 2009 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-3306G	QRS 2011 DSH Medicaid Fraction Dual Eligible Days Group
14-3308G	QRS 2011 DSH SSI Fraction Dual Eligible Days Group
15-0018G	QRS 2012 DSH Medicaid Fraction/Dual Eligible Days Group
15-1067G	QRS 2006 DSH Medicaid Fraction Dual Eligible Days Group (2)
15-1147G	QRS 2006 DSH SSI Fraction Dual Eligible Days Group (2)
15-1152GC	QRS Novant 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-1419G	QRS 2012 DSH SSI Fraction Dual Eligible Days Group
15-2385G	QRS 2010 DSH SSI Fraction Dual Eligible Days Group II
15-2386G	QRS 2010 DSH Medicaid Fraction Dual Eligible Days Group II
15-3031G	QRS 2011 DSH Medicaid Fraction Dual Eligible Days Group 2
15-3039G	QRS 2011 DSH SSI Fraction Dual Eligible Days Group 2
15-3073GC	QRS Progressive Acute Care 2011 DSH Medicaid Fraction/Dual Eligible Days
16-0091GC	HRS DCH 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
16-0092GC	HRS DCH 2010 Medicaid Fraction Dual Eligible Days CIRP Group
16-1142G	QRS 2013 DSH SSI Fraction Dual Eligible Days Group
16-1145G	QRS 2013 DSH Medicaid Fraction Dual Eligible Days Group
16-1750G	QRS 2012 DSH SSI/Medicaid Dual Eligible Days Group II
17-0867G	QRS 2014 DSH SSI/Medicaid Dual Eligible Days Group
17-1405G	QRS 2013 DSH SSI Fraction Dual Eligible Days Group (2)
17-1406G	QRS 2013 DSH Medicaid Fraction Dual Eligible Days Group (2)
17-1409G	QRS 2005 DSH SSI Fraction Dual Eligible Days Group
17-1412G	QRS 2005 DSH Medicaid Fraction Dual Eligible Days Group
17-1426G	QRS 2006 DSH SSI Fraction Dual Eligible Days Group 3

17-1427G	QRS 2006 DSH Medicaid Fraction Dual Eligible Days Group
18-0270G	QRS 2007 DSH SSI Fraction Dual Eligible Days Group (3)
18-0730G	QRS 2011 DSH SSI Fraction Dual Eligible Days Group III
18-1259G	QRS 2014 DSH SSI Fraction Dual Eligible Days Group 2
18-1260G	QRS 2014 DSH Medicaid Fraction Dual Eligible Days Group 2
18-1405G	QRS 2015 DSH Medicaid Fraction Dual Eligible Days Group
18-1408G	QRS 2015 DSH SSI Fraction Dual Eligible Days Group
18-1738GC	AHMC Healthcare CY 2012 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0012GC	AHMC Healthcare CY 2015 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0014GC	AHMC Healthcare CY 2015 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0164GC	AHMC Healthcare CY 2013 DSH Medicaid Fraction Dual Eligible Days CIRP Group
19-0195GC	Houston Methodist CY 2014 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0235GC	Houston Methodist CY 2014 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0270GC	Mercy CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0272GC	Mercy CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP Group
19-0534G	QRS CY 2011 DSH Medicaid Fraction Dual Eligible Days (3) Group
19-0704G	QRS CY 2012 DSH SSI Fraction Dual Eligible Days (3) Group
19-0706G	QRS CY 2012 DSH Medicaid Fraction Dual Eligible Days (3) Group
19-2131GC	Hartford Health CY 2015 DSH SSI Fraction Dual Eligible Days CIRP Group
19-2134GC	Hartford Health CY 2015 DSH Medicaid Fraction Dual Eligible Days CIRP
19-2513G	QRS CY 2016 DSH SSI Fraction Dual Eligible Days Group
19-2515G	QRS CY 2016 DSH Medicaid Fraction Dual Eligible Days Group
19-2594G	QRS CY 2015 DSH SSI Fraction Dual Eligible Days (2) Group
19-2596G	QRS CY 2015 DSH Medicaid Fraction Dual Eligible Days (2) Group
20-0107G	QRS CY 2013 DSH SSI Fraction Dual Eligible Days (3) Group
20-0112G	QRS CY 2013 DSH Medicaid Fraction Dual Eligible (3) Group
20-0209G	QRS CY 2010 DSH SSI Fraction Dual Eligible Days (3) Group
20-0211G	QRS CY 2010 DSH Medicaid Fraction Dual Eligible (3) Group
20-0244G	QRS CY 2007 DSH Medicaid Fraction Dual Eligible Days (4) Group
20-0248G	QRS CY 2006 DSH SSI Fraction Dual Eligible Days (4) Group
20-0250G	QRS CY 2006 DSH Medicaid Fraction Dual Eligible Days (4) Group
20-0367G	QRS CY 2005 DSH SSI Fraction Dual Eligible Days (2) Group
20-0368G	QRS CY 2005 DSH Medicaid Fraction Dual Eligible Days (2) Group
20-0409GC	AHMC Healthcare CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group
20-0411GC	AHMC Healthcare CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP
20-1511G	QRS CY 2014 DSH SSI Fraction Dual Eligible Days (2) Group
20-1513G	QRS CY 2014 DSH Medicaid Fraction Dual Eligible Days (2) Group
20-1655G	QRS CY 2007 DSH SSI Fraction Dual Eligible Days (4) Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Decision***
St. Luke Northland Hospital (Provider Number 26-0062)
FYE: 12/31/2016
Case Number: 20-0286

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documentation in Case No. 20-0286 pursuant to a Jurisdiction Challenge and Motion to Dismiss filed by the Medicare Administrative Contractor ("MAC"). The Board's analysis and determination is set forth below.

Background:

A. Procedural History for Case No. 20-0286

On May 14, 2019, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2016.

On November 5, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained two (2) issues:

Issue 1: Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage- Provider Specific

Issue 2: DSH- Medicaid Eligible Days

On July 1, 2020, the Provider filed its preliminary position paper.

On August 17, 2020, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1.

On October 15, 2020, the Medicare Contractor filed its preliminary position paper.

On January 10, 2023, the Medicare Contractor filed a Final Request for the Medicaid Eligible Days Listing in connection with Issue 3 and requested a response within 30 days. On August 7, 2023, the Medicare Contractor filed its Motion to Dismiss Issue 3 as the Provider failed to file any response.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-1003GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> …
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[1]

The Provider directly filed into a mandatory group under Case No. 19-1003GC entitled "*St. Luke's Health CYs 2013 & 2016 DSH SSI Percentage CIRP Group*." The group describes the DSH/SSI percentage issue as whether the Medicare/SSI Fraction used to calculate their DSH payment is properly calculated. More specifically, Provider lists the following reasons for challenging its SSI percentage:

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.[2]

On July 1, 2020, the Provider submitted its preliminary position paper to the MAC in this appeal. The following is the Provider's complete position on Issue 1 set forth therein:

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

[1] Provider's Request for Hearing, Issue Statement (November 5, 2019)
[2] Group Issue Statement (CIRP Group Case No. 19-1003GC).

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

Medicare Contractor's Contentions

Issue 1 – DSH SSI Percentage (Provider Specific)

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

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact
>
> . . . .
>
> The MAC contends that the Board does not have jurisdiction over the realignment portion of issue 1…there was not a determination, the provider's appeal is premature and the provider has not followed administrative procedures.[3]

Issue 2 – DSH Medicaid Eligible Days

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

> a. That the Provider has failed to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable.
> b. That the Provider has made affirmative statements in its Preliminary Position Paper

[3] Medicare Contractor's Jurisdictional Challenge at 6-7 (August 17, 2020).

that it was submitting such supporting documentation to the MAC.
c. That the Provider's failure to furnish such documentation (or describe why such documentation is unavailable) is in violation of PRRB Rules 7, 25.2.1 and 25.2.2.
d. That the Provider has effectively abandoned its claim for additional Medicaid Eligible Days.
e. That the Provider's claim for additional Medicaid Eligible Days is therefore dismissed.[4]

Provider's 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.[5] The Provider has not filed a response to the Jurisdictional Challenge or Motion to Dismiss and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Similarly, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Board Analysis and Decision:

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

A. DSH Payment/ SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue directly added into Group Case No. 19-1003GC, *St. Luke's Health CYs 2013 & 2016 DSH SSI Percentage CIRP Group*.

[4] Medicare Contractor's Motion to Dismiss at 4-5 (August 7, 2023).
[5] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[6] 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)."[7] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[8]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 19-1003GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in CIRP Group Case No. 19-1003GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[9], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case 19-1003GC, which it is required to do since it is a common issue subject to the mandatory CIRP rules at 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in Baystate, may impact the SSI percentage for each provider differently.[10] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-1003GC in its appeal request. Further, the Provider failed to respond to the Jurisdictional Challenge.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 19-1003GC, but instead refers to systemic Baystate data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be fully developed and include all available documentation necessary to provide a thorough understanding of the parties' positions." For example, the Provider claims that SSI entitlement can be ascertained from State records but fails to explain how or establish what those alleged records show, or

---

[6] Issue Statement at 1.
[7] *Id*.
[8] *Id*.
[9] PRRB Rules v. 2.0 (Aug. 2018).
[10] 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).

identify any days in dispute based on those records (much less explain how the State record issue would be provider specific and not subject to the CIRP group rules and not already part of the CIRP group to which it transferred the systemic issue). Here, it is clear that the Provider failed to fully develop the merits of its position on Issue 1 of it's appeal and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include all exhibits.

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

> 25.2.2 Unavailable and Omitted Documents If documents necessary to support your position are still unavailable, then provide the following information in the position papers: 1. Identify the missing documents; 2. Explain why the documents remain unavailable; 3. State the efforts made to obtain the documents; and 4. Explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[11]

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

[11] Last accessed January 4, 2024.

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 19-1003GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

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

B. DSH- Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid Eligible Days were not included in the calculations of the DSH calculation. The Provider states Issue 2 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[12]

[12] Provider's Appeal Request (November 5, 2019).

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

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover, but no such listing was received by the MAC.

Board Rule 7.2 (B) states:

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

Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2 (B).

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[13]

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

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

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:

---

[13] 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 identify missing documents to support its claim and to explain why those documents remained unavailable.

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

Similarly, with regard to position papers,[14] Board Rule 25.2 (A) requires that "the parties must exchange all available documentation as exhibits to fully support your position." This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

Similarly, consistent with that regulation, Board Rule 25.2 (B) 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 opposing party.

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

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

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

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

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

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

[14] The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. See Board Rule 27.2.

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled, consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for each Medicaid patient day claimed" and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2 (B). Indeed, without any days identified in the position paper filing, the Board assumes that there are no days and $0 of reimbursement actually in dispute for this issue.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has not satisfied the requirements of Board Rules 25.2 (A) and 25.2 (B) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[15]

Accordingly, the DSH Payment – Medicaid Eligible Days issue is dismissed.

Decision

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

1. The DSH Payment/SSI Percentage (Provider Specific) issue from the appeal because it is duplicative of the issue in CIRP Group Case No. 19-1003GC, there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to properly develop the issue to establish it as a separate and distinct issue;

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

In making these dismissals, the Board notes that the Provider failed to respond to the relevant Jurisdictional Challenges and Motions to Dismiss. The appeal is now closed as there are no remaining issues. 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.

[15] Board Rule 25, of which 25.2 (A) and 25.2 (B) are a part, is applicable to final position papers via Board Rule 27.2.

Board Members:

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

For the Board:

2/12/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Geoff Pike
First Coast Service Options, Inc.
532 Riverside Ave.
Jacksonville, FL 32202

RE: ***Board Decision***
Adventist Health System 2011 EHR Charity Care Charges CIRP Group
Case No. 15-0840GC

Dear Ms. Webster and Mr. Pike,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above-referenced appeal in response to the Medicare Administrative Contractor's ("MAC") Jurisdictional Challenge. The Board's decision is set forth below.

Background:

On **December 22, 2014**, the Provider Representative filed a group appeal with one participant, Central Texas Medical Center (Prov. No. 45-0272). The Board acknowledged the Group's Full Formation Notice on August 24, 2022. In the Initial Appeal Request, the Group Issue Statement (abbreviated) states:

> The common issue in this group appeal is *the impropriety of the MAC's determination to exclude some charity care charges from the calculation of the Electronic Health Record (EHR) incentive payment*…. At issue here is the calculation of the Providers' Medicare Share…. As charity care charges increase, the charity care ratio and the Medicare Share denominator decrease, resulting in a larger Medicare Share and greater EHR payment. See 75 Fed. Reg. 44314, 44456 (July 28, 2010).… CMS implemented the EHR program through regulations adopted in 2010 and determined that there is sufficient charity care data existing, as reported on cost report worksheet S-10, to calculate the Medicare Share. See 75 Fed. Reg. at 444456….[T]he MAC misapplied the Medicare bad debt indigence rules to exclude some of the Providers' charity care charges from the calculation of the Medicare Share for the EHR incentive payment. The MAC claims that the Providers did not adequately document the indigence of the patients whose treatment makes up the charity care charges. As a result of this misapplied

> standard, the MAC refused to recognize the full amount of the Providers' charity care charges. These determinations, which significantly reduced the Providers' EHR incentive payments, are not valid…These determinations violate the plain language of the ERR statute and implementing rule. The statute requires that the term "charity care" will be afforded its usual meaning in the context of hospital cost reporting. 42 U.S.C. § 1395ww(d)(n)(2)(D). For cost reporting purposes, charity care is determined by "a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria." PRM, Part II, § 4012. To be reported on a hospital's cost report on line 20 of worksheet 5-10 as charity care, the care must simply have been furnished consistent with a hospital's own policy…The use of the Medicare bad debt indigence standards to reduce the Providers' charity care charges is also plainly contrary to CMS's rule, established in the 2010 rulemaking, on how to determine charity care for EHR payment purposes. CMS determined the charity care charges used to calculate the Medicare Share are those found on cost report Worksheet S-10, Line 20. 75 Fed. Reg. at 44456. The MAC's application of the Medicare bad debt indigence rules to assess these charges violates that rule... The MAC's misappropriation of bad debt indigence standards to determine allowable charity care charges for EHR purposes is arbitrary and capricious….Even if the Section 312 bad debt standard is an appropriate standard for auditing charity care under the ERR incentive formula (and it is not), the patients charges at issue meet this standard and thus should not be excluded because the inability of these patients to pay was established under the Providers' charity care policies.

On **July 31, 2023**, the Board issued a letter which requested the parties submit a briefing regarding the Board's *substantive* jurisdiction over the group appeal.

On **August 30, 2023**, the Providers filed a response. Similarly, on **September 25, 2023**, the MAC filed its response. On **October 13, 2023**, the Providers filed an Optional Jurisdictional Response brief.

Providers' Response

The Providers argues that, while the plain language of the statute precludes review of the agency's methodology used to calculate EHR incentive payment amounts, it does not preclude the MAC's application of that methodology in making those payment determinations, which the Providers are challenging.

The Providers argue the Medicare statute confers the right to review the determinations of the Providers' EHR Incentive Payments. Specifically, they contend that, in its final rule implementing the EHR statute, CMS decided to use amounts reported on Line 20 of Worksheet S-10 for "the charity care charges used to calculate the final Medicare Share" because Line 20 "represent[s] the most accurate measure of charity care charges" as stated at 75 Fed. Reg. 44314, 44456 (July 28, 2010). As a result, the Providers argue that, because they reported their charity care data on Line 20 of Worksheet S-10, the MAC was required by statute to use that charity care data in calculating the Providers' EHR incentive payments.

The Providers maintain Congress granted "provider[s] of services" the right to a hearing before the Board to challenge "a final determination of the [contractor] serving as its fiscal intermediary . . . as to the amount of total program reimbursement due the provider" as stated at 42 U.S.C. § 1395oo(a)(1)(A)(i), (f)(1). In further support, the Providers contend that because Congress did not amend 42 U.S.C. § 1395oo (or otherwise eliminate the right to appeal final reimbursement determinations) when it enacted the EHR incentive payment, the Medicare statue must provide for judicial review of determinations of EHR incentive payments.

The Providers argue CMS requires Medicare contractors to use the amounts reported on Line 20 of Worksheet S-10 for "the charity care charges used to calculate the final Medicare Share" as stated at 75 Fed. Reg. at 44456. The Providers do not dispute that Line 20 of Worksheet S-10 is pursuant to the agency's established "methodology and standards" and assert that they are only challenging the MAC's application of that "methodology and standards" in arriving at their final payment determinations. Rather than using charity care cost reporting standards to determine charity care as the EHR statute and implementing July 28, 2010 final rule demand, the Providers maintain that the MAC inappropriately applied indigent bad debt standards to exclude some of the Providers' charity care charges from their EHR payments.

With regard to the text of the preclusion-of-review provision, the Providers maintain that it excepts from review only the EHR payment methodology and standards, and not determinations reflecting the application of that methodology and associated standards. They assert that the plain language of the preclusion-of-review provision distinguishes between "the methodology and standards," and "determining payment amounts" as stated at 42 U.S.C. § 1395ww(n)(4)(A)(i). Accordingly, they maintain that this distinction makes clear that the provision only precludes review of determining payments not methodology and standards and confirms the Board has jurisdiction over the Providers' challenge to the MAC's *application* of the methodology and standards.

Finally, the Providers argue that the Board has jurisdiction to adjudicate whether the MAC's final determinations are *ultra vires*. In this regard, the Providers assert that the agency exceeded its statutory authority by improperly calculating the Providers' EHR incentive payments, and such *ultra vires* agency action is not shielded by the preclusion-of-review provision. Instead of using charity care cost reporting standards to determine charity care as the EHR statute and implementing July 28, 2010 final rule mandate, the Providers maintain that the MAC improperly used indigent bad debt standards to exclude some of the Providers' charity care charges from

their EHR incentive payments. As such, the Providers conclude that preclusion of review provision does not preclude review of the agency's *ultra vires* actions.

Medicare Contractor's Response

The Medicare Contractor asserts the Providers are challenging the MAC's determination regarding charity care charges on Worksheet S-10, which impacts the EHR payments. The Medicare Contractor argues that the Board lacks jurisdiction over the EHR/HIT issue as jurisdictional and administrative review is barred by statute and regulation. 42 U.S.C. § 1395ww (n)(4)(A) states the following:

> (4) APPLICATION.—
> (A) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise, of—
> (i) the methodology and standards for determining payment amounts under this subsection and payment adjustments under subsection (b)(3)(B)(ix), including selection of periods under paragraph (2) for determining, and making estimates or using proxies of, discharges under paragraph (2)(C) and inpatient-beddays, hospital charges, charity charges, and Medicare share under paragraph (2)(D);
> (ii) the methodology and standards for determining a meaningful EHR user under paragraph (3), including selection of measures under paragraph (3)(B), specification of the means of demonstrating meaningful EHR use under paragraph (3)(C), and the hardship exception under subsection (b)(3)(B)(ix)(II); and
> (iii) the specification of EHR reporting periods under paragraph (6)(B) and the selection of the form of payment under paragraph (2)(F).

The regulations at 42 C.F.R. § 495.110(b) also precludes administrative and judicial review:

> There is no administrative or judicial review under sections 1869 or 1878 of the Act [*i.e.*, 42 U.S.C. § 1395ff or § 1395oo], or otherwise, of the following:
>
> ****
>
> (b) For eligible hospitals—
>
> (1) The methodology and standards for determining the incentive payment amounts made to eligible hospitals, including—
> (i) The estimates or proxies for determining discharges, inpatient-beddays, hospital charges, charity charges, and Medicare share; and

(ii) The period used to determine such estimate or proxy

Accordingly, the MAC contends that jurisdiction over the Providers' appeal over the EHR/HIT incentive payment is precluded by statute and regulation. As this is the sole issue on appeal, the MAC respectfully requests that the case be dismissed in its entirety.

Provider Optional Jurisdictional Response Brief

On October 13, 2023, the Group Representative filed an *optional* jurisdictional response brief. The Group Representative maintain that the Board has jurisdiction over this appeal because "the plain language of the Medicare statute, as confirmed by the statutory context and ordinary meaning of its undefined terms, precludes review of the methodology employed by the agency to calculate EHR incentive payment amounts, but not—as challenged here—the MAC's application of that methodology in making those final payment determinations."[1] The Provider also argues that the MAC's reliance on a single Board jurisdictional decision is misplaced because that case is factually distinguishable, and the parties there did not raise, nor did the Board address, the Providers' arguments here.[2] The Provider contends that the MAC improperly applied the Medicare indigent bad debt rules instead of the charity care rules to exclude some of their charity care charges on Worksheet S-10, Line 20, from the calculation of the Medicare Share for the EHR incentive payments in violation of the Medicare statute and implementing July 28, 2010 final rule.[3]

Board's Analysis and Decision

The Board finds that it does not have jurisdiction over the charity care EHR payment issue in the above-referenced appeal because jurisdiction is precluded by 42 U.S.C. § 1395ww(n) and 42 C.F.R. § 495.110(b).

42 U.S.C. § 1395ww(n) provides for incentives for adoption and meaningful use of certified EHR technology. Specifically, § 1395ww(n)(4) states the following:

> **(4)Application.—**
>
> (A) Limitations On Review.— There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise, of-
>
> (i) the methodology and standards for determining payment amounts under this subsection and payment adjustments under subsection (b)(3)(B)(ix), including selection of periods under paragraph (2) for

[1] Providers' Optional Jurisdictional Response Brief at 1.
[2] *See* MAC's Br. at 3 & n.4 (citing Reid Health (Case No. 19-1379, 09/16/2020)).
[3] *See id.* at 22–23; 42 U.S.C. § 1395ww(n)(2)(D)(ii)(II); 75 Fed. Reg. 44,314, 44,456 (July 28, 2010).

> determining, and *making estimates or using proxies* of, discharges under paragraph (2)(C) and inpatient-bed days, hospital charges, charity charges, and Medicare share under paragraph (2)(D);
>
> (ii) the methodology and standards for determining a meaningful EHR user under paragraph (3), including selection of measures under paragraph (3)(B), specification of the means of demonstrating meaningful EHR use under paragraph (3)(C), and the hardship exception under subsection (b)(3)(B)(ix)(II); and
>
> (iii) the specification of EHR reporting periods under paragraph (6)(B) and the selection of the form of payment under paragraph (2)(F).[4]

The regulations at 42 C.F.R. § 495.110(b) also precludes administrative and judicial review as follows:

> There is no administrative or judicial review under sections 1869 or 1878 of the Act [*i.e*., 42 U.S.C. § 1395ff or § 1395oo], or otherwise, of the following:
>
> ****
>
> (b) For eligible hospitals – (1) The methodology and standards for determining the incentive payment amounts made to eligible hospitals, including –
>
> (i) **The estimates or proxies for determining** discharges, inpatient-bed-days, hospital charges, **charity care charges**, and Medicare share; and
> (ii) The period used to determine such estimate or proxy.[5]

According to the Group Representative, the statute precludes review of the agency's methodology and standards used to calculate EHR incentive payment amounts but *does not* preclude the MAC's application of that methodology in making those payment determinations, which is what the Providers are challenging in this instant appeal. The Board disagrees and finds that the Providers are challenging the estimates for determining the charity care charges which is precluded from review. In particular, the Providers have challenged these estimates when arguing that the MAC improperly applied the Medicare indigent bad debt rules instead of the charity care rules because they contend the Medicare Contractor improperly "concluded that the Providers failed to provide sufficient documentation of patient indigency under the indigent bad debt rules." However, the July 28, 2010 final rule directs Medicare Contractors to use indigent bad debt rules relative "to determine[ing] if a hospital's charity care policy is sufficient to qualify for inclusion of charges in the formula for EHR."[6]

---

[4] (Emphasis added.)
[5] *Id*. (emphasis added).
[6] *See* 75 Fed. Reg. at 44457 discusses the uses of indigent bad debt rules for assessing a hospital's charity care policy:

The Board concludes that it does not have jurisdiction over the charity care EHR issue in the above-referenced appeal because judicial and administrative review of the calculation is barred by self-executing statute and the associated regulation.[7] Case No. 15-0840GC is hereby closed and removed it from the Board's docket.

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

Board Members Participating:

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

For the Board:

2/13/2024

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

Comment: **We received some comments asking if CMS will adopt standards to determine if a hospital's charity care policy is sufficient to qualify for the inclusion of charges in the formula for EHR** and whether that same policy would suffice to meet the criteria to determine the eligibility for Medicare bad debt.
Response: Currently for bad debt purposes, **section 312 of the PRM requires the provider to perform asset/income tests of patient resources for non-Medicaid beneficiaries**. These tests will be used to determine if the beneficiary meets the provider's indigent policy to qualify an unpaid deductible and/or coinsurance amount as a Medicare bad debt. The provider is responsible for developing its indigent policy. Currently, the Medicare contractor will determine if the indigent policies are appropriate for determining allowable Medicare bad debt under section 312 of the PRM and § 413.89 of the regulations. **We believe that the Medicare contractor will continue to determine if the provider's indigent policy for bad debt purposes is appropriate and can determine if the same policy would be sufficient to use for charity care purposes**.
(Italics emphasis in original and underline and bold emphasis added.) The preamble to the July 28, 2010 final implies that the need for this assessment arises from that fact that "in the past CMS did not review the worksheet S-10 because the data had no Medicare payment implications." 75 Fed. Reg. at 44458.

[7] 75 Fed. Reg. at 44468 (describing the EHR statutory provisions precluding certain administrative and judicial review as self-executing).

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

Ken Janowski
Strategic Reimbursement Group, LLC
16408 E. Jacklin Drive
Fountain Hills, AZ 85268

RE: ***Dismissal for Erroneous Filing Pursuant to Board Rules 20 and 20.1***

SRI Adventist 2013 DSH Medicaid Ratio Part C Dual Eligible CIRP Group
Case Number: 17-1138GC

Dear Mr. Janowski:

The Provider Reimbursement Review Board (the "Board") has completed its review of the subject common issue related party ("CIRP") group appeal in response to the Medicare Contractor's February 9, 2024 "Rule 22 - Jurisdictional Review" letter. The Board notes that the CIRP group was filed on February 21, 2017, which was prior to the implementation of the Office of Hearing Case & Document Management System ("OH CDMS"). As such, the electronic record for the CIRP group, which is considered a "Legacy" case, has not yet been populated in OH CDMS. A brief history of the facts and the Board's determination are set forth below.

For background, on November 1, 2021, the Board issued revised Board Rules which changed certain procedures for group appeals. Specifically, Rule 20 addresses the population of Issues/Providers in the Office of Hearings Case & Document Management System ("OH CDMS"). Rule 20 advises that, "***within (60) sixty days of the full formation of the group***, the group representative must file a statement certifying that the group is fully populated in OH CDMS with the relevant supporting jurisdictional documentation (i.e., all participants in the group are shown under the Issues/Providers Tab for the group in OH CDMS with the relevant supporting jurisdictional documentation."[1]

On November 7, 2022, the Board issued Alert 23, which gave notice that effective December 7, 2022, the Board was resuming its normal operations following the COVID- 19 Pandemic. The Alert 23 included a reminder to the Parties regarding the Rule 20 Certification requirement.

Pertinent Facts with Regard to Case No. 17-1138GC:

On **October 11, 2023**, Strategic Reimbursement Group, LLC ("Strategic"/"Group Representative") designated the CIRP group fully formed. On the same date, Strategic filed a Rule 20 Certification indicating the group was fully populated in OH CDMS.

[1] Emphasis added.

On **October 13, 2023**, the Board issued a Group Completion Notice and Critical Due Dates notification setting preliminary position paper deadlines for the subject appeal. The Group's preliminary position paper deadline was set for December 12, 2023.

On **December 12, 2023**, Strategic filed its preliminary position paper.

On **February 9, 2024**, the Medicare Contractor filed its Rule 22 Jurisdictional Review letter in which it advised the Board that it was unable to make a jurisdictional assessment on all providers in the group because, although the Representative certified the group was fully populated, not all providers are in the participant listing in OH CDMS. The Medicare Contractor also indicated that the jurisdictional documentation in OH CDMS is unclear as there is confusion regarding whether one of the Providers, Adventist Health St. Helena (Provider Number 05-0013) is appealing FYE 2013 or 2014.[2] The Medicare Contractor asserts that a PDF Schedule of Providers with full support should have been filed in this case as required by Board Rule 20.1.

As set forth below, Strategic has failed to meet the requirements of Rules 20 and 20.1. Below is a discussion regarding Rule 20 and Rule 20.1 requirements and the information that was required in this case.

Rule 20/20.1 Background:

Rule 20 addresses the population of Issues/Providers in OH CDMS. Pursuant to Board Rule 20:

> If ***all*** the participants in a fully-formed group are ***populated*** under the Issues/Providers Tab in OH CDMS with supporting jurisdictional documentation (*see* Rule 21), then the representative is exempt from filing a ***hard copy*** of the schedule of providers with supporting jurisdictional documentation. In this instance, the Board uses the schedule of providers and supporting jurisdictional documentation that is created in OH CDMS using the information and documents included in each participating provider's request for transfer or direct add to the group.
>
> ***Prior to*** certifying that the group is fully formed or the date on which a group is fully formed, the 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.[3] If *all* of the participants in a fully-formed group are ***populated*** under the Issues/Providers Tab in OH CDMS, then ***within (60) sixty days of the full formation of the group***, the group representative must file a statement certifying that the group is *fully* populated in OH CDMS with the relevant supporting jurisdictional documentation (*i.e.*, all participants in the group are shown under the

[2] The Board notes there is no determination or issue information in OH CDMS for this provider, yet the Representative certified the group to be fully populated.

[3] If all participants are populated but jurisdictional support is not complete, the Rule 20 Certification must certify that all participants are populated but should include an identification of the documents that are missing and then ***only*** file in OH CDMS those additional missing documents. See, https://www.cms.gov/files/document/oh-cdms-prrb-user-manual-supplement-supplemental-document-uploads-group-appeals.pdf.

> Issues/Providers Tab for the group in OH CDMS with the relevant supporting jurisdictional documentation).[4]

Board Rule 20.1 applies to **"Group Cases that Are Not Fully Populated in OH CDMS."** Pursuant to Board Rule 20.1:

> If any participants in a fully-formed group are ***not*** populated under the Issues/Providers Tab in OH CDMS with supporting jurisdictional documentation (*see* Rule 21), then the Representative must prepare a traditional schedule of providers (*i.e.* Model Form G at Appendix G), for *all* participants in the group **following the instructions in this Rule and Rule 21, unless the Board instructs otherwise.** Specifically, *within sixty (60) days of the full formation of the group* (see Rule 19), the group representative must prepare and file a schedule of providers with the supporting jurisdictional documentation for all providers in the group that demonstrates that the Board has jurisdiction over each participant named in the group appeal (*see* Rule 21) . . . .

In this group case, not all providers are populated behind the Participants tab and, therefore, Rule 20.1 applies.[5] As such, the Representative was required to separately file a PDF copy of the full SoP with **all relevant supporting jurisdictional documentation** within the 60-day period allotted under Board Rule 20.1.[6]

Board Determination:

Pursuant to 42 C.F.R. § 405.1868:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. *The Board's powers include the authority to take appropriate actions in response to the* ***failure of a party*** *to a Board appeal* ***to comply with Board*** rules and ***orders*** or for inappropriate conduct during proceedings in the appeal.
>
> (b) *If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—*

[4] (Underline emphasis added.)
[5] After a cursory review of Case 17-1138GC, the Board notes on February 11, 2019, a hard copy Model Form E – Direct Add was filed for Adventist Health Hanford (Prov. No. 05-0121) for FYE 12/31/2013. This provider is not listed in the participant listing in OH CDMS.
[6] Rule 20/20.1 Certifications must be stand-alone filings and never part of another filing *(e.g., never embedded within a preliminary position paper filing, group status response, etc.).*

> *(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.

The Board is also cognizant of the fact that, on more than one occasion, it has explained the background and requirements of Board Rule 20 and Rule 20.1.[7] Numerous times, as a courtesy, the Board has extended Strategic additional time to correct such deficiencies, however Strategic continues to miss or make deficient filings related to this Board Rule.

Specifically, regarding Case No. 17-1138GC, the Board admonishes Strategic for falsely filing a Rule 20 Certification in a case which has obviously not been fully populated. Additionally, the Board notes that the Medicare Contractor made Strategic aware of the deficiencies in this group in its February 9, 2024 correspondence, and yet despite this and all the Board's prior warnings with regard to Rule 20/20.1 submissions, Strategic has failed to correct the record in this case, suggesting to the Board that Strategic has abandoned its appeal. Consequently, because the full SoP with supporting documentation was not timely filed in the subject group as required under Board Rule 20.1, the Board hereby dismisses Case No. 17-1138GC pursuant to its authority under 42 C.F.R. § 405.1868.

Finally, regarding the inclusion of CY 2014 participants in the CY 2013 group under Case No. 17-1138GC, the Board notes that Case No. 17-1138GC was previously expanded to include CY 2014. The Board agreed to the expansion to allow the addition of Ukiah Valley Medical Center's (Prov. No. 05-0301) appeal of its CY 12/31/2014, seemingly because it was the only participant in the chain pursuing the Medicaid Ratio Part C Dual Eligible issue for that year. However, on June 22, 2019, it was requested that Ukiah Valley Medical Center be transferred from the expanded SRI Adventist 2013-2014 Medicaid Ratio Part C Dual Eligible CIRP group, Case No. 17-1138GC, to the "Adventist Health 2014 Exclusion of Dual Eligible Part C Days – Medicaid Ratio CIRP Group" under Case No. 18-1725GC.[8] Although the Group Representative did not submit an explanation with its Transfer request, the Board noted that there were additional providers in the Adventist Health chain pursuing the Medicaid Ratio Part C Dual Eligible issue for CY 2014. In order to keep each group appeal for a single CY, the Board agreed to allow the transfer of Ukiah Valley Medical Center's CY 2014 appeal of the Medicaid Ratio Part C Dual Eligible issue from the expanded group, Case No. 17-1138GC to Case No. 18-1725GC.[9]

On February 16, 2023, Case No. 18-1725GC was subsequently consolidated into another Toyon group, Case No. 19-1359GC, the "Adventist Health CY 2014 DSH Medicare Part C - SSI Ratio/DE Part C - Medicaid Ratio CIRP Group."[10] On March 10, 2023, Toyon certified Case No. 19-1359GC to be fully formed **without** the inclusion of the two CY 2014 providers that had been

---

[7] See 2/8/2023 Board Order to File Applicable Documents Required under Board Rules 20 & 20.1 issued in Case Nos. 20-0222GC, 21-1356GC, 21-1358GC, 22-0011GC. Also see 4/10/2023 Board Determination on Motion to Dismiss for Failure to (Timely) File Rule 20 Certification issued in Case No. 14-1402GC.
[8] Toyon Associates, Inc. filed Case No. 18-1725GC on September 20, 2018.
[9] With the transfer of the CY 2014 participant, the group name for Case No. 17-1138GC was modified back to the "SRI Adventist **2013** DSH Medicaid Ratio Part C Dual Eligible CIRP Group."
[10] Toyon filed the "Adventist Health CY 2014 DSH Medicare Part C - SSI Ratio/DE Part C - Medicaid Ratio CIRP Group" on March 11, 2019.

erroneously included in Strategic's CY 2013 CIRP group, Case No. 17-1138GC: Adventist Health St. Helena (Prov. No. 05-0013) and Glendale Medical Center (Prov. No. 05-0239).

Accordingly, the Board finds that Adventist Health St. Helena (Prov. No. 05-0013) and Glendale Medical Center (Prov. No. 05-0239) are unable to pursue the DSH Medicare Part C - SSI Ratio/DE Part C - Medicaid Ratio issue for CY 2014 as:

- they were erroneously included in Case No. 17-1138GC, which has now been dismissed;
- they were required to pursue the common issue in a CIRP group, and the appropriate CIRP group was Case No. 19-1359GC; and
- Toyon certified Case No. 19-1359GC, to be fully formed without their inclusion.[11]

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

Board Members:
Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

2/14/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Amin. (J-E)
Dylan Chinea, Toyon Associates, Inc.

[11] Toyon filed a Rule 20 Certification indicating that Case No. 19-1359GC was fully populated. Neither Provider No. 05-0013 nor Provider No. 05-0239 were included in the participant listing.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
AllianceHealth Midwest, Prov. No. 37-0094, FYE 06/30/2017
Case No. 19-2704

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-2704. Set forth below is the decision of the Board to dismiss the 3 remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific), Medicaid Eligible Days, and Uncompensated Care ("UCC") payments.

Background

A. *Procedural History for Case No. 19-2704*

On **March 12, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2017. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **September 11, 2019**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

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

[1] On April 21, 2020, this issue was transferred to Case No. 20-1332GC.
[2] On April 21, 2020, this issue was transferred to Case No. 20-1333GC.
[3] On April 21, 2020, this issue was transferred to Case No. 20-1334GC.
[4] On June 21, 2023, the Medicare Contractor filed a jurisdictional challenge over Issue 5 and Motion to Dismiss.
[5] On April 21, 2020, this issue was transferred to Case No. 20-1335GC.

7. DSH Medicaid Fraction / Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[6]
8. Uncompensated Care ("UCC") Distribution Pool
9. 2 Midnight Census IPPS Payment Reduction[7]

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **April 21, 2020**, the Provider transferred Issues 2, 3, 4, 6, 7, and 9 to CHS CIRP groups. As a result of the case transfers, there are three (3) remaining issues in this appeal: Issue 1 (the DSH – SSI Percentage Provider Specific), Issue 5 (the DSH – Medicaid Eligible Days), and Issue 8 (UCC Distribution Pool).

On **September 20, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[8]

On **May 4, 2020**, the Provider timely filed its preliminary position paper. With respect to Issue 5, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2017 cost report does not reflect an accurate number of Medicaid eligible days." As a result, , the Provider included, as an Exhibit, the original "estimated impact" for this issue of $54,712 based on an *estimated* 100 days.

On **July 7, 2020**, the Medicare Contractor timely filed a Jurisdictional Challenge[9] with the Board over Issues 1 and 8 requesting that the Board dismiss these issues. Pursuant to Board Rule

---

[6] On April 21, 2020, this issue was transferred to Case No. 20-1336GC.
[7] On April 21, 2020, this issue was transferred to Case No. 20-1337GC.
[8] (Emphasis added.)
[9] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a

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 21, 2020**, the Medicare Contractor filed its preliminary position paper. With regard to Issue 5, the Medicare Contractor's position paper noted that: (1) the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position; and (2) the Provider had failed to respond to any of the Medicare Contractor's requests for that Medicaid eligible days listing.

On **August 24, 2020**, the Medicare Contractor filed a Substantive Claim Challenge[10] relative to Issues 1, 5, and 8 requesting that the Board find that there is not an appropriate cost report claim for these issues per 42 C.F.R. § 413.24(j) and that these items are not reimbursable, regardless of whether the Board were to issue a favorable final hearing decision under 42 C.F.R. § 405.1871(a). Significantly, under Board Rule 44.5.1, the Provider had 30 days to respond to the Substantive Claim Challenge. However, the Provider ***failed*** to file any response.

On **January 4, 2023**, the Medicare Contractor filed its 3rd and Final Request for DSH Package in connection with Issue 5. In this filing, the Medicare Contractor noted that, on January 28, 2020 (1st request) and on November 14, 2021 (2nd request), it had previously requested that the Provider send it a DSH package to resolve Issue 5. 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 3, 2023 (*i.e.*, within 30 days). Notwithstanding the formal request, the Provider failed to file any response to the Medicare Contractor.

As no response was received from the Provider, on **June 21, 2023**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to furnish documentation in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); (2) the Provider failed to furnish the Medicaid eligible days listing with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2; and (3) the Provider has effectively abandoned Issue 3. Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** timely respond to that Motion.

---

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

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

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

On **November 13, 2023**, almost 4 months after the deadline for responding to the Motion to Dismiss Issue 5, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the *caveat* that the "Listing [is] *pending finalization* upon receipt of State eligibility data."[11] The Listing was 20 pages with roughly 3000 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 3000 days) was being submitted at this late date or why it was not final (*i.e*., why it was "pending finalization") at this late date, ***more than 6 years after the fiscal year at issue had closed***. NOTE—the roughly 3000 included in this belated listing is *exponentially* larger than the original *estimated* impact of 100 days included with the appeal request.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20-1332GC - CHS CY 2017 HMA DSH SSI Percentage CIRP Group

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).[12]

The Group issue Statement in Case No. 20-1332GC, 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

[11] (Emphasis added.)
[12] Issue Statement at 1 (Sept. 11, 2019).

> covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[13]

On May 4, 2020, the Board received the Provider's preliminary position paper in 19-2704. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation based on the Provider's Fiscal Year End (June 30).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services,* No. CV-94-0055 (C.D. Cal June 2, 1995), the SSI entitlement of individuals can be ascertained from [s]tate records. However, at this time, the Provider has been unable to analyze the

[13] Group Appeal Issue Statement in Case No. 20-1332GC.

> Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the completed MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008).[14]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $51,000.

MAC's Contentions

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

The MAC argues that the Board should dismiss the DSH – SSI Percentage (Provider Specific) issue for two reasons. First, the MAC argues that the appeal is duplicative:

> The MAC contends that Issue 1 has 3 sub-issues. Sub-issues 1 and 3 are duplicative of Issue 2. In sub-issues 1 and 3, the Provider states:
>
> 1. The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
>   The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
>   The Provider contends that the SSI percentage is flawed.

[14] Provider's Preliminary Position Paper at 11-12 (May 4, 2020).

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

The MAC contends that the Provider makes the same argument in Issue 2. The Provider states in Issue 2:

> The Provider contends that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Provider contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.

The MAC contends that the above argument is duplicative of sub-issue 1 of Issue 2. The Provider further argues in Issue 2:

> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The MAC [contends] the above argument is duplicative of sub-issue 3 of Issue 2. [15]

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

> The decision to realign a hospital's SSI percentage with its fiscal year end is a provider election. It is not a final MAC determination. The provider must make a formal request to the MAC and CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of the reimbursement impact.
>
> ****
>
> The Provider's appeal of this item is premature. The Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3); therefore, the Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue. The MAC requests that the PRRB dismiss this issue consistent with recent jurisdictional decisions.[16]

Issue 3 – DSH – Medicaid Eligible Days

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

> The MAC's Motion [to dismiss] is supported by the nearly [four] years which have elapsed since the appeal was filed, inclusive of the Medicaid Eligible Days issue. This passage of time and the failure to respond to the MAC's multiple requests for documentation, belies the Provider's affirmative statements in its

[15] Jurisdictional Challenge at 5-6 (Jul. 7, 2020).
[16] *Id.* at 7-8.

> Preliminary Position Paper that an eligibility listing was being sent to the MAC under separate cover.[17]

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)."[18] The MAC also contends that this issue is a duplicate of PRRB Case No. 16-0769GC and should therefore be dismissed.[19]

Provider's Jurisdictional Response

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

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

Decision of the Board

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

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

A. DSH Payment/SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine

[17] Medicare Contractor's Motion to Dismiss at 4 (Jun. 21, 2023).
[18] *Id.* at 10.
[19] *Id*. at 12.
[20] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

the DSH percentage; and (2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Case No. 20-1332GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[21] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[22] The Provider argues in its issue statement, which was included in the appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[23]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-1332GC 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. 19-2704 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-1332GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[24], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

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

---

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

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 201332GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records" but fails to explain how it can, explain how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2.[26] Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Aug. 29, 2018), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

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

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

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

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

used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[28]

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

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 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. 20-1332GC.

Accordingly, *based on the record before it*,[30] the Board finds that the SSI Provider Specific issue in Case No. 19-2704 and the group issue from the CHS CIRP group under Case No. 20-1332GC 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.

[28] Last accessed January 9, 2024.
[29] Emphasis added.
[30] 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.

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.[31]

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

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

---

[31] (Bold emphasis added.)

Rule 25 Preliminary Position Papers[32]

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

25.1 Content of Position Paper Narrative

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

25.1.1 The Provider's Position Paper

A. Identify any issues that were raised in the appeal but are 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.

[32] (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 September 20, 2019 included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

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

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

> paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[33]

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 May 4, 2020, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[34] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $54,712 based on an estimated 100 days). The Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that

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

> all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2017 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

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

Notably, the Medicare Contractor sent 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 January 28, 2020 and the second request was sent to the Provider on November 14, 2021. The third, final request was filed formally with the Board in OH CMDS on January 4, 2023, *five years after the end of the Provider's cost reporting period*. The Medicare Contractor also informed the Provider in its final request for information that the deadline to respond was February 3, 2023. The Provider failed to file any response to the 3rd and final request.

Due to the non-responsiveness of the Provider, on **June 21, 2023**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the

Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish the list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2 (or when request by the Medicare Contractor 3 separate times after that). The Medicare Contractor thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the regulations and the Board Rules.[35]

Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** timely respond to that Motion by the July 21, 2023 filing deadline (*i.e.*, 30 days after June 21, 2023).

However, on November 13, 2023 (4 months after the deadline to respond to the Motion), QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the caveat that the "Listing [is] pending finalization upon receipt of State eligibility data." The Listing was 20 pages with roughly 3000 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 3000 days) was being submitted at this late date or why it was not final (*i.e.*, why it was "pending finalization") at this late date, ***more than 6 years after the fiscal year at issue had closed***. NOTE—the roughly 3000 included in this belated listing is *exponentially* larger than the original estimate of 100 days included with the appeal request. Regardless, this filing was more than 4 months past the deadline for responding to the Motion to Dismiss *and, more importantly,* ***was roughly 3½ year past the deadline for including it with its preliminary position paper*** since the position paper deadline was May 8, 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 4 days after the Provider changed its designated representative to QRS does not excuse the Provider for its failure to include the information with its preliminary position paper or its failure to timely respond to the Motion to Dismiss. Board Rule 5.2 makes clear that "the recent appointment of a new representative will also not be

[35] *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.

considered cause for delay of any deadlines or proceedings." Moreover, the Board rejects the Provider's attempt to label the November 13, 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)). Indeed, the Provider failed to timely reply to the Medicare Contractor's Motion to Dismiss Issue 5 and the alleged "Supplement" was filed ***more than 3 months*** *after the deadline* for filing a response to the Motion to Dismiss Issue 5.

2. The alleged "Supplement" fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the roughly 3000 days was not previously available, *in whole or in part* (*i.e*., it is not clear why the Provider failed to identify a single day at issue until more than 4 years after this appeal was filed and more than 6 years after the fiscal year at issue had closed); and (c) why the listing still was ***not*** a "*final*" listing at this late date.

3. Neither the Board Rules nor the September 20, 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* 3000 days listed in the alleged "Supplement" is, without explanation, *exponentially* larger than the original estimated 100 days included with the appeal request).[36]

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[37] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provider the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under

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

42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

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

C. UCC Distribution Pool

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

1. Bar on Administrative Review

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

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[39]
>
> (B) Any period selected by the Secretary for such purposes.

---

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

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

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

2. Interpretation of Bar on Administrative Review

a. Tampa General v. Sec'y of HHS

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs*. ("*Tampa General*"),[40] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[41] 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."[42] 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.[43]

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.[44]

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*").[45] 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

[40] 830 F.3d 515 (D.C. Cir. 2016).
[41] 89 F. Supp. 3d 121 (D.D.C. 2015).
[42] 830 F.3d 515, 517.
[43] *Id.* at 519.
[44] *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*").
[45] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").

way to review the Secretary's method of estimation without reviewing the estimate itself."[46] 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.[47]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[48] 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.[49] 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.[50] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[51] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[52]

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.[53]

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

---

[46] *Id.* at 506.
[47] *Id.* at 507.
[48] 514 F. Supp. 249 (D.D.C. 2021).
[49] *Id.* at 255-56.
[50] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[51] *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.
[52] *Id.*
[53] *Id.* at 262-64.

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."[54] 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.[55] 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.[56]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[57] 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*").[58] 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.[59] 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."[60] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[61] 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

---

[54] *Id.* at 265.
[55] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[56] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[57] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[58] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[59] *Id*. at *4.
[60] *Id.* at *9.
[61] 139 S. Ct. 1804 (2019).

within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[62]

The Board concludes that the same findings are applicable to the Provider's challenge to their FFY 2017 UCC payments. The Provider is challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2017. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review.

* * * * *

Based on the foregoing, the Board has dismissed the three (3) remaining issues in this case – (Issues 1, 5 and 8). As no issues remain, the Board hereby closes Case No. 19-2704 and removes it from the Board's docket.[63] Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

2/15/2024

X Clayton J. Nix

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

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

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

[63] The Board notes that the Medicare Contractor's August 24, 2020 Substantive Claim Challenges regarding Issues 1, 5, and 8 and that the Provider failed to file a response to the Substantive Claim Challenges within the 30-day period under Board Rule 44.5.1. As the Board dismissed Issue 8 for lack of jurisdiction pursuant to 42 C.F.R. § 405.1840(c), 42 C.F.R. § 405.1873(e)(1) prohibits the Board from making any findings regarding Issue 8. Regarding Issues 1 and 5, the Board notes that the very nature of these issues (as detailed in the appeal request) confirms that they could not be claimed on the cost report but rather had to be protested consistent with 42 C.F.R. § 413.24(j)(2). The Board's review of the documentation included with the Medicare Contractor's August 24, 2020 filing (Exhibits C-1 to C-4) confirms that the Provider failed to include Issues 1 and 5 as a protested item. The Board recognizes that the Provider listed retroactive Medicaid eligibility but the Provider failed to list any protested amount for that item (much less included the requisite workpaper specified in 42 C.F.R. § 413.24(j)(2)(ii). Indeed, the Provider's failure to respond to the Substantive Claim Challenges suggests that it does not dispute them. Based on the above, the Board finds that, for Issues 1 and 5, the Provider failed to comply with the § 413.24(j)(2) requirements and that regardless of whether it were to be successful on the merits of its appeal, it would not be entitled to any reimbursement for those issues due to its noncompliance.

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, Esq.
King & Spalding, LLP
1700 Pennsylvania Ave. NW, Ste. 900
Washington, DC 20006

Re: ***Determination on Clarification of Group Issue Statement***
Case No. 23-1757GC – CHS CY 2020 Capital DSH CIRP Group

Dear Mr. Hettich:

The Provider Reimbursement Review Board (the "Board") has reviewed the subject common issue related party ("CIRP") group case for Community Health Systems, Inc. ("CHS") in response to correspondence from King & Spalding, LLP ("King & Spalding") dated December 29, 2023, which it titled "Notice of Clarification of Issue Statement." In its correspondence, King & Spalding recognizes that "detailed issue statement" filed to establish the group "focuses on a particular aspect of the Capital DSH calculation, namely the treatment of Part C days." However, King & Spalding filed its correspondence to: (1) clarify that the group appeal "challenges CMS's policy, codified at 42 C.F.R. § 412.320(a)(1)(iii), of categorically denying capital DSH payments to hospitals that have reclassified as rural under 42 C.F.R. § 412.103"; and (2) request that "the Board accept this Clarification and Revised Issue Statement to resolve any potential ambiguity" in the original group issue statement. The pertinent facts and the Board's determination are set forth below.

Background:

On September 25, 2023 at 6:22 pm EDT, King & Spalding filed the group appeal request to establish this CIRP group. The issue statement in the appeal request read as follows:

> **Issue Statement: Effect of Treatment of Part C Days for Which Part A Did Not Make Payment on Capital DSH**
>
> The issue relates to CMS's determination of the Capital DSH payment owed to the Providers. The Capital DSH payment is calculated based on the Medicare disproportionate share hospital ("DSH") payment, which in turn is based upon a hospital's disproportionate patient percentage ("DPP"). The DPP is the sum of two fractions, the Medicaid fraction and the Medicare/SSI fraction ("SSI fraction"). The Providers contend that the inclusion in the SSI fraction of days for which Medicare Part A did not make payment, such as days paid under Medicare Part C ("Medicare Advantage" days), is contrary to law. The Providers also contend that the exclusion from the Medicaid fraction of days for which Medicare Part A did not make payment, such as days paid **under Medicare Part C**

> for which patients were also eligible for Medicaid, is contrary to law. These policies had the effect of diluting the Providers' DPP, and thereby understating its capital DSH payment.
>
> As a preliminary matter, the Providers note that the [U.S.] Court of Appeals for the District of Columbia has held **the policy to include Medicare Advantage days** adopted by CMS in 2004 was "deficient" from a notice standpoint and therefore vacated. *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1111 (D.C. Cir. 2014) (*Allina I*). . . .
>
> CMS, however, attempted to issue a regulatory "fix," essentially re-**formalizing its policy to treat Part C days** as days "entitled to benefits under part A" in its FY 2014 IPPS Final Rule in reaction to *Allina I*. *See* 78 Fed. Reg. 50496, 50614-20 (Aug. 19, 2013). That "fix" went into effect October 1, 2013. That "fix" went into effect October 1, 2013 and is thus applicable to the time period at issue. While the procedural errors discuss in *Allina I* and *Allina II* were purportedly corrected, the substantive failings of the Secretary's regulation as detailed below still remain. . . .
>
> *First*, the Secretary's policy is inconsistent with the plain meaning of the Medicare DSH statute. *See, e.g., Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 24 (D.C. Cir. 2011) (Kavanaugh, J., concurring) ("[D]espite HHS's effort to fog it up, § 1395ww(d)(5)(F)(vi) is sufficiently clear in establishing that a Part C beneficiary is not simultaneously entitled to benefits under Part A for any specific patient day."), *aff'ing on limited grounds* 699 F. Supp. 2d 81 (D.D.C. 2010).
>
> ****
>
> *Fourth*, even if the DSH statute were unclear (and it is not), the Secretary's current interpretation is not reasonable, and is arbitrary and capricious, because the Secretary has provided no explanation whatsoever for the inconsistent interpretation of the exact same phrase –"entitled to benefits under part A" – as used in the DSH statute (42 U.S.C. § 139Sww(d)(5)(F)) and in the immediately adjacent subparagraph governing Medicare dependent hospitals (42 U.S.C. § 1395ww(d)(S)(G)).
>
> ****
>
> Accordingly, the Providers contend that days for which Medicare Part A did not make payment, such as **Medicare Part C days**, should be excluded from the Medicare/SSI fraction and, to extend such patients are also Medicaid-eligible, included in the Medicaid fraction. **The MACs' improper calculation of the Providers' DPP had an adverse effect on the Providers' Capital DSH payment, resulted in negative reimbursement impacts to the Providers**.[1]

Currently, Case No. 23-1757GC contains only 2 participants. Specifically, on **September 25, 2023** at 6:22 pm EDT, concurrent with the filing of the group, King & Spalding directly added the

[1] (Italics emphasis in original, bold emphasis added except in title, and underline emphasis added.)

first participant, Regional Hospital of Scranton (Prov. No. 39-0237), to Case No. 23-1757GC. On **October 23, 2023**, King & Spalding directly added the second participant, Physicians Regional Medical Center (Prov. No. 39-0237).

On **December 29, 2023**, King & Spalding filed a "Notice of Clarification of Issue Statement" for the CIRP group appeal. King & Spalding states that it "regrets the potential for confusion" but that it would simply make no sense for the Providers to challenge the treatment of Part C days in the Capital DSH calculation when, under 42 C.F.R. §412.320(a)(1)(iii), they were entitled to no Capital DSH payments at all. Instead, King & Spalding maintains that "[t]aken together, the group title, the reimbursement impact calculations and the explicit statement regarding what "[t]he appeal asserts" unambiguously describe the categorical disallowance of the capital DSH payments under 42 C.F.R. § 412.320(a)(1)(iii)."

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.

42 C.F.R. § 405.1837(a) specifies that "[a] provider . . . has a right to a Board hearing, as part of a group appeal with other providers . . . ***only if***— (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 . . . ."[2] To this end, 42 C.F.R. § 405.1837(f)(1) discusses "Limitations on group appeals" and specifies that no issues may be added to a group appeal:

> (1) After the date of receipt by the Board of a group appeal hearing request under paragraph (c) of this section, *a provider may* ***not add other questions*** *of fact or law to the appeal***,** regardless of whether the question is common to other members of the appeal (as described in §405.1837(a)(2) and (g) of this subpart).[3]

Finally, 42 C.F.R. § 405.1837(c) describes the "Contents of request for a group appeal" and the minimum content requirements for a group appeal request include the following:

> (c) *Contents of request for a group appeal*. The request for a Board hearing as a group appeal must be submitted in writing to the Board, and **the request must include all of the following**:
>
> (1) A demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section.

[2] (Emphasis added.)
[3] (Emphasis added.)

> (2) An explanation (for each specific item at issue) of each provider's dissatisfaction with the final contractor or Secretary determination under appeal, including an account of—
>
> (i) **Why the provider believes Medicare payment is incorrect** for each disputed item;
>
> (ii) **How and why** the provider believes Medicare **payment must be determined differently** for each disputed item; and
>
> (iii) If the provider self-disallows a specific item (as specified in § 413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.
>
> (3) A copy of each final contractor or Secretary determination under appeal, and any other documentary evidence the providers consider to satisfy the hearing request requirements of paragraphs (c)(1) and (c)(2) of this section, and **a precise description of the one question of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matter at issue in the group appeal**.

Consistent with § 405.1837(c), Board Rule 13 provides the following additional guidance regarding the content of the group issue statement:

> **Rule 13 Common Group Issue**
>
> The matter at issue in a group appeal must involve a single common question of fact or interpretation of law, regulation, or CMS policy or ruling. A group case is not appropriate if facts that must be proved are unique to the respective providers or if the undisputed controlling facts are not common to all group members. Likewise, a group appeal is inappropriate if the Board could make different findings for the various providers in the group.[4]

Board Rule 8 providers further clarification:

> **Rule 8 Framing Issues for Adjustments Involving Multiple Components**
>
> Some issues may have multiple components. To comply with the requirements of 42 C.F.R. § 405.1835, appeal requests must specifically identify the items in dispute, and each contested component must be

[4] Board Rule v. 3.1 (Nov. 1, 2021).

appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7. Several examples are identified below, but these examples are not exhaustive lists of categories or issues.

A. Disproportionate Share Hospital Payments

Common examples include, but are not limited to:

- Dual eligible Medicare Part A/Medicaid, which is often referred to as dual eligible Medicare Part A Exhausted and Noncovered Days (*see, e.g.*, CMS Ruling 1498-R at 7-8);
- Dual eligible Medicare Part C/Medicaid, which is often referred to as DSH Medicare Advantage Days (*see, e.g.*, CMS Ruling 1739-R);
- Pre-1999 dual eligible Medicare HMO days;
- SSI data matching (*see, e.g.*, CMS Ruling 1498-R at 4-6);
- SSI eligible days (*see, e.g.*, *Hall Render Individual, Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction v. Wisconsin Physicians Servs*., PRRB Dec. No. 2017-D12 (Mar. 28, 2017));
- State/program specific general assistance days;
- Section 1115 waiver days (program/waiver specific);
- Medicaid adolescent/child days in a psychiatric residential treatment center; and
- Observation bed days.

****

D. Wage Index

Common examples include, but are not limited to:

- Wage data corrections;
- Occupational mix;
- Wage vs. wage-related costs;
- Pension;
- Rural floor; and
- Data corrections.[5]

In the Notice of Clarification of Issue Statement, King & Spalding recognizes that, ". . . language in the *more detailed* [group] issue statement focuses on a particular aspect of the Capital DSH calculation, namely the treatment of Part C days" but, notwithstanding, asserts that the group "the group appeal challenges CMS's policy, codified at 42 C.F.R. § 412.320(a)(1)(iii), of categorically denying capital DSH payments to hospitals that have reclassified as rural under 42 C.F.R. § 412.103. In support of this position, King & Spalding argues:

[5] (Underline emphasis added.)

> Taken together, the group title, the reimbursement impact calculations and the explicit statement [included on the impact calculations] regarding what "[t]he appeal asserts" unambiguously describe the *categorical* disallowance of the capital DSH payments under 42 C.F.R. § 412.320(a)(1)(iii). In addition to these specific items and explicit statements, it would simply make no sense for the Providers to challenge the treatment of Part C days in the Capital DSH calculation when, under 42 C.F.R. § 412.320(a)(1)(iii), they were entitled to no Capital DSH payments at all.

The Board finds the Notice of Clarification of Issue Statement to be an attempt to *improperly* add an issue to a group appeal in violation of 42 C.F.R. § 405.1837(f)(1). Consistent with 42 C.F.R. § 405.1837(c)(2)-(3) and Board Rules 8 and 13, King & Spalding included a very *detailed* group issue statement with the group appeal request that it filed to establish the instant CIRP group and this issued stated gave "a ***precise*** description of the one question of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matter at issue in the group appeal."[6] Specifically, as described below, the Board reviewed the group issue statement and finds that: (1) the group issue statement identified the "precise description" of the group issue appealed as the DSH Part C issue; and (2) the group issue statement did not include the alleged "challenge[d to] CMS's policy, codified at 42 C.F.R. § 412.320(a)(1)(iii), of categorically denying capital DSH payments to hospitals that have reclassified as rural under 42 C.F.R. § 412.103."[7]

The original group issue statement in Case No. 23-1757GC is very detailed and clearly relates ***only*** to the Capital DSH Part C issue. At the outset, the Board notes that it has a long history of recognizing the DSH Part C issue (as embodied in the *Allina* litigation) as a distinct DSH issue as demonstrated by the 100s of expedited judicial review decisions issued by the Boad in connection with the *Allina* litigation[8] and as memorialized in Board Rule 8 (as quoted above). Second, the group issue statement is entitled the "Effect of ***Treatment of Part C Days*** for Which Part A Did Not Make Payment on Capital DSH" and asserts that CMS' attempt to "fix" its DSH Part C days policy by re-formalizing its policy in the FY 2014 IPPS final Rule (in reaction to the procedural errors raised in the *Allina I* litigation) failed because the policy remains substantively invalid and those substantive issues were not addressed in either the *Allina I* or *Allina II* litigation. In this regard, the group issue states that the Part C days should be excluded from the SSI fraction and that their inclusion in the SSI fraction "had an adverse effect on the Providers' Capital DSH payment, result[ing] in negative reimbursement impacts to Providers." Indeed, King & Spalding recognizes in its correspondence that group issue statement is "detailed" and "focuses on a particular aspect of the Capital DSH calculation, namely the treatment of Part C days."

Significantly, the *detailed* group issue statement does ***not*** refer to reclassifications of hospitals as "rural" or refer to either 42 C.F.R. § 412.320(a)(1)(iii) or § 412.103. Similarly, the *detailed* issue statement does not refer to CMS "categorically denying capital DSH payments to hospitals that

---

[6] 42 C.F.R. § 405.1837(c)(3) (emphasis added).
[7] The Board's dismissal is consistent with *Evangelical Community Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 459846 (D.D.C. Sept. 30, 2022).
[8] The Board takes administrative notice that King & Spalding was the representative for many cases in which the Board issued Part C EJR decisions.

have reclassified as rural." To the contrary, the group issue statement as noted above represents that the group participants received "capital DSH payments": "The MACs' improper calculation of the Providers' DPP had an adverse effect *on the Providers' Capital DSH payment*, resulted in negative reimbursement impacts to the Providers."[9] Thus, the fact that the group title *generically* refers to Capital DSH is consistent with the detailed group issue statement concerning the impact of the Part C days issue on the purported Capital DSH payments the providers received.[10] In sum, the Notice of Clarification of Group Issue statement is not a "clarification" since there is nothing in the detailed issues statement that needed clarification; rather, it was very specific and detailed as to the specific ***one issue*** being appealed consistent with 42 C.F.R. § 405.1837(c).

The Board recognizes that, in support of its position, King & Spalding instead focuses on the "Calculation Support Document" that it uploaded for each of the 2 participants that were directly added to the CIRP group, one added concurrent with the establishment of the CIRP group and the other added a month later. However, each participant's "Calculation Support Document" is a copy of what is identified as a Protest Workpaper included with its relevant as-filed cost report.[11] As such, each of these documents was created specific to a provider (and does ***not*** directly relate to the group itself). Further, since these documents were Protest Workpapers included with the relevant as-filed cost report, they were not specifically created for the group appeal filing but rather were created *at an earlier point in time* for the Medicare Contractor as part of their obligations under 42 C.F.R. § 413.24(j) to include an appropriate cost claim on their as-filed cost report. Finally, since no issue may be added to a group appeal, the ***only*** "Calculation Support Document" that can be considered relevant to the group appeal request is the Calculation Support Document for the first participant directly added to the group *concurrent* with the establishment of the group.[12] The participant directly added to the appeal was Regional Hospital of Scranton. As this Provider appealed from its NPRs, its face value is limited because there could have been intervening developments following the as-filed cost report such that the Provider could have received a Capital DSH payment in the NPR.[13] Based on the above findings, the Board declines to consider the "Calculation Support Documents" as supplanting and replacing the purposeful, very *detailed* document identified and filed as the group issue statement document.[14] It is the Provider's

[9] (Emphasis added.)

[10] As such, these documents cannot be used to *clarify* the group issue statement since the detailed group issue statement itself does not reference or even imply any challenge to 42 C.F.R. § 412.320(a)(1)(iii). Rather, the Providers are attempting to replace the otherwise detailed issue statement with another issue. As such, the Notice of Clarification of Issue Statement is not *clarification* of the original issue appealed as detailed in the group issue statement because that statement does not reference any challenge to § 412.320(a)(1)(iii) but rather describes the in detail the Capital DSH Part C issue and represents that the group participants received Capital DSH payments (which would not have occurred if § 412.320(a)(1)(iii) were applied).

[11] The Calculation Support Document for Regional Hospital of Scranton is a Workpaper entitled "Exhibit 6.18B: Capital DSH for Certain Rural Hospitals Protest" and the fiscal year at issue is subject to 42 C.F.R. § 413.24(j). Similarly, footnote 2 of the Notice of Clarification of Issue Statement refers to this workpaper as "protested item support."

[12] The second participant was not added until a month after the appeal request and is not relevant since an issue may not be added to a group appeal once the group is established.

[13] The Board notes that, unlike the other participant, Regional Hospital of Scranton's Calculation Support Document leaves the "Protest Amount" blank as a "-". In contrast, the other participant lists "$66,064" as the "Protest Amount." In addition, the Board notes that the other documents included in the direct add for Regional Hospital of Scranton did not include the audit adjustment report or any detail or portion of the *settled* cost report.

[14] To do so otherwise would allow the tail (*i.e.*, the Calculation Support Document submitted for the amount in controversy for the participant) to wag the dog, (*i.e.*, the very detailed group issue statement). It appears that King &

responsibility to comply with the filing requirements to establish a group appeal and they failed to do so and may not now add an issue as explained at 42 C.F.R. § 405.1837(f)(1).

Based on the above findings, the Board considers the Representative's Notice of Clarification of Group Issue Statement to be an improper attempt to "add" an issue not originally included/defined in the group appeal consistent with 42 C.F.R. § 405.1837(c) and Board Rules 8 and 13. 42 C.F.R. § 405.1837(f)(1) makes clear that no issue may be added to a group appeal once it is established. Accordingly, the Board declines to accept the December 29, 2023 Notice of Clarification of Issue Statement because the group appeal does ***not*** include the purported clarified group issue statement relating to 42 C.F.R. §§ 412.320(a)(1)(iii) and 412.103 that is detailed within that Notice.

Finally, as a result of the Board's Ruling on King & Spalding's Notice of Clarification of Issue Statement, the Board further finds that the group has abandoned its original group issue and dismisses the group appeal consistent with Board Rule 41.2. In this regard, the Notice makes clear that the Providers did ***not*** establish a separate CIRP group for their regulatory challenge to 42 C.F.R. § 412.320(a)(1)(iii)[15] and instead suggests the group issue statement in this group incorrectly focused on a particular aspect of the Capital DSH payment – Part C days. Indeed, King & Spalding concedes that the Providers did not receive any Capital DSH payments (notwithstanding the material fact representations in the group issue statement to the contrary), and that the DSH Part C issue is irrelevant if they do not receive a Capital DSH payment in the first instance.[16] As detailed above, whether the Providers are entitled to a Capital DHS payment is an independent and distinct threshold issue which the Providers unfortunately failed to include in their group issue statement[17] and apparently failed to properly establish a valid separate CIRP group for that regulatory challenge to § 412.320(a)(1)(iii) as they were supposed to do consistent with 42 C.F.R. § 405.1835(a)(2) and Board Rules 12.2 and 13.[18]

Spalding may have filed the incorrect group issue statement and, if so, is now improperly trying to transform the filed issue statement into another separate and distinct issue. The group issue is purposefully very ***detailed*** and does not include any challenge to § 412.320(a)(1)(iii). Essentially, the Providers needed to have pursued any challenge to § 412.320(a)(1)(iii) in a separately-established CIRP group consistent with 42 C.F.R. §§ 405.1837(a)(2) and 405.1837(c)(3); however, they apparently failed to do so.

[15] The Board further notes that, unfortunately, the period to file an appeal based on the NPRs at issue for these 2 participants had lapsed, prior to the filing of the Notice of Clarification of Issue Statement.

[16] The Notice of Clarification of Issue Statement states: "it would simply make no sense for the Providers to challenge the treatment of Part C days in the Capital DSH calculation…." However, this statement presupposes that they did not separately file a group appeal for the threshold issue of their challenge to 42 C.F.R. § 412.320(a)(1)(iii) which they were supposed to do since a group appeal can only have one issue. Again, the Providers could have established a *valid* CIRP group appeal to challenge 42 C.F.R. § 412.320(a)(1)(iii). Had the Providers done so, they could have also pursued the separate and distinct DSH Part C issue in this CIRP group as set forth in the very detailed issue statement filed to establish this CIRP group appeal.

[17] The validity of 42 C.F.R. § 412.320(a)(1)(iii) is a separate and distinct issue from the Capital DSH Part C issue detailed in the group issue statement filed to establish Case No. 23-1757GC and, as such, needed to be (but was not) separately identified in that detailed group issue statement. Indeed, if both issues had been identified in the group issue statement (despite 42 C.F.R. § 405.1837(a)(2)), the Board would need to bifurcate the group as a group may contain only one issue.

[18] *See supra* notes 14 and 16.

Based on the above findings, the Board hereby dismisses Case No. 23-1757GC and removes it from the docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

2/22/2024

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Michael Redmond, Novitas Solutions, Inc. (J-L)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

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

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

Memorial Hospital (Provider Number 14-0185)
FYE: 06/30/2018
Case Number: 21-1722

Dear Mr. Kramer and Ms. VanArsdale,

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

Background:

A. ***Procedural History for Case No. 21-1722***

On June 22, 2021, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2018.

On September 14, 2021, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained two (2) issues:

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

On May 14, 2022, the Provider filed its preliminary position paper.

On August 26, 2022, the Medicare Contractor filed its preliminary position paper.

On September 6, 2022, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 2.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 21-1724GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[1]

As the Provider is commonly owned by BJC HealthCare, the Provider was directly added to the Common Issue Related Party ("CIRP") group under 21-1724GC, BJC Healthcare CY 2018 DSH SSI Percentage CIRP Group, on September 14, 2021. The Group Issue Statement in Case No. 21-1724GC reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

[1] Issue Statement at 1 (Sept. 14, 2021).

> 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.[2]

The amount in controversy listed for both Issue 1 in the instant appeal and for the Provider as a participant in PRRB Case No. 21-1724GC is $463,683.

On May 14, 2022, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

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

[2] Group Issue Statement, Case No. 21-1724GC.

> *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[3]

MAC's Contentions

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

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

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The provider's appeal is premature. To date, the provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the provider has not exhausted all available remedies for this issue. The MAC requests that the PRRB dismiss this issue consistent with recent jurisdictional decisions.[4]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH/SSI Percentage (Systemic Errors) issue in PRRB Case No. 21-1724GC are considered the same issue by the Board.[5]

Finally, the MAC argues "the Provider did not file a **complete** preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3."[6] The MAC posits that the Provider "failed to fully develop the merits of its position and include all exhibits to support that position."[7]

Issue 2 – DSH Payment – Medicaid Eligible Days

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

---

[3] Provider's Preliminary Position Paper at 8-9 (May 14, 2022).
[4] Jurisdictional Challenge at 5-6 (Sept. 6, 2022).
[5] *Id*. at 3-5.
[6] *Id*. at 6 (emphasis added).
[7] *Id*. at 8.

> The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.
>
> Within its Provider's preliminary position paper, the Provider makes the broad allegation, ". . . the Provider contends that the total number of days reflected in its' [sic] 2017 cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats their appeal request.[8]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[9] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2020), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. DSH Payment/SSI Percentage (Provider Specific)

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

[8] *Id*. at 10.
[9] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 21-1724GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[10] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[11] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[12]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 21-1724GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 21-1724GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6,[13] the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 21-1724GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[14] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be

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

distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 21-1724GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 21-1724GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[15]

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to*

[15] (Emphasis added).

decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh [16]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[17] At the very least, a portion of the Provider's data for the current cost report is available in this application.

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

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 21-1724GC are the same issue.[18] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

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

[16] Last accessed February 12, 2024.
[17] Emphasis added.
[18] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a BJC HealthCare CIRP group per 42 C.F.R. § 405.1837(b)(1).

Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid Eligible Days were not included in the calculations of the DSH calculation. The Provider states Issue 2 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends 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.[19]

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

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[20]

Board Rule 7.3.1.2 states:

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

[19] Individual Appeal Request, Issue 2.
[20] Provider's Preliminary Position Paper at 8.

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

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[21]

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[22]

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

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

Similarly, with regard to position papers,[23] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[24] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

---

[21] *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.

[22] (Emphasis added).

[23] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.

[24] (Emphasis added).

Similarly, consistent with that regulation, Board Rule 25.2.2 provides the instruction noted above (see Page 7) on the content of position papers as it relates to unavailable documentation/exhibits.

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

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

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

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

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

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

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[25] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. Indeed, without any days identified in

[25] (Emphasis added).

the position paper filing, the Board assumes that there are no days or amount in dispute for this issue.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[26]

Accordingly, the DSH Payment – Medicaid Eligible Days issue is dismissed.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 21-1724GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 21-1722 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

2/22/2024

X Kevin D. Smith, CPA

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

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

[26] Board Rule 25, of which 25.2 (A) and 25.2 (B) are a part, is applicable to final position papers via Board Rule 27.2.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Robert Roth, Esq.
Hooper, Lundy & Bookman, P.C.
401 9th St., N.W., Ste. 550
Washington, D.C. 20004

Scott Berends, Esq.
Federal Specialized Services
1701 S. Racine Avenue
Chicago, IL 60608-4058

RE: ***Request for Restoration of Group Appeals***

19-0849GC	Univ. of Chicago FFY 2019 Standardized Amount Base Rate Accuracy CIRP Grp
20-1432G	Hooper Lundy & Bookman FFY 2020 Stand. Amt. Base Rate Accuracy Grp
20-1494GC	Univ. of Chicago MC FFY 2020 Standard. Amt. Base Rate Accuracy CIRP Grp
21-0803G	Hooper Lundy & Bookman FFY 2021 Standard. Amt. Base Rate Accuracy Grp

Dear Messrs. Roth and Berends:

The Provider Reimbursement Review Board ("Board" or "PRRB") is in receipt of the Provider's December 28, 2023 Request for Restoration of Group Appeals filed by the Providers' representative, Mr. Robert Roth, Esq. of Hooper, Lundy & Bookman, P.C. ("HLB"). The Request seeks to have the Board restore or reinstate/reopen the four above-referenced group appeals that the Board closed by letter dated August 9, 2022 consistent with 42 C.F.R. § 405.1842(h)(3)(iii).[1] The decision of the Board is set forth below.

Background:

The four-above referenced group appeals consist of two Common Issue Related Part ("CIRP") group cases and two Optional group cases. They currently sit in a similar procedural posture, but their case histories differ and are outlined below:

A. Case No. 19-0849GC (Univ. of Chicago FFY 2019)

This CIRP group was established January 25, 2019, fully formed on January 21, 2020, and deemed complete by the Board on April 20, 2020. Preliminary Position Papers were filed and the Providers requested Expedited Judicial Review ("EJR") on August 10, 2020.

B. Case No. 20-1432G (Hooper Lundy FFY 2020)

This optional group was established January 28, 2020 and fully formed on August 10, 2020. Prior to the filing of any position papers, the Providers requested EJR on August 10, 2020.

[1] Request for Restoration of Group Appeals to the Board's Docket Following Final Decision in Lawsuit and Other Relief (Dec. 28, 2023) ("Restoration Requestion").

C. Case No. 20-1494GC (Univ. of Chicago FFY 2020)

This CIRP group was established January 28, 2020, fully formed on September 2, 2020, and deemed complete by the Board on March 4, 2021. The Provider filed its Preliminary Position Paper and then filed a request for EJR on September 28, 2021.

D. Case No. -0803G (Hooper Lundy FFY 2021)

This optional group was established February 23, 2021. It was fully formed on September 28, 2021, and the Providers filed a request for EJR on the same day.

E. Decisions in Case Nos. 19-0849GC, 20-1432G, 20-1494GC, and 21-0803G

The Board issued two decisions on October 27, 2021: one decision for Case Nos. 19-0849GC and 20-1432G, and another for Case Nos. 21-0803G and 20-1494GC. Each decision was materially identical, *denying* the requests for EJR in each case, notifying the parties that additional briefing was required, and setting a schedule to begin the briefing process. Following these decisions, many (though not all) filings and decisions in these cases concerned all four cases.

Both parties ultimately briefed the issue with the final brief being made on March 18, 2022 (HLB's response to the Medicare Contractor's February 4, 2022 filing). However, 21 days later, on April 22, 2022, the Providers filed a ***second*** request for EJR arguing that the Board had the information requested in the RFI and asserting that this information established jurisdiction such that the Board could rule on the second EJR request.

On April 25, 2022, the Board issued a Status of Request for Expedited Judicial Review & Notice of Stay of the 30-Day Period. In particular, the Board's letter notified the parties that "the 30-day clock [for the Board to review an EJR request] does not start until ***after*** the Board determines that it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers are participants) underlying an EJR request." In this regard, the Board noted that "there are already ongoing, pending jurisdictional reviews in these group cases"; the jurisdictional questions raised therein are "novel and highly complex"; and "the parties' jurisdictional brief and responsive brief (with supporting documents) are currently under Board review." Finally, the Board confirmed that it would notify the parties "when the jurisdiction and substantive claim review process has been completed and the 30-day period begins."

On May 6, 2022, HLB filed objections to the Board's April 25, 2022 letter's indefinite stay, disputing the status of the group appeals in the Office of Hearings Case and Document Management System ("OH CDMS") and arguing that the Board did not have the authority to stay its determination of the EJR request beyond 30 days from its filing. Significantly, HLB's objections cited only to 42 U.S.C. § 1395oo(f)(1) and did not reference or discuss 42 C.F.R. 405.1842 which implemented that statutory provision or any case law applying those statutory and regulatory provisions.

On May 12, 2022, the lead Medicare Contractor in Case No. 21-0803G filed a Substantive Claim Challenge[2] against 3 participants in that case claiming that these participants failed to either properly claim or self-disallow the Standardized Amount issue in compliance with the substantive claim requirements in 42 C.F.R. § 413.24(j).

On May 16, 2022, the Board issued two communications regarding these group cases. First, the Board **denied** the Providers' objections to the Board Stay of the 30-day review period, stating that the objections "are incorrect and improperly ignore the Secretary's regulations that otherwise interpret and implement" the EJR provisions in 42 U.S.C. § 1395oo(f)(1). To this end, the Board gave a thorough history of the Secretary's implementation of the EJR provisions in 42 U.S.C. § 1395oo(f)(1) at 42 C.F.R. § 405.1842 and case law applying those statutory and regulatory provisions. The regulation and case law make clear, for good reason, that the 30-day period for the Board to review an EJR request does not begin to run until after the Board finds jurisdiction over the matter in the appeal and notifies the parties that the EJR request is complete. The Board reiterated that 30 days had not yet begun to run since the Board had not yet completed its jurisdictional review and noted that HLB's "Response does not dispute the Board's characterization of the jurisdictional questions raised in this case as 'novel and highly complex' as reflected in the Board's requests for information, the parties' jurisdictional brief and responsive briefs (with supporting documents), and the length of time needed for that briefing (including the Providers' briefing extension request)."

The second May 16, 2022 Board communication was another RFI in the optional groups under Case Nos. 20-1432G and 21-0803G after questions arose during the Board's jurisdictional review of the Schedule of Providers ("SoP") for these cases. The RFI sought certain jurisdictional information regarding the Providers' compliance with the rules and regulations mandating that, in certain situations, commonly owned or controlled providers pursue common issues as part of common issue related party ("CIRP") groups. The Board confirmed that the RFI affected the 30-day period for responding to the EJR request citing to 42 C.F.R. §§ 405.1842(b), (e)(2)(ii) and (e)(3)(ii).

On June 6, 2022, HLB responded to the Board's RFI, answering the RFI questions and identifying additional noncompliance with the mandatory CIRP group regulations yet requesting that the Board disregard the CIRP requirement that commonly owned or controlled providers appeal a common issue from the same calendar year as members of a CIRP group appeal. Significantly, HLB stated that it could not rule out that "one or more PIH Health hospitals will at some time in the future appeal the Standardized Amount Issue for a portion of FFY 2020."[3] HLB disagreed with the Board's assertion that the 30-day period for Case Nos. 20-1432G and

[2] As explained in Board Rule 44.5, "the Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items" ***as required*** *by 42 C.F.R. § 413.24(j)*.
[3] Response to Board's May 16, 2022 Request for Information ("HLB May 16, 2022 Response"), p. 2.

21-0803G was affected by the Board's RFI because HLB contended that "the issues raised in the Board's May 16, 2022 letter *do not implicate either the Board's jurisdiction over the Group Appeals* or whether the Board has the legal authority to decide the legal issue under appeal, which are the only two criteria for determining whether EJR is appropriate."[4]

On June 6, 2022, HLB also filed a response to the Substantive Claim Challenge in Case No. 21-0803G, asserting that: (a) 2 of the 3 participants properly protested the Transfer/Discharge Issue on their relevant as-filed Medicare cost reports by including narrative explanations explicitly protesting the Transfer/Discharge Issue and workpapers calculating the estimated underpayment amounts; (b) while the lead Medicare Contractor is correct that the remaining participant failed to properly self-disallow, HLB gave "the Board notice that they plan to challenge both the Board's finding and the validity of the Secretary's refabricated self-disallowance requirement in §413.24(j)" if the Board were to make adverse findings against any of the 3 participants.[5]

On June 14, 2022, the Board issued a determination confirming that the Providers' compliance with the mandatory CIRP regulations was not discretionary and *required* that, within 30 days, HLB establish CIRP groups for any CIRP providers in the optional groups appealing the 2020 and 2021 standardized amount issues and then transfer the CIRP providers to those groups. The Board also explained how these pending issues were jurisdictional in nature and continued to affect the commencement of the 30-day EJR review period.

On June 29, 2022, HLB created 3 new CIRP group appeals (which are not covered by this letter), and requested that the Board transfer 3 providers from Case No. 20-1432G and 2 providers from Case No. 21-0803G into those CIRP groups.

The Board acknowledged the creation of the 3 CIRP groups on July 1, 2022 and then granted the 5 transfer requests submitted by HLB on July 8, 2022. In granting the transfer requests, the Board reaffirmed that the 30-day period had not yet begun and the Board continued its jurisdictional review.

Meanwhile, it came to the Board's attention that, ***before*** it could execute the transfers or complete its jurisdictional review process, HLB had ***filed*** (then unbeknownst to the Board) ***a Complaint*** *in the U.S. District Court for the District of Columbia* ***regarding the merits of their EJR requests*** as filed in these appeals.[6] This filing is significant because 42 C.F.R. § 405.1842(h)(3) specifies that in such instances the Board conduct no further proceedings.

Accordingly, on August 9, 2022, the Board issued a decision admonishing the Providers' Representative "for blatantly ignoring Board Rule 1.3 through its failure to communicate with the Board and the opposing party of the litigation it filed and its intention to abandon the Board's ongoing proceedings[.]" The Board outlined how it was still (i) reviewing whether it had

[4] *Id.* pp. 1-2.
[5] HLB Response to Substantive Claim Challenge, Case No. 21-0803G, at 23 (June 6, 2022).
[6] *The Univ. of Chicago Med. Ctr., et al. v. Becerra*, No. 1:22-cv-01964-TSC (D.D.C. July 6, 2022).

substantive jurisdiction over the appealed issue, (ii) reviewing the sufficiency of the record and whether there were any factual disputes, (iii) effectuating transfers requested by the Provider, and (iv) reviewing and considering Substantive Claim Challenges in the optional group cases.[7]

Nevertheless, the Board concluded that the "regulation at 42 C.F.R. § 405.1842(h)(iii) bars the Board from conducting any further proceedings[,]" and since the "Providers [were] pursuing the merits of their appealed issue in the District Court for the District of Columbia, and there [were] no remaining issues beyond that covered by the EJR requests. . . . consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure 62.1[,]" the Board closed the four group cases, removed them from the Board's docket, and suspended completion of its jurisdictional and substantive claim review process. The Board specifically noted:

> The Board will conduct no further proceedings in these appeals absent a remand from the Administrator, pursuant to 42 C.F.R. § 405.1877(g)(2).

Nearly 1½ years later, on December 28, 2023, the Providers filed the pending Request for Restoration/Reinstatement.

Positions of the Parties:

The Providers' Restoration Request explains that their appeal in federal court, *University of Chicago Medical Center v. Becerra*, Case No. 1:22-cv-1964-RCL, was consolidated with the related case *St. Francis Medical Center v. Becerra*, Case No. 1:22-cv-1960-RCL ("*St. Francis*"). It summarizes the proceedings in *St. Francis* as follows:

> September 27, 2023, the court in *St. Francis* denied the Hospitals' Motion for Partial Summary Judgment and granted the Secretary's Cross-Motion to Dismiss for Lack of Jurisdiction, finding that the court lacked jurisdiction. Specifically, the court found that it lacked jurisdiction under 42 U.S.C. §1395oo(f)(1) because the Board must rule on its jurisdiction before the 30-day period to determine EJR begins to run and, thus, the Hospitals had not exhausted their administrative remedies. The court also did not find grounds to grant mandamus relief. Accordingly, the court dismissed the action. The court's judgment in *St. Francis* was not appealed and is now final.[8]

[7] To this end, if these cases are later remanded back to the Board, an open issue for the Board to consider as raised in that letter is whether to take remedial action to take to address the failures of Providers to follow the Board's rules and process, including the Board's *multiple* rulings on the stay of the 30-day period due to the Board's ongoing review of *multiple* jurisdictional, claims filing and substantive claim issues. Pursuant to its authority under 42 C.F.R. § 405.1868(b) such remedial action may include, but is not limited to, dismissal (*e.g.*, dismissal a case or dismissal certain participants for which there were an open jurisdictional/claims filing/substantive claim issue).
[8] Provider's Restoration Request at 3.

The Providers contend that the Board merely closed these cases, rather than dismiss them, so Board Rule 47.1 related to the reinstatement of dismissed cases is inapplicable. They also claim that "restoration is consistent with Section 405.1842(h)(3)(iii) because the Board is no longer barred from conducting proceedings." While they acknowledge the Board's August 9, 2022 decision clearly stated it would conduct no further proceedings in these appeals absent a remand from the Administrator pursuant to 42 C.F.R. § 405.1877(g)(2), they also note that the D.C. District Court in *St. Francis* dismissed the appeal without a remand order. The Restoration Request further requests that, once these cases are restored, the Board set a scheduling order for the Medicare Contractor to file any jurisdictional challenges and for the Providers to file any responses thereto.

The Medicare Contractor filed a response on January 22, 2024,[9] objecting to the restoration of these four group cases. They recount that the Providers filed an appeal in federal district court before the Board had ruled on jurisdiction and that the Providers were generally admonished for their handling of the cases. They argue that the Providers have "offered no basis for reinstating the appeal[s], [and that] the appeal[s were] closed because of the Providers' actions." They suggest that the Board should decline to reinstate the appeals based on the "past, improper actions with respect to the District Court filing and their violation of Board rules[.]"

The Providers filed a Reply to the Medicare Contractor's objection on January 26, 2024.[10] They note that their Complaint in district court was transparent about the Board's position that the thirty-day timeline for adjudicating an EJR request had not elapsed because it was still reviewing jurisdiction.[11] They also reiterate that these cases were "closed" by the Board, not "dismissed," so any arguments related to "reinstatement" of a dismissed case pursuant to Board Rule 47.1 are misplaced.[12]

The Providers note that 42 C.F.R. § 405.1842(h)(3)(iii) only prohibits the Board from conducting further proceedings in a case where a lawsuit is filed *before* a final EJR decision is issued "until the lawsuit is resolved." This is in contrast to 42 C.F.R. § 405.1842(h)(1), governing Board proceedings in a case where a lawsuit is filed *after* granting EJR, which also prohibits the Board from conducting further proceedings, but also requires the Board *dismiss* the issue from the case. The regulation cited by the Board here allows further proceedings once the lawsuit is "resolved" and offers no authority for the Board to dismiss the case or issue.

The Providers conclude by noting, once again, that the D.C. District Court in *St. Francis* dismissed the case without a remand order so they are not pending before the Administrator to

[9] Response and Objection to Providers' Request for Restoration of Group Appeals to the Board's Docket (Jan. 22, 2024).
[10] Hospitals' Reply to MACs' Objection to Hospitals' Request for Restoration of Group Appeals and Other Relief (Jan. 26, 2024).
[11] *Id.* at 2 (citing Complaint at ¶ 69, *Univ. of Chicago Med. Ctr. v. Becerra*, 1:22-cv-01964-RCL (D.D.C. July 6, 2022), ECF No. 1).
[12] *Id.* at 3.

remand to the Board. They claim, however, "42 C.F.R. §405.1842(h)(3)(iii) does not require a 'remand from the Administrator' for the Board to conduct further proceedings in the Group Appeals and does not provide legal justification for the Board to continue to suspend further proceedings here until such a remand is issued." Instead, 42 C.F.R. § 405.1877(g)(3) anticipates a court decision that does not include a remand order, noting that section (g)(2) does not apply to the extent it is inconsistent with a court order.[13]

Nevertheless, the Providers note they will present their position to the Administrator if the Board declines to "restore" these cases without a remand order.

Relevant Law:

42 C.F.R. § 405.1842(h) governs the effect of lawsuits on further Board proceedings. Specifically, with regard to Provider lawsuits, section (h)(3) states:

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

Once a provider institutes an action for judicial review (here the action sought judicial review on the meris of their Board appeal in these cases), 42 C.F.R. § 405.1877 governs. Subsection (g) explains the procedures following such a lawsuit:

> (g) *Remand by a court*—(1) *General rule*. Under section 1874 of the Act, and § 421.5(b) of this chapter, t**he Secretary is the real party in interest in a civil action seeking relief under title XVIII of the Act**. The Secretary has delegated to the Administrator the authority under section 1878(f)(1) of the Act to review decisions of the Board and, as applicable, render a final

[13] *Id.* at 4-5.

> agency decision. **If a court, in a civil action brought by a provider against the Secretary as the real party in interest regarding a matter pertaining to Medicare payment to the provider, orders a remand for further action by the Secretary**, any component of HHS or CMS, or the contractor, **the remand order must be deemed**, except as provided in paragraph (g)(3) of this section, **to be directed to the Administrator in the first instance**, regardless of whether the court's remand order refers to the Secretary, the Administrator, the Board, any other component of HHS or CMS, or the contractor.[14]
>
> (2) *Procedures*. (i)Upon receiving notification of a court remand order, the Administrator must prepare an appropriate remand order and, if applicable, file the order in any Board appeal at issue in the civil action.
>
> (ii) The Administrator's remand order must –
>
> (A) Describe the specific requirements of the court's remand order;
> (B) Require compliance with those requirements by the pertinent component of HHS or CMS or by the contractor, as applicable; and
> (C) Remand the matter to the appropriate entity for further action
>
> ****
>
> (3) *Exception.* The provisions of paragraphs (g)(1) and (g)(2) of this section do not apply to the extent they may be inconsistent with the court's remand order or any other order of the court regarding the civil action. [15]

The same regulation at subsection (h) governs the implementation of a final court judgment:

> (h) *Implementation of final court judgment*. (1)When a final, non-appealable court judgment is issued in a civil action brought by a provider **against the Secretary as the real party in interest** regarding a matter affecting Medicare payment, a court judgment is subject to the provisions of § 405.1803(d) of this subpart.

[14] (Emphasis added).
[15] (Italics emphasis in original and bold and underline emphasis added.)

> (2) The provisions of paragraph (h)(1) of this section do not apply to the extent they may be inconsistent with the court's final judgment or any other order of a court regarding the civil action.[16]

42 C.F.R. § 1803(d) concerns the effect of certain final court judgments:

> (d) *Effect of certain final agency decisions and final court judgments; audits of self-disallowed and other items*. (1) This paragraph applies to the following administrative decisions and court judgments:
>
> ****
>
> (iii) A final, non-appealable judgment by a court on a Medicare reimbursement issue that the court rendered in accordance with jurisdiction under section 1878 of the Act (as described in §§ 405.1842 and 405.1877 of this subpart).
>
> (2) For any final agency decision or final court judgment specified in paragraph (d)(1) of this section, the contractor must promptly, ***upon notification from CMS***[17]—
>
> (i) Determine the effect of the final decision or judgment on the contractor determination for the cost reporting period at issue in the decision or judgment; and
>
> (ii) Issue any revised contractor determination . . . for the period that may be necessary to implement the final decision or judgment on the specific matters at issue in the decision or judgment.

Decision of the Board:

The Providers filed suit in the federal district court for D.C. to pursue the merits of their appeals resulting in the closure of these appeals consistent with 42 C.F.R. § 405.1842(h)(3)(iii). The Board could not dismiss the appeals since the appeals had moved on from the Board to federal court where the Providers were pursuing the merits of their appeal and, as a result, the Board closed the appeals.[18] To this end, when the Board closed these cases, it explicitly stated that it

---

[16] (Italics emphasis in original and bold emphasis added.)
[17] (Emphasis added).
[18] *See also supra* note 7 and accompanying text. If the Board's rules governing reinstatement were applicable, there would be no good cause for reinstatement since the Providers were at fault for their premature pursuit of the merits of these cases as outlined in the D.C. District Court's decision: "Additionally, the Secretary's interpretation of the statute is not unreasonable merely because the Hospitals were unwilling to wait for a decision. Had the Hospitals continued waiting, they likely would have received a determination of jurisdiction earlier this year, as the Board

would not conduct further proceedings until it received a remand order from the Administrator pursuant to 42 C.F.R. § 405.1877(g)(2).

Again, the fact that the D.C. District Court dismissed the suit without remand may well indicate that these 4 cases are not to be reinstated[19] and this is for the Secretary (as the real party of interest in that suit) to determine pursuant to 42 C.F.R. § 405.1877(h) as part of the "Implementation of final court judgment"[20] and, if so, for the Administrator to issue a remand order to the Board, as appropriate and relevant. To this end, 42 C.F.R. § 1803(d)(2) makes clear that the Board is to implement a court judgment ***upon notification from CMS***. Here, the Board has received no order from the CMS Administrator to act on the D.C. District Court's order and, pursuant to the applicable regulations and the Board's August 9, 2022 decision closing these cases (due to the fact that the appeals had left the Board and were otherwise, at that point, pending in federal district court), the Board declines to reopen or conduct further proceedings in these cases until such time the Administrator issue an order, if any, directing it to do so.

Board Members:

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

For the Board:

2/22/2024

X Clayton J. Nix

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

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Adm'rs (J-E)
Jacqueline Vaughn, CMS OAA

rendered jurisdictional determinations in several group appeals asserting substantively identical claims on April 6, 2023." *St. Francis Med. Ctr. v. Becerra*, No. 1:22-cv-1960, 2023 WL 6294168 *6 (D.D.C. Sept. 27, 2023).

[19] In this regard, the Court also denied the Hospital's request for mandamus relief. *Id.* at *7-*8. Instead, the Court granted the Secretary's Motion to Dismiss. *Id.* at*1.

[20] As the real party at interest, the Secretary responsibility to implement, as relevant, the D.C. District Court's dismissal.

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, Esq.
King & Spalding, LLP
1700 Pennsylvania Ave. NW, Suite 900
Washington, DC 20006

Re: ***Determination on Clarification of Group Issue Statement***
PRRB Case No. 24-0145GC - CHS CY 2021 Capital DSH CIRP Group

Dear Mr. Hettich:

The Provider Reimbursement Review Board (the "Board") has reviewed the subject common issue related party ("CIRP") group case for Community Health Systems, Inc. ("CHS") in response to correspondence from King & Spalding, LLP ("King & Spalding") dated January 5, 2024, which it titled "Notice of Clarification of Issue Statement." In its correspondence, King & Spalding recognizes that "detailed issue statement" filed to establish the group "focuses on a particular aspect of the Capital DSH calculation, namely the treatment of Part C days." However, King & Spalding filed its correspondence to: (1) clarify that the group appeal "challenges CMS's policy, codified at 42 C.F.R. § 412.320(a)(1)(iii), of categorically denying capital DSH payments to hospitals that have reclassified as rural under 42 C.F.R § 412.103"; and (2) request that "the Board accept this Clarification and Revised Issue Statement to resolve any potential ambiguity" in the original group issue statement. The pertinent facts and the Board's determination are set forth below.

Background:

On November 7, 2023 at 3:40 pm EDT, King & Spalding filed the group appeal request to establish this CIRP group. The issue statement in the appeal request read as follows:

> **Issue Statement: Effect of Treatment of Part C Days for Which Part A Did Not Make Payment on Capital DSH**
>
> The issue relates to CMS's determination of the Capital DSH payment owed to the Providers. The Capital DSH payment is calculated based on the Medicare disproportionate share hospital ("DSH") payment, which in turn is based upon a hospital's disproportionate patient percentage ("DPP"). The DPP is the sum of two fractions, the Medicaid fraction and the Medicare/SSI fraction ("SSI fraction"). The Providers contend that the inclusion in the SSI fraction of days for which Medicare Part A did not make payment, such as days paid under Medicare Part C ("Medicare Advantage" days), is contrary to law. The Providers also contend that the exclusion from the Medicaid fraction of days for which Medicare Part A did not make payment, such as days paid **under Medicare Part C** for which patients were also eligible for Medicaid, is contrary to law.

> These policies had the effect of diluting the Providers' DPP, and thereby understating its capital DSH payment.
>
> As a preliminary matter, the Providers note that the [U.S.] Court of Appeals for the District of Columbia has held **the policy to include Medicare Advantage days** adopted by CMS in 2004 was "deficient" from a notice standpoint and therefore vacated. *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1111 (D.C. Cir. 2014) (*Allina I*). . . .
>
> CMS, however, attempted to issue a regulatory "fix," essentially re**formalizing its policy to treat Part C days** as days "entitled to benefits under part A" in its FY 2014 IPPS Final Rule in reaction to *Allina I*. *See* 78 Fed. Reg. 50496, 50614-20 (Aug. 19, 2013). That "fix" went into effect October 1, 2013. That "fix" went into effect October 1, 2013 and is thus applicable to the time period at issue. While the procedural errors discuss in *Allina I* and *Allina II* were purportedly corrected, the substantive failings of the Secretary's regulation as detailed below still remain. . . .
>
> *First*, the Secretary's policy is inconsistent with the plain meaning of the Medicare DSH statute. *See, e.g., Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 24 (D.C. Cir. 2011) (Kavanaugh, J., concurring) ("[D]espite HHS's effort to fog it up, § 1395ww(d)(5)(F)(vi) is sufficiently clear in establishing that a Part C beneficiary is not simultaneously entitled to benefits under Part A for any specific patient day."), *aff'ing on limited grounds* 699 F. Supp. 2d 81 (D.D.C. 2010).
>
> ****
>
> *Fourth*, even if the DSH statute were unclear (and it is not), the Secretary's current interpretation is not reasonable, and is arbitrary and capricious, because the Secretary has provided no explanation whatsoever for the inconsistent interpretation of the exact same phrase –"entitled to benefits under part A" – as used in the DSH statute (42 U.S.C. § 139Sww(d)(5)(F)) and in the immediately adjacent subparagraph governing Medicare dependent hospitals (42 U.S.C. § 1395ww(d)(S)(G)).
>
> ****
>
> Accordingly, the Providers contend that days for which Medicare Part A did not make payment, such as **Medicare Part C days**, should be excluded from the Medicare/SSI fraction and, to extend such patients are also Medicaid-eligible, included in the Medicaid fraction. **The MACs' improper calculation of the Providers' DPP had an adverse effect on the Providers' Capital DSH payment, resulted in negative reimbursement impacts to the Providers.**[1]

Currently, Case No. 24-0145GC includes only one participant. Specifically, on **November 7, 2023** at 3:40 pm EDT, concurrent with the filing of the group, King & Spalding directly added the first participant, Regional Hospital of Scranton (Prov. No. 39-0237), to Case No. 24-0145GC.

[1] (Italics emphasis in original, bold emphasis added except in title, and underline emphasis added.)

On **January 5, 2024**, King & Spalding filed a "Notice of Clarification of Issue Statement" for the CIRP group appeal. King & Spalding states that it "regrets the potential for confusion" but that it would simply make no sense for the Providers to challenge the treatment of Part C days in the Capital DSH calculation when, under 42 C.F.R. §412.320(a)(1)(iii), they were entitled to no Capital DSH payments at all. Instead, King & Spalding maintains that "[t]aken together, the group title, the reimbursement impact calculations and the explicit statement regarding what "[t]he appeal asserts" unambiguously describe the categorical disallowance of the capital DSH payments under 42 C.F.R. § 412.320(a)(1)(iii)."

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.

42 C.F.R. § 405.1837(a) specifies that "[a] provider . . . has a right to a Board hearing, as part of a group appeal with other providers . . . ***only if***— (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 . . . ."[2] To this end, 42 C.F.R. § 405.1837(f)(1) discusses "Limitations on group appeals" and specifies that no issues may be added to a group appeal:

> (1) After the date of receipt by the Board of a group appeal hearing request under paragraph (c) of this section, *a provider may* ***not add other questions*** *of fact or law to the appeal***,** regardless of whether the question is common to other members of the appeal (as described in §405.1837(a)(2) and (g) of this subpart).[3]

Finally, 42 C.F.R. § 405.1837(c) describes the "Contents of request for a group appeal" and the minimum content requirements for a group appeal request include the following:

> (c) *Contents of request for a group appeal*. The request for a Board hearing as a group appeal must be submitted in writing to the Board, and **the request must include all of the following**:
>
> (1) A demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section.
>
> (2) An explanation (for each specific item at issue) of each provider's dissatisfaction with the final contractor or Secretary determination under appeal, including an account of—
>
> (i) **Why the provider believes Medicare payment is incorrect** for each disputed item;

[2] (Emphasis added.)
[3] (Emphasis added.)

> (ii) **How and why** the provider believes Medicare **payment must be determined differently** for each disputed item; and
>
> (iii) If the provider self-disallows a specific item (as specified in § 413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.
>
> (3) A copy of each final contractor or Secretary determination under appeal, and any other documentary evidence the providers consider to satisfy the hearing request requirements of paragraphs (c)(1) and (c)(2) of this section, and **a precise description of the one question of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matter at issue in the group appeal**.

Consistent with § 405.1837(c), Board Rule 13 provides the following additional guidance regarding the content of the group issue statement:

> **Rule 13 Common Group Issue**
>
> The matter at issue in a group appeal must involve a single common question of fact or interpretation of law, regulation, or CMS policy or ruling. A group case is not appropriate if facts that must be proved are unique to the respective providers or if the undisputed controlling facts are not common to all group members. Likewise, a group appeal is inappropriate if the Board could make different findings for the various providers in the group.[4]

Board Rule 8 providers further clarification:

> **Rule 8 Framing Issues for Adjustments Involving Multiple Components**
>
> Some issues may have multiple components. To comply with the requirements of 42 C.F.R. § 405.1835, appeal requests must specifically identify the items in dispute, and each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7. Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include, but are not limited to:
>
> •Dual eligible Medicare Part A/Medicaid, which is often referred to as dual eligible Medicare Part A Exhausted and Noncovered Days (*see, e.g.*, CMS Ruling 1498-R at 7-8);

[4] Board Rule v. 3.1 (Nov. 1, 2021).

- Dual eligible Medicare Part C/Medicaid, which is often referred to as DSH Medicare Advantage Days (*see, e.g.*, CMS Ruling 1739-R);
- Pre-1999 dual eligible Medicare HMO days;
- SSI data matching (*see, e.g.*, CMS Ruling 1498-R at 4-6);
- SSI eligible days (*see, e.g.*, *Hall Render Individual, Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction v. Wisconsin Physicians Servs*., PRRB Dec. No. 2017-D12 (Mar. 28, 2017));
- State/program specific general assistance days;
- Section 1115 waiver days (program/waiver specific);
- Medicaid adolescent/child days in a psychiatric residential treatment center; and
- Observation bed days.

****

D. Wage Index

Common examples include, but are not limited to:

- Wage data corrections;
- Occupational mix;
- Wage vs. wage-related costs;
- Pension;
- Rural floor; and
- Data corrections[5]

In the Notice of Clarification of Issue Statement, King & Spalding recognizes that, ". . . language in the *more detailed* [group] issue statement focuses on a particular aspect of the Capital DSH calculation, namely the treatment of Part C days" but, notwithstanding, asserts that the group "the group appeal challenges CMS's policy, codified at 42 C.F.R. § 412.320(a)(1)(iii), of categorically denying capital DSH payments to hospitals that have reclassified as rural under 42 C.F.R. § 412.103. In support of this position, King & Spalding argues:

> Taken together, the group title, the reimbursement impact calculations and the explicit statement [included on the impact calculations] regarding what "[t]he appeal asserts" unambiguously describe the *categorical* disallowance of the capital DSH payments under 42 C.F.R. § 412.320(a)(1)(iii). In addition to these specific items and explicit statements, it would simply make no sense for the Providers to challenge the treatment of Part C days in the Capital DSH calculation when, under 42 C.F.R. § 412.320(a)(1)(iii), they were entitled to no Capital DSH payments at all.

The Board finds the Notice of Clarification of Issue Statement to be an attempt to *improperly* add an issue to a group appeal in violation of 42 C.F.R. § 405.1837(f)(1). Consistent with 42 C.F.R. § 405.1837(c)(2)-(3) and Board Rules 8 and 13, King & Spalding included a very *detailed* group issue statement with the group appeal request that it filed to establish the instant CIRP group and this issued stated gave "a ***precise*** description of the one question of fact or interpretation of law,

[5] (Underline emphasis added.)

regulations, or CMS Rulings that is common to the particular matter at issue in the group appeal."[6] Specifically, as described below, the Board reviewed the group issue statement and finds that: (1) the group issue statement identified the "precise description" of the group issue appealed as the DSH Part C issue; and (2) the group issue statement did not include the alleged "challenge[d to] CMS's policy, codified at 42 C.F.R. § 412.320(a)(1)(iii), of categorically denying capital DSH payments to hospitals that have reclassified as rural under 42 C.F.R. § 412.103."[7]

The original group issue statement in Case No. 24-0145GC is very detailed and clearly relates ***only*** to the Capital DSH Part C issue. At the outset, the Board notes that it has a long history of recognizing the DSH Part C issue (as embodied in the *Allina* litigation) as a distinct DSH issue as demonstrated by the 100s of expedited judicial review decisions issued by the Boad in connection with the *Allina* litigation[8]and as memorialized in Board Rule 8 (as quoted above). Second, the group issue statement is entitled the "Effect of ***Treatment of Part C Days*** for Which Part A Did Not Make Payment on Capital DSH" and asserts that CMS' attempt to "fix" its DSH Part C days policy by re-formalizing its policy in the FY 2014 IPPS final Rule (in reaction to the procedural errors raised in the *Allina I* litigation) failed because the policy remains substantively invalid and those substantive issues were not addressed in either the *Allina I* or *Allina II* litigation. In this regard, the group issue states that the Part C days should be excluded from the SSI fraction and that their inclusion in the SSI fraction "had an adverse effect on the Providers' Capital DSH payment, result[ing] in negative reimbursement impacts to Providers." Indeed, King & Spalding recognizes in its correspondence that group issue statement is "detailed" and "focuses on a particular aspect of the Capital DSH calculation, namely the treatment of Part C days."

Significantly, the *detailed* group issue statement does ***not*** refer to reclassifications of hospitals as "rural" or refer to either 42 C.F.R. § 412.320(a)(1)(iii) or § 412.103. Similarly, the *detailed* issue statement does not refer to CMS "categorically denying capital DSH payments to hospitals that have reclassified as rural." To the contrary, the group issue statement as noted above represents that the group participants received "capital DSH payments": "The MACs' improper calculation of the Providers' DPP had an adverse effect *on the Providers' Capital DSH payment*, resulted in negative reimbursement impacts to the Providers."[9] Thus, the fact that the group title *generically* refers to Capital DSH is consistent with the detailed group issue statement concerning the impact of the Part C days issue on the purported Capital DSH payments the providers received.[10] In sum, the Notice of Clarification of Group Issue statement is not a "clarification" since there is nothing in the detailed issues statement that needed clarification; rather, it was very specific and detailed as to the specific ***one issue*** being appealed consistent with 42 C.F.R. § 405.1837(c).

---

[6] 42 C.F.R. § 405.1837(c)(3) (emphasis added).

[7] The Board's dismissal is consistent with *Evangelical Community Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 459846 (D.D.C. Sept. 30, 2022).

[8] The Board takes administrative notice that King & Spalding was the representative for many cases in which the Board issued Part C EJR decisions.

[9] (Emphasis added.)

[10] As such, these documents cannot be used to *clarify* the group issue statement since the detailed group issue statement itself does not reference or even imply any challenge to 42 C.F.R. § 412.320(a)(1)(iii). Rather, the Providers are attempting to replace the otherwise detailed issue statement with another issue. As such, the Notice of Clarification of Issue Statement is not *clarification* of the original issue appealed as detailed in the group issue statement because that statement does not reference any challenge to § 412.320(a)(1)(iii) but rather describes the in detail the Capital DSH Part C issue and represents that the group participants received Capital DSH payments (which would not have occurred if § 412.320(a)(1)(iii) were applied).

The Board recognizes that, in support of its position, King & Spalding instead focuses on the "Calculation Support Document" that it uploaded for the sole participant that was concurrently added with the establishment of the CIRP group. However, the participant's "Calculation Support Document" is a copy of what is identified as a Protest Workpaper included with its relevant as-filed cost report.[11] As such, this document was created specific to the provider (and does ***not*** directly relate to the group itself). Further, since this document was a Protest Workpaper included with the relevant as-filed cost report, it was not specifically created for the group appeal filing but rather were created *at an earlier point in time* for the Medicare Contractor as part of their obligations under 42 C.F.R. § 413.24(j) to include an appropriate cost claim on the provider's as-filed cost report. As Regional Hospital of Scranton appealed from its NPRs, its face value is limited because there could have been intervening developments following the as-filed cost report such that the Provider could have received a Capital DSH payment in the NPR.[12] Based on the above findings, the Board declines to consider the "Calculation Support Documents" as supplanting and replacing the purposeful, very *detailed* document identified and filed as the group issue statement document.[13] It is the Provider's responsibility to comply with the filing requirements to establish a group appeal and they failed to do so and may not now add an issue as explained at 42 C.F.R. § 405.1837(f)(1).

Based on the above findings, the Board considers the Representative's Notice of Clarification of Group Issue Statement to be an improper attempt to "add" an issue not originally included/defined in the group appeal consistent with 42 C.F.R. § 405.1837(c) and Board Rules 8 and 13. Further, 42 C.F.R. § 405.1837(f)(1) makes clear that no issue may be added to a group appeal once it is established. Accordingly, the Board declines to accept the January 5, 2024 Notice of Clarification of Issue Statement because the group appeal does not include the purported clarified group issue statement relating to 42 C.F.R. §§ 412.320(a)(1)(iii) and 412.103 that is detailed within that Notice.

Finally, as a result of the Board's Ruling on King & Spalding's Notice of Clarification of Issue Statement, the Board further finds that the group has abandoned its original group issue and dismisses the group appeal consistent with Board Rule 41.2. In this regard, the Notice makes clear that the Providers did not establish a separate CIRP group for their regulatory challenge to 42 C.F.R. § 412.320(a)(1)(iii)[14] and instead suggests the group issue statement in this group incorrectly focused on a particular aspect of the Capital DSH payment – Part C days. Indeed, King & Spalding concedes that the Provider did not receive any Capital DSH payments (notwithstanding the material fact representations in the group issue statement to the contrary), and that the DSH Part C issue is irrelevant if they do not receive a Capital DSH payment in the

[11] The Calculation Support Document for Regional Hospital of Scranton is a Workpaper entitled "Exhibit 6.18B: Capital DSH for Certain Rural Hospitals Protest" and the fiscal year at issue is subject to 42 C.F.R. § 413.24(j).

[12] The Board notes that the other documents included in the direct add for Regional Hospital of Scranton did not include the audit adjustment report or any detail or portion of the *settled* cost report.

[13] To do so otherwise would allow the tail (*i.e.*, the Calculation Support Document submitted for the amount in controversy for the participant) to wag the dog, (*i.e.*, the very detailed group issue statement). It appears that King & Spalding may have filed the incorrect group issue statement and, if so, is now improperly trying to transform the filed issue statement into another separate and distinct issue. The group issue is purposefully very ***detailed*** and does not include any challenge to § 412.320(a)(1)(iii). Essentially, the Providers needed to have pursued any challenge to § 412.320(a)(1)(iii) in a separately-established CIRP group consistent with 42 C.F.R. §§ 405.1837(a)(2) and 405.1837(c)(3); however, they apparently failed to do so.

[14] The Board further notes that, unfortunately, the period to file an appeal based on the NPR at issue for the sole participant had lapsed, prior to the filing of the Notice of Clarification of Issue Statement.

first instance.[15] As detailed above, whether the Providers are entitled to a Capital DSH payment is an independent and distinct threshold issue which the Providers unfortunately failed to include in their group issue statement[16]and apparently failed to properly establish a valid separate CIRP group for that regulatory challenge to § 412.320(a)(1)(iii) as they were supposed to do consistent with 42 C.F.R. § 405.1835(a)(2) and Board Rules 12.2 and 13.[17]

Based on the above findings, the Board hereby dismisses Case No. 24-0145GC and removes it from the docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:
Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

2/26/2024

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Michael Redmond, Novitas Solutions, Inc. (J-L)

[15] The Notice of Clarification of Issue Statement states: "it would simply make no sense for the Providers to challenge the treatment of Part C days in the Capital DSH calculation…." However, this statement presupposes that they did not separately file a group appeal for the threshold issue of their challenge to 42 C.F.R. § 412.320(a)(1)(iii) which they were supposed to do since a group appeal can only have one issue. Again, the Representative could have established a valid CIRP group appeal to challenge 42 C.F.R. § 412.320(a)(1)(iii). Had the Representative done so, it could have also pursued the separate and distinct DSH Part C issue in this CIRP group as set forth in the very detailed issue statement filed to establish this CIRP group appeal.

[16] The validity of 42 C.F.R. § 412.320(a)(1)(iii) is a separate and distinct issue from the Capital DSH Part C issue detailed in the group issue statement filed to establish Case No. 24-0145GC and, as such, needed to be (but was not) separately identified in that detailed group issue statement. Indeed, if both issues had been identified in the group issue statement (despite 42 C.F.R. § 405.1837(a)(2)), the Board would need to bifurcate the group as a group may contain only one issue.

[17] See supra notes 14 and 16.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Decision***
Mary Lanning Healthcare (Provider Number 28-0032)
FYE: 12/31/2015
Case Number: 19-0982

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Medicare Contractor's Jurisdiction Challenge and Motion to Dismiss. The Board's analysis and determination is set forth below.

Background:

A. Procedural History for Case No. 19-0982

Mary Lanning Memorial Hospital submitted a request for hearing on January 10, 2019, from a Notice of Program Reimbursement ("NPR") dated July 12, 2018. The hearing request included the following issues:

- Issue 1: Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage- Provider Specific
- Issue 2: Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage
- Issue 3: SSI Fraction Medicare Managed Care Part C Days
- Issue 4: SSI Fraction Dual Eligible Days
- Issue 5: DSH- Medicaid Eligible Days
- Issue 6: Medicaid Fraction Medicare Managed Care Part C Days
- Issue 7: Medicaid Fraction Dual Eligible Days
- Issue 8: Uncompensated Care Distribution Pool
- Issue 9: 2 Midnight Census IPPS Payment Reduction
- Issue 10: Standardized Payment Amount

On September 5, 2019, Issues #2, 3, 4, 6, 7, 8, 9, and 10 were transferred to various Optional Group cases, leaving only Issues #1 and 5 remaining in the individual appeal.

On December 3, 2019, the MAC filed a Jurisdictional Challenge over Issue 1- DSH SSI Provider Specific. The Provider did not file a response to the MAC's Jurisdictional Challenge.

On August 1, 2023, the Medicare Contractor filed a Motion to Dismiss Issue 5- DSH Medicaid Eligible Days. The Provider's representative has not filed any response to the Medicare Contractor Motion to Dismiss which, per Board Rule 44.3, was due within 30 days.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-2592G

The Provider's appeal request describes Issue 1 – DSH SSI Percentage (Provider Specific) issue as follows:

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include

patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[1]

The Provider was also transferred into an optional group under Case No. 19-2592G entitled "*QRS CY 2015 DSH SSI Percentage (2) Group*." This optional group has the following issue statement:

Statement of the Issue:

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

Statement of the Legal Basis:

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

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

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

On September 5, 2019, the Provider filed its preliminary position paper. The following is the Provider's complete position on Issue 1 set forth therein:

[1] Provider's Request for Hearing, Issue Statement (January 10, 2019)
[2] See Group Issue Statement, PRRB Case No. 19-2592G

Calculation of the SSI Percentage

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's Fiscal Year End (December 31).

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

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

Medicare Contractor's Contentions:

Issue 1 – DSH SSI Percentage (Provider Specific)

On December 3, 2019, the Medicare Contractor filed a Jurisdictional Challenge over Issue 1. The MAC contends that the portion of Issue 1 concerning SSI data accuracy should be dismissed because it is duplicative of an issue which was transferred into Group Case No. 19-2592G, *"QRS CY 2015 DSH SSI Percentage (2) Group*". The Portion of Issue 1 concerning realignment "should be dismissed because there was no final determination over SSI realignment and the Provider's appeal is premature as the Provider has not exhausted all available remedies."[3]

Issue 5 – DSH Medicaid Eligible Days

On August 1, 2023, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue arguing that the Provider has effectively abandoned the issue by failing "to furnish documentation in

[3] MAC's Jurisdictional Challenge, at 2. .

support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable."[4] The Motion outlines the Board's Rules which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The Medicare Contractor also points to 42 C.F.R. § 412.106(b)(4)(iii) and § 413.24(c), which places the burden on the Provider with regard to furnishing this documentation. Finally, the Motion notes that the Provider's Preliminary Paper stated that an eligibility listing was being sent under separate cover. The Medicare Contractor claims that no listing has ever been provided in the 4 years since the appeal was filed. The MAC requests the Board to dismiss the additional Medicaid Eligible Days issue because the Provider has failed to furnish documentation in support of its claim.[5]

Provider's Response:

The Provider did not file a response to the Jurisdictional Challenge, nor did the Provider file a response to the Motion to Dismiss.

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

Board Analysis and Decision:

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

A. SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The Board finds that 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 transferred into Group Case No. 19-2592G, *"QRS CY 2015 DSH SSI Percentage (2) Group*.

[4] MAC's Motion to Dismiss at 5 (Aug. 1, 2023).
[5] *Id.* at 1-5.

The first aspect of Issue 1 in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[6] The Provider's legal basis for this aspect of Issue 1 is simply 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)."[7] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . 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."[8] The DSH systemic issue transferred into Case No. 19-2592G, similarly alleges that the Medicare Contractor and CMS improperly calculated 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 first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 19-2592G, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations, and to that end, the Provider is pursuing that issue as part of the group under Case No. 19-2592G. 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.[9] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-2592G.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 19-2592G, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

---

[6] Individual Appeal Request, Issue 1.
[7] *Id.*
[8] *Id.*
[9] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

> 25.2.2 Unavailable and Omitted Documents If documents necessary to support your position are still unavailable, then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH. [10]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[11]

Accordingly, the Board must find that Issues 1 and the group issue in Group 19-2592G are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final

[10] (Last accessed Feb. 27, 2024.)
[11] (Emphasis added.)

determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

2. Second Aspect of Issue 1

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—must be dismissed for lack of jurisdiction and as premature. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…" Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider's DSH SSI Percentage realignment as such there is no "determination" to appeal and the appeal of this issue is otherwise premature.

B. DSH- Medicaid Eligible Days

According to its Appeal Request filed on January 10, 2019, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations for FY 2015. The Provider states Issue 5 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[12]

[12] Provider's Appeal Request (January 10, 2019).

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal and which they desire to be included in their Medicaid percentage and DSH computations.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Dec. 2013) 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.

However, when the Provider filed its January 10, 2019 appeal request, it did not indicate that there were any issues with accessing information underlying the adjustment to its Medicaid eligible days.

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.[13]

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.

The Board has issued Board Rule 27.2 (2018) which specifies that "[t]he final position paper should address each remaining issue" and that "[t]he ***minimum*** requirements for the position paper narrative and exhibits are the ***same*** as those outlined for preliminary position papers at Rule 25."[14] Board Rule 25 (2018) gives the following instruction on the content of position papers:

---

[13] (Bold emphasis added.)
[14] (Bold emphasis added.)

Rule 25 Preliminary Position Papers

COMMENTARY:

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

25.1 Content of Position Paper Narrative

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

25.1.1 Provider's Position Paper

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.

B. For each issue that has not been fully resolved, state the material facts that support the provider's claim.

C. Identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting the provider's position.

D. Provide a conclusion applying the material facts to the controlling authorities.

****

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange all available documentation as exhibits to fully support your position. The Medicare contractor must also give the provider all evidence the Medicare contractor considered in making the determination (see 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Medicare contractor believes is necessary for resolution but has not been submitted by the provider. When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4.

Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

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 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

Consistent with Board Rule 25 and § 405.1853(b)(2)-(3), the Commentary to Board Rule 23.3 discussing the filing of proposed joint scheduling orders versus preliminary position papers includes the following commentary on position paper requirements:

COMMENTARY:

The regulations and Board Rules impose preliminary position paper requirements that ensure ***full development*** *of the parties' positions in order to foster efficient use of the administrative review process*. The due date timeframe is set to give the parties the optimal opportunity to develop their case. Because the date for adding issues will have expired and transfers are to be made prior to filing the preliminary position papers, *the Board requires preliminary position papers to be* ***fully developed*** *and include* ***all available documentation*** *necessary to provide a* ***thorough understanding*** *of the parties' positions*.

CAUTION: New arguments and documents not included in the preliminary position paper may be excluded at the hearing unless the parties demonstrate good cause (e.g., subsequent case law or documents were unavailable through no fault of the party offering the evidence).

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

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

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

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

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

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

On September 5, 2019, the Provider filed their preliminary position paper in which it indicated that they would be sending the eligibility listing under separate cover.[15] The position paper did not identify how many Medicaid eligible days remained in dispute in this case. Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible

[15] Provider's Preliminary Position Paper (September 5, 2019).

> 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' [*sic*] 2015 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Motion to Dismiss, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days. While the Calculation Support filed with their appeal notes a net impact of $9,000, with an increase in days, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper. Moreover, the MAC asserts that the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[16]

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

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled, consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3), and Board Rules 25.2.1 and 25.2.2, related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable as well as failing to fully develop the merits of the Medicaid eligible days issue because CHS has failed to identify any specific Medicaid eligible days at issue and failed to produce a listing of the specific days at issue (much less any supporting documentation for those days.)[17] Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed" [18] 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. In this regard, the Board notes that the Provider represented in its preliminary position paper filed on September 5, 2019 that "the Listing of Medicaid Eligible days [is] being sent under separate cover."[19] This implied that a listing had been completed and was imminent. However, no such listing has ever been received by either the Board or the Medicare Contractor, notwithstanding the Provider's representation that such a listing was available and ready.

****

In summary, the Board hereby dismisses the SSI Provider Specific Issue from this appeal as it is duplicative of the issue in Case No. 19-2592G, there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to meet the Board requirements for position papers.

The Board also dismisses Issue 5, DSH Medicaid Eligible Days, as the Provider has failed to meet the Board requirements for position papers for this issue relative to developing the merits of its case and filing supporting exhibits as required under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)- (3) and Board Rules 27.2 and 25. The Provider has not provided any timely explanation to the MAC as to why the documentation was absent or what is being done to obtain it, notwithstanding the age of this case.

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

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

[17] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.
[18] (Emphasis added.)
[19] Provider Preliminary Position Paper at 8.

Board Members:

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

For the Board:

2/27/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Decision***
Carlisle Regional Medical Center (Prov. No. 39-0058)
FYE 06/30/2017
Case No. 20-0582

Dear Mr. Summar:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the record in Case No. 20-0582 pursuant to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). This case involves Carlisle Regional Medical Center ("Provider") which is commonly owned by Community Health Systems, Inc. ("CHS"). The Board's decision is set forth below.

Background

A. Procedural History for Case No. 20-0582

On **July 16, 2019**, the MAC issued to Provider a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2017 ("FY 2017").

On **January 6, 2020**, the Board received the Provider's individual appeal request appealing the FY 2017 NPR. The appeal request contained the following nine (9) issues:

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

[1] On August 19, 2020, this issue was transferred to Case No. 20-1332GC.
[2] On August 19, 2020, this issue was transferred to Case No. 20-1333GC.
[3] On August 19, 2020, this issue was transferred to Case No. 20-1334GC.
[4] On March 2, 2023, the Provider withdrew Issue 5 from the appeal.
[5] On August 19, 2020, this issue was transferred to Case No. 20-1335GC.

7. DSH – Medicaid Fraction/DE Days (Exhausted Part A Benefit Days, MSP Days, and No-Pay Part A Days)[6]
8. Uncompensated Care ("UCC") Distribution Pool[7]
9. 2 Midnight Census IPPS Payment Reduction[8]

On **August 19, 2020**, the Provider transferred Issues 2, 3, 4, 6, and 7 to CHS CIRP groups as the Provider is commonly owned by CHS and, thereby, subject to the mandatory Common Issue Related Party ("CIRP") regulation at 42 C.F.R. § 405.1837(b)(1). Further, the Provider withdrew Issues 5, 8, and 9 on **March 2, 2023**, **July 12, 2023**, and **July 13, 2023**, respectively. As a result of these transfers and withdrawals, the ***only*** remaining issue in this appeal is Issue 1, DSH – SSI Percentage (Provider Specific).

On **August 27, 2020**, the Provider filed its preliminary position paper.

On **November 20, 2020**, the MAC filed a jurisdictional challenge over Issues 1 and 9. Board Rule 44.4.3 makes clear that "[p]roviders must file a response within 30 days of the Medicare contractor's jurisdictional challenge" and that "[f]ailure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Notwithstanding Board Rule 44.4.3, the Provider failed to file a jurisdictional response with the 30-day period (or even to date).

On **December 9, 2020**, the MAC filed its preliminary position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20-1332GC, "CHS CY 2017 HMA DSH SSI Percentage CIRP Group"

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

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

[6] On August 19, 2020, this issue was transferred to Case No. 20-1336GC.
[7] On July 12, 2023, the Provider withdrew Issue 8 from the appeal.
[8] On July 13, 2023, the Provider withdrew Issue 9 from the appeal.

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

The Group issue Statement in Case No. 20-1332GC, to which the Provider transferred issue #2 reads, in part:

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

On August 27, 2020, the Board received the Provider's preliminary position paper in Case No. 20-0582. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

[9] Provider's Appeal Request at 11 (Jan. 6, 2020).
[10] Group Issue Statement, Case No. 20-1332GC at 1.

Provider Specific

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

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

MAC's Contentions

The MAC contends that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) because the appeal is duplicative and premature, as the Provider has not requested realignment in accordance with 42 C.F.R. § 412.106(b)(3). The MAC argues:

> According to the Provider's appeal request, Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. As noted above, the Provider transferred Issue 2 to Group Case No. 20-1332GC, "CHS CY 2017 HMA DSH SSI Percentage CIRP Group." The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of the issue under appeal in Group Case No. 20-1332GC. The Board should also dismiss the portion related to SSI realignment

[11] Provider's Preliminary Position Paper at 11-12 (Aug. 27, 2020).

> because there was no final determination over SSI realignment and the appeal is premature, as the Provider has not exhausted all available remedies.[12]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[13] The Provider has not filed a response to the Jurisdictional Challenge and its requests for dismissal and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Similarly, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Analysis and Recommendation

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.

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Case No. 20-1332GC.

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

[12] Jurisdictional Challenge at 3 (Nov. 20, 2020).
[13] Board Rule 44.4.3, v. 2.0 (Aug. 2018).
[14] Issue Statement at 1.
[15] *Id.*
[16] *Id.*

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-1332GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 20-0582 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-1332GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[17], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[18] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors are specific to this provider.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the issue in Case No. 20-1336GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records" but fails to explain how it can, explain how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2.[19] Moreover, the Board finds the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

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

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

[17] PRRB Rules v. 2.0 (Aug. 2018).

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

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

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

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[20]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[21]

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

Accordingly, *based on the record before it*, the Board finds that the SSI Provider Specific issue in Case No. 20-0582 and the group issue from Group Case 20-1332GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final

[20] Last accessed February 1, 2024.
[21] Emphasis added.

determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

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

****

In summary, the Board hereby dismisses the sole remaining issue in this case, Issue I (the SSI Provider Specific Issue) from this appeal because: (1) the first aspect of the issue is duplicative of the issue in Case No. 20-1332GC and are common issues required to be pursued in a CIRP; (2) there is no final determination for the second aspect of the issue concerning SSI realignment from which the Provider can appeal; and (3) as an alternative and independent basis, the Provider failed to properly brief Issue 1 in its position paper filings in that these filings failed to meet the minimum Board requirements for position papers set forth at 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules 25 and 27.2 consistent with the Provider's "burden of production of evidence and burden of proof [to] establish[], by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue" as set forth at 42 C.F.R. § 405.1871(a)(3).

As no issues remain pending, the Board hereby closes Case No. 20-0582 and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

2/27/2024

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal – Updated Rationale***
Toyon Associates Standardized Amount CIRP Group Cases
Case Nos. 19-0355GC, *et al.* (*see* **Appendix A** listing 74 group cases)

Dear Ms. Ellis:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the seventy-four (74) above-referenced common issue related party ("CIRP") *and* optional group cases relating to the standardized amounts used in federal rates for the inpatient prospective payment system ("IPPS") during federal fiscal year ("FFY") 1984, the initial year of IPPS.[1] The Medicare Contractor has filed Jurisdictional Challenges in all of those group cases. The Providers' Representative filed responses to these challenges. As set forth below, the Board has determined that, consistent with 42 U.S.C. §§ 1395ww(d)(7) and 1395oo(g)(2) and 42 C.F.R. § 405.1840(b), it lacks substantive jurisdiction over the appealed issue and is therefore dismissing all seventy-four (74) CIRP and optional group cases in their entirety. This determination is consistent with its prior dismissal determinations in other cases involving the same issue where the Board found no *substantive* jurisdiction;[2] however, in response to the additional briefing on this issue by other parties, the Board's decision has been updated to clarify and confirm that the federal rates for FFY 1986 and subsequent FFYs used the FFY 1985 budget neutrality-adjusted federal rates.

In summary, the Board finds that it lacks substantive jurisdiction over the issue raised in these appeals because the standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY and the 1984 and 1985 budget neutrality adjustments are presumably designed to be corrective of the initial base rate that was set

[1] *See* **Appendix A**.
[2] Prior Board dismissal determinations of the issue in the instant group appeals include but are not limited to: Board dec. dated Apr. 6, 2023 (lead Case No. 19-0233GC); Board dec. dated Dec. 14, 2023 (lead Case No. 23-0695GC); Board dec. dated Jan. 23, 2024 (lead Case No. 19-1094GC); Board dec. dated Jan. 24, 2024 (lead Case No. 23-1522GC); and Board dec. dated Jan. 31, 2024 (lead Case No. 19-0847GC). These jurisdictional decisions are posted on the Board's website, by the relevant year and month, at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/list-prrb-jurisdictional-decisions.

using 1981 data.[3] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably intertwined* with those applicable budget neutrality adjustments.[4] Indeed, the standardized amounts were too high for FFYs 1984 and 1985 and the budget neutrality adjustments applied to those years reduced the standardized amounts (reduced by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985) and, thus, these budget neutrality adjustments appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on 1981 data).[5] Because the FFY 1985 budget neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs and because 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments, the Board may not review the standardized amount used for the FFYs appealed as it relates to the common issue in these appeals. In this regard, the Board again notes that the rates for FFY 1986 and subsequent years are based on the budget neutrality adjusted FFY 1985 rates. Accordingly, the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985, *for purposes of future FFYs*,[6] because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.[7]

Background:

Toyon Associates, Inc. ("Providers' Representative") represents a number of providers in common issue related party ("CIRP") and optional groups which are challenging the IPPS standardized amount. The Medicare Contractor filed three (3) Jurisdictional Challenges covering seventy-four (74) group cases.[8] The Providers' Representative filed responses to these challenges. The group issue statements, jurisdictional challenges, and responses thereto for all seventy-four (74) cases are materially identical and can be considered together.

The group issue statement presented is:

---

[3] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[4] *See infra* note 61 (citing to decisions that discuss similar circumstances involving Medicare provisions found to be inextricably tied to certain other provisions for which Congress precluded administrative and judicial review).

[5] *See infra* note 43 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

[6] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns.

[7] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns that could potentially serve as an alternative rationale.

[8] *See* **Appendix A**.

> In this group appeal, the Providers challenge whether it was proper for CMS to establish a standardized amount for a 1983 "base year" using a cost calculation that did not differentiate the transfer of a patient from true "discharges," and to perpetuate that standardized rate year after year without correction, despite acknowledging including transfers in the calculation was problematic.[9]

Procedural Background:

A. Appealed Issue

In the Providers' preliminary position papers, they explain that:

> Since 1983, the amount of Medicare reimbursement provided to hospitals for inpatient services has been based on fixed and prospectively determined rates, and CMS' calculation begins with a figure called the "standardized amount," or average cost incurred by hospitals nationwide for each patient they treat and discharge. 42 U.S.C. §1395ww(d)(2).[10]

CMS opted to use 1983 as a "base year" to calculate these rates, and thus data was collected from hospitals' 1981 cost reports to determine average costs for each discharge category. The data was adjusted for inflation and standardized, but the Providers argue that the initial calculation of this standardized amount continues to serve as the base for all future calculations. Since the Providers allege this initial calculation was understated, they argue that the calculation for each subsequent year has also been understated.[11]

The Providers claim that the data sources used in collecting the 1981 data did not distinguish between patients who were discharged from the hospital, and patients who were transferred to another hospital or facility. They state that CMS views transfers as distinct from discharges, but in calculating the average cost per discharge using the 1981 data, CMS erroneously included transfers in the total number of discharges. They claim that CMS has acknowledged this error in at least one other context (*i.e.*, during the implementation of the capital PPS), and that this error was the reason for certain DRG weight recalibrations, but that CMS failed to fully correct the flawed Standardized Amount.[12]

In each case, the Providers are challenging the applicable FFY IPPS rates as set forth in the Federal Register.[13] They claim that the average cost per discharge should not include transfers,

---

[9] *E.g.*, Case 19-0355GC, Providers' Preliminary Position Paper at 1 (Nov. 24, 2020).
[10] *Id*. at 2.
[11] *See id*. at 3.
[12] *Id.* (citing 56 Fed. Reg. 43358, 43387 (Aug. 30, 1991) (related to capital PPS).
[13] *See id*. at 3 ("[B]ecause the standardized rate is simply carried forward year after year and only updated for inflation, CMS has wrongfully perpetuated that arbitrary and flawed calculation of the 1983 IPPS standardized rate year after year.")

that CMS has acknowledged this as well as the fact that certain Standardized Amounts erroneously included transfers. They also argue that hospitals have not been permitted to appeal the rate under CMS' improper interpretation of 42 C.F.R. 405.1885(a)(1).[14] They go on to argue:

> The *St. Francis* Court's reversal of CMS' interpretation of the predicate fact rule establishes Providers' rights to appeal the IPPS Standardized Rate, a flawed calculation which has negatively impacted Providers year after year. Providers now seek that the rate be corrected through this appeal.[15]

B. Jurisdictional Challenges

The Medicare Contractor filed challenges in seventy-four (74) different group cases, and the Providers filed responses in each case.[16] The Medicare Contractor argues that the merits of the appealed issue are illegitimate, but more importantly, that the Board lacks subject matter jurisdiction and need not even address the merits of the issue. It references the Board's April 6, 2023 decision dismissing five (5) different CIRP group appeals concerning the same issue. The Medicare Contractor argues the Board should apply the same rationale and find that 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative review of the base year standardized amounts. It also claims that budget neutrality adjustments after the base year amount was calculated have corrected any potential errors from prior years, and that the data shows the base year was, in fact, initially set too high (rather than understated).

The Providers' responded "that the MAC has not met its "heavy burden" in showing that the Providers challenge to the 1983 standardized amount is precluded from review by a preclusion provision governing budget neutrality adjustments applied in 1984 and 1985."[17] They claim that the budget-neutral adjustments and any preclusion provisions do not apply to their IPPS challenges. They ask the Board to deny the Jurisdictional Challenges.

The Providers counter the Medicare Contractor by arguing that budget neutrality adjustments are not applicable to these appeals. The Providers claim they do not seek to challenge the budget neutrality adjustments for FYs 1984 or 1985, rather "CMS's calculation of the "costs per discharge" in the first step of the methodology prescribed by statute for calculating the original, 1983 standardized amounts."[18] They argue that there is a strong presumption in favor of judicial review,[19] and that such a presumption may only be overcome by clear and convincing evidence of a specific legislative intent to preclude review of the matter at issue.[20]

---

[14] *Id*.
[15] *Id*. (Citing *St. Francis Medical Center v. Azar*, 894 F. 3d 290 (D.C. Cir. 2018)).
[16] *See* **Appendix A** for a complete list of challenges and cases impacted. As previously noted, the challenges are all materially identical.
[17] *See e.g.*, PRRB Case No. 23-1616GC, *et al.*, Response to Jurisdictional Challenge at 1 (Feb. 5, 2024).
[18] *Id.* at 2.
[19] *Id*. at 1. (Citing *Am. Clinical Lab. Ass'n v. Azar*, 931 F.3d 1195, 1204 (D.C. Cir. 2019)).
[20] *Id.* (Citing *Abbot Labs. v. Gardner*, 387 U.S. 136, 141 (1967)).

Board Decision:

As described more fully below, the Board finds that it lacks substantive jurisdiction over each of the 74 groups because: (1) the initial IPPS standardized amounts set for FFY 1984[21] are ***inextricably*** tied to the FFY 1984 and 1985 budget neutrality adjustments to the "applicable percentage increases" for IPPS[22]; (2) the FFY 1985 budget neutrality-adjusted rates were used to determine the rates for FFY 1986 and, thus, became embedded into the rates determined for subsequent FFYs; and (3) and 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments. Further, the fact that the Secretary's budget neutrality adjustment to the FY 1984 Federal Rates was 0.970[23] demonstrates that, contrary to the Providers' assertions, the initial standardized amount was ***not*** understated but rather was *overstated* by a factor of 0.030 (*i.e.*, 1.000 – 0.970).

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the IPPS.[24] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[25]

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services."[26] The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain ***base period*** *cost data* be developed and modified in several specified ways (i.e., inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[27] Specifically, § 1395ww(d)(2) (Jan. 1985) stated, in pertinent part:

> (2) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region, for which

---

[21] The Board notes that, initially, there was not just one standardized amount. Rather there were 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation and each of these 20 rates is further divided into a labor and nonlabor portion. *See* 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[22] 42 U.S.C. § 1395ww(e) is entitled "Proportional adjustments in applicable percentage increases." The 1984 and 1985 budget neutrality adjustments are set forth is § 1395ww(e)(1)(B) which is cross-referenced for 1984 IPPS rates at § 1395ww(d)(2)(F) and for 1985 IPPS rates at § 1395ww(d)(3)(C).
[23] In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970. 49 Fed. Reg. 234, 334 (Jan. 3, 1984).
[24] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[25] *Id.*
[26] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[27] *Id.* (emphasis added).

> payment may be made under part A of this subchapter. Each such rate shall be determined for hospitals located in urban or rural areas within the United States or within each such region, respectively, as follows:
>
> (A) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.
>
> (B) UPDATING FOR FISCAL YEAR 1984.—The Secretary shall update each amount determined under subparagraph (A) for fiscal year 1984 by—
>
> (i) updating for fiscal year 1983 by the estimated average rate of change of hospital costs industry-wide between the cost reporting period used under such subparagraph and fiscal year 1983 and the most recent case-mix data available, and
>
> (ii) projecting for fiscal year 1984 by the applicable percentage increase (as defined in subsection (b)(3)(B)) for fiscal year 1984.
>
> (C) STANDARDIZING AMOUNTS.—The Secretary shall standardize the amount updated under subparagraph (B) for each hospital by—
>
> (i) excluding an estimate of indirect medical education costs,[28]
>
> (ii) adjusting for variations among hospitals by area in the average hospital wage level, and
>
> (iii) adjusting for variations in case mix among hospitals.[29]

---

[28] Consistent with the concerns raised by the Board in **Appendix B**, the Board notes that Congress has amended this clause (i) numerous times and, as a result, it currently reads as follows:

> (i) excluding an estimate of indirect medical education costs (taking into account, for discharges occurring after September 30, 1986, the amendments made by section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985), except that the Secretary shall not take into account any reduction in the amount of additional payments under paragraph (5)(B)(ii) resulting from the amendment made by section 4621(a)(1) of the Balanced Budget Act of 1997 or any additional payments under such paragraph resulting from the application of section 111 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, of section 302 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, or the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,

[29] The Board notes that Congress later added clause (iv) in 1985 and, consistent with the concerns raised by the Board in **Appendix B**, the Board notes that Congress has amended this clause (iv) numerous times and, as a result, it currently reads as follows:

> (iv) for discharges occurring on or after October 1, 1986, excluding an estimate of the additional payments to certain hospitals to be made under paragraph (5)(F), except that the Secretary shall not exclude additional payments under such paragraph made as a result of the enactment of section

Thus, as quoted above, § 1395ww(d)(2)(A) requires that the Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available. Further, consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the 1984 "base period" operating cost per discharge amount using the 1981 operating costs per discharge amount *updated* by an inflationary factor.[30] The Providers dispute how the Secretary determined "discharges" and allege that the Secretary improperly treated transfers as discharges for purposes of this calculation.

The Secretary then "standardized" the FFY 1984 base period operating cost per discharge using the process prescribed at 42 U.S.C. § 1395ww(d)(2)(c). The standardization process removed the effects of certain variable costs from the cost data, including (but not limited to) excluding costs associated with indirect medical education costs, adjusting for variations in average hospital wage levels, and adjusting for variations in case mix among hospitals.

The initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"), the standardized amount is not adjusted each year simply for inflation.[31] Significantly, some of these annual adjustments were required to be *budget neutral* and are not subject to administrative review and others are discretionary. In particular, 42 U.S.C. § 1395ww(e)(1)(B) provides the budget neutrality adjustment for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

> **(e) Proportional adjustments in *applicable percentage increases***
>
> (1) . . . .
>
> (B) *For discharges occurring in fiscal year 1984 or fiscal year 1985*, *the Secretary* shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—
>
> (i) *the aggregate payment amounts* otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) *for that fiscal yea*r for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),

---

6003(c) of the Omnibus Budget Reconciliation Act of 1989, the enactment of section 4002(b) of the Omnibus Budget Reconciliation Act of 1990, the enactment of section 303 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, or the enactment of section 402(a)(1) 4 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

[30] *Id*. at 39763-64.

[31] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

> *are not greater or less than*—
>
> (ii) the DRG percentage (as defined in subsection (d)(1)(C)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).[32]

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 rate year and 1985 rate year respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

> (i) *Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c) through (h) of this section **as required for fiscal year 1984** so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of **the payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1984 **under the Social Security Act as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[33]

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

> (v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of **the reduced standardized amounts** determined under paragraph (c) of this section **as required for fiscal year 1985** to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is **not greater or less** than 50 percent of the **payment amounts that would have been**

[32] (Bold emphasis in original and italics and underline emphasis added.) The budget neutrality adjustment at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).
[33] (Italics emphasis in original and bold and underline emphasis added.)

> **payable** for the inpatient operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[34]

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than* ***or*** *less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e*., reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average payment per case, is prescribed by law to be *no more* ***and*** *no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget neutrality for 1984 and 1985 are ***external*** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.[35] Since these points are ***fixed,*** it also means that it is capped (*i.e*., cannot be increased subsequently outside of the budget neutrality adjustment).

This conclusion is supported by the fact that the normal annual inflation adjustments to the standardized amount provided for in IPPS apply ***only*** for FY 1986 forward, as set forth in 42 U.S.C. § 1395ww(b)(3)(B)(3)(i) and cross referenced in § 1395ww(d)(3)(A). Specifically, 42 U.S.C. § 1395ww(b)(3)(B)(i) (2018) defines the term "applicable percentage increase" ***starting with fiscal year 1986*** (as opposed to 1984):

---

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

[35] 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board's pie concept:

> Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.
>
> Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

(B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—

(I) ***for fiscal year <u>1986</u>***, 1⁄2 percent,

(II) for fiscal year ***1987***, 1.15 percent,

(III) for fiscal year ***1988***, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,

(IV) for fiscal year ***1989***, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,

(V) for fiscal year ***1990***, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,

(VI) for fiscal year ***1991***, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,

(VII) for fiscal year ***1992***, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,

(VIII) for fiscal year ***1993***, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 1 for hospitals located in a rural area,

(IX) for fiscal year ***1994***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,

(X) for fiscal year ***1995***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located

> in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),
>
> (XI) for fiscal year ***1996***, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,
>
> (XII) for fiscal year ***1997***, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,
>
> (XIII) for fiscal year ***1998***, 0 percent,
>
> (XIV) for fiscal year ***1999***, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,
>
> (XV) for fiscal year ***2000***, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,
>
> (XVI) for fiscal year ***2001***, the market basket percentage increase for hospitals in all areas,
>
> (XVII) for fiscal year ***2002***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XVIII) for fiscal year ***2003***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XIX) for each of fiscal years ***2004*** through ***2006***, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and
>
> (XX) ***for each subsequent fiscal year***, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.[36]

The "applicable percentage increase" as defined in § 1395ww(b)(3)(B) is incorporated into § 1395ww(d)(3)(A), as it relates to updating of the standardized amount:

> **(B) UPDATING** PREVIOUS STANDARDIZED AMOUNTS.—(i) For discharges occurring in a fiscal year beginning ***before*** October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, ***equal to*** *the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph*, ***increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B)***.

[36] (Emphasis added.)

With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).

(ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.

(iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large

> urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

Thus, while 42 U.S.C. § 1395ww(d)(2) provides the methodology for calculating the standardized amount to be used for each year, and that the amount is subject to the "applicable percentage increase" under subsection (b)(3)(B) *for years after 1984*, it remains that it is not always a simple inflationary or market basket adjustment. In particular, the FFY 1984 and 1985 budget neutrality adjustments (as referenced in § 1395ww(d)(2)(F) and in § 1395ww(d)(3)(C)) were the applicable percentage increases for FFYs 1984 and 1985 and, as described below, those adjustments are not administratively reviewable. Further, as discussed *infra*, it is clear that the Secretary has interpreted 42 U.S.C. § 1395ww(d)(3)(A)(i) to require that the FFY 1985 budget neutrality-adjusted rates be used in determining the rates for FFY 1986 and subsequent FFYs. This is reflected in the following excerpt from 42 C.F.R. § 405.473(c) as initially adopted in the September 3, 1983 final rule:

> (c) *Federal rates for fiscal years after Federal fiscal year 1984.*
>
> ****
>
> (2) *Updating previous standardized amounts.* (i) *For fiscal year 1985*. HCFA will compute an average standardized amount for each group of hospitals described in paragraph (b)(5) of this section . . . equal to the respective adjusted average standardized amount computed for fiscal year 1984 under paragraph (b)(7) of this section—
> (A) Increased for fiscal year 1985 by the applicable percentage increase under § 405.463(c);
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475; and
> (D) **Adjusted for budget neutrality under paragraph (c)(4) of this section**.
> (ii) **For fiscal year 1986** and thereafter, **HCFA will compute an average standardized amount** for each group of hospitals described in paragraph (b)(5) of this section, **equal to the respective adjusted average standardized amounts computed for the previous fiscal year**—
> (A) Increased by the applicable percentage increase determined under paragraph (c)(3) of this section; and

> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements.
> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475.
> (3) *Determining applicable percentage changes for fiscal year 1986 and following*. The Secretary will determine for each fiscal year (beginning with fiscal year 1986) the applicable percentage change which will apply for purposes of paragraph (c)(2)(ii) of this section as the applicable percentage increase for discharges in that fiscal year, and which will take into account amounts the Secretary believes necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In making this determination, the Secretary will consider the recommendations of the Prospective Payment Assessment Commission.[37]

---

[37] 48 Fed. Reg. at 39823 (italics emphasis in original and bold and underline emphasis added). This provision was later moved to 42 C.F.R. § 412.63(c)(2022) which states in pertinent part:

> (c) *Updating previous standardized amounts*.
> ****
> (2) Each of those amounts is equal to the respective adjusted average standardized amount computed for fiscal year 1984 under §412.62(g)—
> (i) Increased for fiscal year 1985 by the applicable percentage increase in the hospital market basket;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
> (iii) Reduced by a proportion equal to the proportion (estimated by CMS) of the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part; and
> (iv) **Adjusted for budget neutrality under paragraph (h) of this section**.
> (3) ***For fiscal year 1986*** *and thereafter*. CMS computes, for urban and rural hospitals in the United States and for urban and rural hospitals in each region, average standardized amount equal to the respective **adjusted average standardized amounts computed for the previous fiscal year**—
> (i) Increased by the applicable percentage increase determined under paragraphs (d) through (g) of this section;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements; and
> (iii) For discharges occurring on or after October 1, 1985 and before October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments that are additional payment amounts attributable to outlier cases under

B. Jurisdictional Findings -- 42 U.S.C. § 1395ww(d)(7)(A) Precludes Administrative Review of the Base Year Standardized Amounts

The Providers essentially are challenging the standardized amount used in the IPPS rates for several FFYs claiming that the Secretary improperly treated transfers as discharges when using 1981 cost report data to determine the initial FFY 1984 base cost per discharge which, in turn, was standardized to arrive at the FFY 1984 standardized amounts. More specifically, the Providers maintain that, the understatement of the standardized amount in the FFY 1984 IPPS Final Rule caused a corresponding underpayment in IPPS payments in FFY 1984 ***and every FFY thereafter*** *because the standardized amount for all IPPS payments for every FFY are based on CMS's calculation of the FFY 1984 standardized amount*.[38]

The published standardized amount for each FFY in these appeals reflects the prior year's standardized amount plus "the applicable percentage increase" as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i) (as referenced in 42 U.S.C. § 1395ww(d)(3)(A)) *as well as other potential adjustments*. Significantly, the "applicable percentage increase[s]" for 1984 forward are ***not*** always simply a cost inflation adjustment or other similar percentage adjustment. To this point, for the first two (2) years of IPPS, Congress mandated that the budget neutrality adjustments for FFYs 1984 and 1985 serve as the "applicable percentage increase" for those years. As a result, the IPPS rates that the Secretary used *for the very first year of IPPS* and then the second year of IPPS were adjusted for budget neutrality. For FFYs 1986 and forward, Congress provided for an "applicable percentage increase" in 42 U.S.C. § 1395ww(b)(3)(B)(i) as referenced in 42 U.S.C. § 1395ww(d)(3)(A). In addition, there are other *permanent* adjustments (*i.e*., adjustments not for that year only but that also apply on a going-forward basis) to the standardized amount that have occurred in other years outside of the "applicable percentage increase."[39] Thus, the standardized amount for a particular year is an amalgamation that builds upon the prior year's standardized amount and then adds additional adjustments for the current year. As noted *supra* and discussed more *infra*, the Secretary has used the FFY 1985 budget neutrality-adjusted rates for determining the FFY 1986 rates and those for subsequent FFYs.

The Providers are, essentially, seeking to peel back the amalgamated standardized amount for each applicable FFY *and, thus, reach back* ***more than 30 years*** to increase the initial FFY 1984 base rate that was used to set the initial FFY 1984 standardized amount***s***. They would then incorporate the alleged increased base rate into the FFY 1984 standardized amount***s*** and then simply carry or flow that *increase forward 35 years*. However, in order to peel the amalgamated standardized amounts for the FFYs at issue (singular[40]) *as used in the IPPS rates for each FFY* back to the

---

subpart F of this part, and for discharges occurring on or after October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments that, based on the total amount of prospective payments for urban hospitals and the total amount of prospective payments for rural hospitals, are additional payments attributable to outlier cases in such hospitals under subpart F of this part.

[38] *See e.g.*, PRRB Case 19-0355GC *et al.*, Providers' Response to MACs' Jurisdictional Challenges at 2.

[39] *See* **Appendix B.**

[40] *See supra* note 21 accompanying text.

initial standardized amount***s*** (plural[41]) used in FFY 1984, and then carry/flow any change forward *to the FFY at issue*, the Providers would have to pass through the FFY 1984 and 1985 budget neutrality adjustments which were the only "applicable percentage increase[s]" for those years. However, they cannot do so because the budget neutrality adjustments had the effect of ***fixing*** the pie for FFYs 1984 and 1985 to (*i.e*., no more ***and*** no less than) the aggregate amounts that would have been paid had IPPS not been implemented.[42] More specifically, the amalgamated standardized payment amount for each FFY at issue reflects the *fixed* FFY 1985 budget neutrality adjustment (and not the initial FFY 1984 standardized amount since the standardized amounts for both FFYs 1984 and 1985 were each adjusted for budget neutrality became *fixed* for purposes of subsequent years as a result of those budget neutrality adjustments). Thus, in the Board's view, the Providers cannot get back to the FFY 1984 standardized amounts without first passing through the FFY 1984 and 1985 budget neutrality adjustments. Regardless, the Providers would not be able to flow forward any adjustments made to the FFY 1984 standardized amounts to FFYs after FFY 1985 because:

> (1) they, again, would not be able to get through the FFY 1984 and 1985 budget neutrality adjustments that Congress otherwise ***fixed*** to an external point (no greater and no less); and
>
> (2) the IPPS rates paid for FFYs 1984 and 1985 are based on standardized amounts that were adjusted downwards as a result of the budget neutrality adjustment for FFY 1984 and also for FFY 1985 (*see* discussion below in Sections B.1 and B.2).[43]

---

[41] *See id.*

[42] *See, e.g.,* 48 Fed. Reg. 39752, 39805 (Sept. 1, 1983) (stating: "Hospital Impact—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20,1983.").

[43] Indeed, the FY 1986 IPPS Final Rule included an example where the Secretary recognized an adjustment to the budget neutrality adjustments would be impacted by the removal of nurse anesthetists costs and confirmed that the adjustments to the standardized amounts had already taken this removal into account:

> c. Nonphysician anesthetist costs. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987.
>
> We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, *because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts*. (See 49 FR 34794; August 31, 1984). ***Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment***. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.

50 Fed. Reg. at 35708 (emphasis added). *See also* 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (stating: "In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, *it was incorporated in the overall* ***budget neutrality adjustment*** (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived, we did not propose to make further adjustments to the average standardized amounts for FY 1988.").

Accordingly, the Board finds that the Providers challenge to the standardized amounts at issue are *inextricably* tied to the budget neutrality adjustments made for FFY 1984 and 1985.[44] Furthermore, Congress has precluded Board (and judicial) review of the FFY 1984 and 1985 budget neutrality adjustments. Specifically, 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and juridical review of the neutrality adjustment at § 1395ww(e)(1):

> (7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii), . . .[45]

Similarly, the statute governing Board appeals is located at 42 U.S.C. § 1395oo and states in subsection (g)(2):

> The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

The Secretary incorporated the exclusion of the 1984 and 1985 budget neutrality provisions into the Board's governing regulations at 42 C.F.R. § 405.1804 which states in pertinent part:

> Neither administrative nor judicial review is available for controversies about the following matters:

---

[44] The Board notes that the D.C. Circuit's decision in *Saint Francis* is not applicable to the 1984 and 1985 budget neutrality adjustments given the statutory provision precluding administrative and judicial review of those adjustments. Further, *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[45] With regard to implementing this statutory provision, 48 Fed. Reg. 39752, 39785 (Sept. 1, 1983) states:

> Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
> —A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or
> —The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost. It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs. Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98-25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

> (a) The determination of the requirement, or the proportional amount, of the budget neutrality adjustment in the prospective payment rates required under section 1886(e)(1) of the Social Security Act [*i.e.* 42 U.S.C. § 1395ww(e)(1)].[46]

Since the FFY 1984 and 1985 budget neutrality adjustments are based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and are not reviewable, the Board finds that the FFYs 1984 and 1985 budget neutrality adjustments effectively fixed the standardized amounts from FFY 1985 forward for use in the IPPS system *for purposes of future FFYs*.[47]

Moreover, the Secretary's implementation of the fixed FFY 1984 and 1985 budget neutrality adjustments confirms that the Providers' allegation that the standardized rates for ***each FFY at issue*** are somehow understated due to alleged errors in the FFY 1984 base rate is moot.

1. *The Secretary determined that the initial standardized amounts for FFY 1984 were too high and, therefore, reduced the FFY 1984 standardized amounts through the FFY 1984 budget neutrality adjustment as reflected in the* ***final*** *FFY 1984 IPPS rates*.

In the interim final rule published on September 1, 1983, the Secretary issued a FFY 1984 budget neutrality adjustment to the FFY 1984 standardized amounts of 0.969:

> Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for fiscal years 1984 and 1985, the prospective payment system should be "budget neutral."
>
> Under the Amendments, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Section 1886(e)(1)(A) of the Act requires that aggregate payments for the hospital specific portion should equal the comparable share of estimated reimbursement under prior law. **Similarly, section 1886(e)(1)(B) of the Act requires that aggregate reimbursement for the Federal portion of the prospective payment rates plus any adjustments and special treatment of certain classes of hospitals should equal the corresponding**

[46] The Secretary recently clarified 42 C.F.R. § 405.1804(a) and affirmed that 42 U.S.C. § 1395ww (e)(1) "required that, for cost reporting periods beginning in FYs 1984 and 1985, the IPPS result in aggregate program reimbursement equal to 'what would have been payable' under the reasonable cost-based reimbursement provisions of prior law; that was, for FYs 1984 and 1985, the IPPS would be 'budget neutral.'" 78 Fed. Reg. 74825, 75162 (Dec. 10, 2013) (making technical change to the 42 C.F.R. § 405.1804(a)).

[47] *See, e.g.,* 48 Fed. Reg. 39752, 39765 (Sept. 1, 1983) (stating "We point out that aside from being technically desirable, the effect of standardizing nonlabor hospital costs in Alaska and Hawaii is to decrease the reduction for budget neutrality stemming from the requirements in section 1886(e)(1)(B) of the Act.").

> **share of estimated outlays prior to the passage of Pub. L. 98--21**. Thus, for fiscal year 1984, 75 percent of total projected reimbursement based on the hospital-specific portion should equal 75 percent of total estimated outlays under law as in effect prior to April 20, 1983. Likewise, total estimated prospective payment system outlays deriving from the 25 percent Federal portion, including adjustments and special payment provisions, should equal 25 percent of projected reimbursement under prior laws.
>
> **The adjustment of the Federal portion was determined as follows**:
>
> - *Step 1*—Estimate total incurred payments for inpatient hospital operating costs for fiscal year 1984 that would have been made on a reasonable cost basis under Medicare prior to Pub. L. 98-21.
> - *Step 2*—Multiply total incurred payments by 25 percent, i.e., the Federal portion of total payment amounts for fiscal year 1984.
> - *Step 3*—Estimate the Federal portion of total payments that would have been made without adjusting for budget neutrality, but with the adjustment for outlier payments.
> - *Step 4*—Add an estimate of total adjustments and payments under special payment provisions to the Federal portion (e.g., outliers, indirect medical education).
> - *Step 5*—The difference between the step 2 and step 4 amounts is divided proportionally among the standardized amounts, resulting in the budget neutrality adjusted (standardized) amounts.
>
> **The resulting adjustment factor for the fiscal year 1984 <u>Federal portion</u> is .969**. Payment amounts of hospitals excluded from the prospective payment system (e.g., psychiatric and children's hospitals) and of hospitals not participating in prospective payment because of their participation in demonstrations and studies were not included in the calculations above.[48]

In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970 using the same methodology.[49] Significantly, in the January 1984 final rule, the Secretary suggests that, in calculating the budget neutrality adjustment factor, CMS made no attempt to adjust for transfers under IPPS:

---

[48] 48 Fed. Reg. 39752, 39840-41 (Sept. 1, 1983) (bold, underline emphases added, and italics emphasis in original).
[49] 49 Fed. Reg. 234, 334 (Jan. 3, 1984).

> Regarding additional adjustments recommended by commenters, we made no adjustments to either the adjusted standardized amounts or to the budget neutrality estimates for conditions that could not be quantified on the basis of currently available data, even if there were a likelihood that these conditions might exist under prospective payment. For example, no adjustment was made for the likelihood that admissions would increase more rapidly under prospective payment than under the provisions of Pub. L. 97-248, or for costs that might be disallowed as a result of audit or desk review by the intermediaries. *Likewise, we made no attempt to quantify adjustments* ***for the likelihood of transfers*** *under prospective payment*, emergency room services, and disallowed costs which are successfully appealed.[50]

Accordingly, while the Providers did not appeal the 1984 or 1985 budget neutrality adjustments, the above excerpt suggests that the Providers' concern about the Secretary's alleged mistreatment of transfers may be misplaced and that the treatment of transfers in the in the context of the budget neutrality adjustment for FFY 1984 may have more significance.

Finally, the Secretary also declined to increase the base standardized amount to reflect the increased costs associated with the shift in costs of hospital-based physician services from Part B to Part A, as suggested in a comment. The Secretary noted that such an increase would simply be offset or neutralized by a corresponding increase in the budget neutrality adjustment for FFY 1984:

> Finally, applying such an adjustment to the average standardized amounts (and, by extension, to the per case budget neutrality estimates of Federal rate payments) would not actually increase the level of payments under budget neutrality. If we were to increase the initial standardized amounts to reflect this shift, the budget neutrality adjustment factor would have to be recalculated, would accordingly be increased, and the net result would be virtually identical. As a result, such an adjustment would have no effect on payment levels during FYs 1984 and 1985, which are subject to budget neutrality.[51]

Regardless, the Secretary's application of a 0.970 budget neutrality adjustment factor to the FFY 1984 standardized amounts ***prospectively set*** for the Federal rates for FFY 1984 confirms that these standardized rates were too high and were reduced by a factor of 0.030. Thus, the ***final*** IPPS

---

[50] *Id.* at 255 (Emphasis added.) *See also id.* at 331 (stating as part of the discussion on the budget neutrality adjustments: "The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a DRG-adjusted limit on the allowable amount of inpatient operating costs per case and a per case limit on the rate of increase of operating costs of inpatient hospital services. Due to these per case limits, the incentives that influence hospital admission patterns are similar under TEFRA and prospective payment. Accordingly, ***we have assumed that the number of admissions under both prior law and the prospective payment system will be the same***. As a result, the budget neutrality factors can be calculated by comparing reimbursement per discharge for each of the systems, and there is no need to estimate an actual number of hospital admissions." (emphasis added)).

[51] *Id.* at 255.

payment rates as used for the first year of IPPS (*i.e.*, FFY 1984), as finalized on January 3, 1984, reflect the Secretary's FFY 1984 budget neutrality adjustment. Moreover, as previously noted, since the FFY 1984 budget neutrality adjustment is based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and is not reviewable, the FFY 1984 budget neutrality adjustment effectively ***fixed*** the standardized amounts for FFY 1984 as used from that point forward (*i.e.*, as used both for the FFY 1984 IPPS payment rates and for subsequent years).

2. *The FFY 1985 budget neutrality adjustment also reduced the FFY 1985 standardized amounts, reaffirming that the Secretary's determined that the initial standardized amounts for FFY 1984 were set too high.*

For FFY 1985 in the August 31, 1984 IPPS final rule, the Secretary applied a budget neutrality adjustment of 0.954 to the standardized amounts used for the Federal national rates and 0.950 to the standardized amounts used for the regional rates and ***specifically confirmed*** that *"*[t]hese budget neutrality-adjusted rates for FY 1985 are then to be used *as the basis for the determination of rates* ***for later years***."[52] The Secretary described these adjustments as follows:

> In accordance with section 1886(e)(1) of the Act, the prospective payment system should result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for FYs 1984 and 1985, the prospective payment system must be "budget neutral".
>
> During the transition period, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. ***Further, effective October 1,1984***, *the Federal portion will be a blend of national and regional rates*. As a result, we must determine three budget neutrality adjustments— one each for both the national and regional rates, and one for the hospital-specific portions. The methodology we are using to make these adjustments is explained in detail in section V. of this addendum.
>
> Based on the data available to date, we have computed the following Federal rate budget neutrality adjustment factors:
>
> Regional—.950
> National—.954[53]
>
> ****

By finalizing an adjustment factor less than 1, the Secretary confirmed that the standardized amounts were too high. Thus, like her budget neutrality adjustments made for FFY 1984, the

[52] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added).
[53] 49 Fed. Reg. 34728, 34769 (Aug. 31, 1984).

Secretary again confirmed that the standardized amounts were too high and exercised her discretion to reduce the standardized amounts to be used in the ***final*** FFY 1985 IPPS rates.[54]

3. *The Secretary has applied the FFY 1985 budget neutrality-adjusted rates to FFY 1986 and subsequent years.*

For FFY 1986, the Secretary confirmed that she used the FFY 1985 budget neutrality adjusted federal rates as the basis for determining the FFY 1986 federal rates:

> [T]he FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be ***neither more nor less than*** *we estimated would have been paid under prior legislation for the costs of the same services*. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) ***These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years***.
>
> Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts. To this end, we have identified several factors, discussed in section III.A.3.c., below, that contributed to the overstatement of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and have combined them into a proposed composite correction factor for FY 1986 that equals —7.5 percent.[55]

---

[54] In the preamble to the FFY 1985 Final Rule, the Secretary "noted that most of the data that the budget neutrality adjustment is based on has already been made available [to the public]. We believe that these data in conjunction with the explanation of the budget neutrality methodology presented in the NPRM (49 FR 27458) should enable individuals to replicate the adjustment factors. . . . In addition, we believe the lengthy and detailed description of the data and the development of rates contained in the **Federal Register**, along with the many examples furnished, afford the reader all the information necessary for an understanding of the prospective payment system. Those individuals, hospitals, or associations desiring additional data and other material, either for verification of rates or for other purposes, may request this date under the Freedom of Information Act." 49 Fed. Reg. at 34771.

[55] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added). *See also* 49 Fed. Reg. at 34767 (stating "We believe the explicit language of section 2310 of Pub. L. 98-369 and section 1886(d)(3)(A) of the Act requires a reduction in the standardized amounts used to compute the Federal rates before adjusting for budget neutrality. . . . Thus, while the Federal rates . . . . have been reduced in this final rule to reflect the inflation factor prescribed by section 2310 of

Significantly, in the above excerpt, the Secretary further confirmed that "[t]hese budget neutrality-adjusted rates for FY 1985 are then to be used *as the basis for the determination of rates* ***for later years***."[56] While it is true that the implementation of these rates for FFY 1986 were delayed by Congressional action extending the FFY 1985 rates through April 30, 1986 (as discussed further in **Appendix B**), the Secretary confirmed that it used the rates published in the FFY 1986 IPPS Final Rule plus a 1.0 percent modification specified by Congress:

> Section 9101(a) of Pub. L. 99-272 amends section 5(c) of Pub. L. 99-107 to extend the FY 1985 inpatient hospital prospective payment rates through April 30,1986. Therefore, the DRG classification changes and recalibrated DRG weights that were set forth in the September 3,1985 final rule (50 FR 35722) are effective for discharges occurring on or after May 1, 1986.
>
> ****
>
> In accordance with the provisions of section 9101(b) and (e) of Pub. L. 99-272, the adjusted standardized amounts that were published in the September 3,1985 final rule (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986. The revised standardized amounts are set forth in Table 1, below.[57]

Significantly, *a glaring gap in the Providers' response to the Medicare Contractor's jurisdictional challenge* is their failure discuss or even recognize how the Secretary interpreted and applied the FFY 1985 budget neutrality adjustment.

The Board has set forth in **Appendix C** excerpts from the preambles of other final rules to provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates applied to later years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 budget neutrality adjustment*, it is clear that:

1. The Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and

2. The FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

Accordingly, the Board finds that the Providers' issue is inextricably tied, at a minimum, to the FFY 1985 budget neutrality adjustments.

Pub. L. 98-369, we point out that the offset for budget neutrality has also been adjusted. The reduction in the regional and national standardized rates . . . attributable to section 2310 of Pub. L. 98-369 is entirely due to the revised budget neutrality adjustments for 1984 and 1985.").

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

[57] 87 Fed. Reg. 16772, 16773 (May 6, 1986).

* * * * *

In summary, the Providers confirm they do not seek to challenge the FFY 1984 or 1985 IPPS payments or the associated FFY 1984 and 1985 budget neutrality adjustments, but rather they "challenge CMS's calculation of the "costs per discharge" in the first step of the methodology prescribed by statute for calculating the original, 1983 standardized amounts."[58] They also claim that the Budget Neutrality Preclusion Provisions are not applicable here because they only bar administrative and judicial review of *a **narrow** category of challenges* to the Secretary's determination of the requirement, or the proportional amount, of any budget neutrality adjustment effected pursuant to 42 U.S.C. § 1395ww(e)(1) in FFYs 1984 and 1985.[59]

The Board disagrees and finds that it lacks substantive jurisdiction over the issue raised in these appeals because the ***prospectively-set*** standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY and the 1984 and 1985 budget neutrality adjustments are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[60] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably intertwined* with those applicable budget neutrality adjustments.[61] Indeed, the

---

[58] *E.g.,* Case No. 19-0355GC *et al.*, Response to ASC Jurisdictional Challenges at 2.
[59] *Id*.
[60] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts
[61] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably intertwined, section 1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and so the shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the "data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is ... a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board notes that the Board erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget neutrality***. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it

Secretary applied a budget neutrality adjustment to those years to reduce the standardized amounts by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985 and, thus, these budget neutrality adjustments appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on *1981 data*).[62] Because the FFY 1985 budget neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs and because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments and the resulting *final* standardized amount for FFY 1985 was carried/flowed forward to FFY 1986 and succeeding FFYs, the Board may not review the standardized amount used for the FFYs being appealed as it relates to the common issue in these appeals. In this regard, the Board again notes that the rates for FFY 1986 and subsequent years are based on the budget neutrality adjusted FFY 1985 rates and the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985, *for purposes of future FFYs*, because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.

Accordingly, the Board finds that: (1) the appealed issue is *inextricably* intertwined with the FFY 1984 and 1985 budget neutrality adjustments to the standardized amounts *for purposes of future FFYs* under the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), and both 1395ww(d)(2)(F) and 1395ww(d)(3)(C) which reference 1395ww(e)(1)(B), as demonstrated by the fact that the FFY 1985 budget-neutrality adjusted rates were used as the basis for the determination of rates for FFY 1986 and later years; and; (2) 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations[63]) prohibit administrative and judicial review of those budget neutrality adjustments. Based on these findings, the Board concludes that it does not have substantive jurisdiction over the issue in the seventy-four (74) CIRP and optional group cases listed in **Appendix A**, and hereby closes these seventy-four (74) group cases 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 Participating:

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

For the Board:

2/28/2024

X Clayton J. Nix

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

right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the Board's discussion herein) demonstrates that any adjustment to the FFY 1984 standardized amounts would be *inextricably* tied to the ensuing budget neutrality adjustments made for FFYs 1984 and 1985.

[62] *See supra* note 43 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

[63] *See, e.g.*, 42 C.F.R. §§ 405.1804, 405.1840(b)(2).

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Pamela VanArsdale, National Government Services, Inc. (J-6)
Wilson Leong, FSS
Jacqueline Vaughn, CMS OAA

APPENDIX A
Jurisdictional Challenges and Responses; Cases at Issue

On September 13, 2023, the Medicare Contractor filed a challenge to the following twelve (12) cases which all share a common lead Medicare Contractor, National Government Services, Inc. (J-6):

19-1650GC	Essentia Health CY 2014 IPPS Standardized Payment Rate CIRP Group
19-1651GC	Essentia Health CY 2015 IPPS Standardized Payment Rate CIRP Group
19-2687GC	Essentia Health CY 2016 IPPS Standardized Payment Rate CIRP Group
20-0894GC	Essentia Health FFY 2020 IPPS Standardized Rate CIRP Group
21-0077GC	Essentia Health CY 2013 Inpatient Prospective Payment System Standardized Pymt Rate CIRP Group
21-0952GC	Essentia Health FFY 2021 IPPS Standardized Rate CIRP Group
21-1002GC	Essentia Health CYs 2010-2012 IPPS Standardized Payment Rate CIRP Group
21-1083GC	Essentia Health CY 2017 IPPS Standardized Payment Rate CIRP Group
22-0656GC	Essentia Health FFY 2022 IPPS Standardized Rate CIRP Group
22-0931GC	Essentia Health CY 2018 IPPS Standardized Payment Rate CIRP Group
23-0773GC	Essentia Health FFY 2023 IPPS Standardized Payment Rate CIRP Group
23-1066GC	Essentia Health CY 2019 IPPS Standardized Payment Rate CIRP Group

On September 22, 2023, the Medicare Contractor filed a challenge to the following six (6) cases which all share a common lead Medicare Contractor, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E):

20-1652GC	Sutter Health CY 2009 Predicate Facts CIRP Group
20-1706GC	Sutter Health FFY 2015 Predicate Facts CIRP Group
20-1856GC	Sutter Health CY 2016 Predicate Facts CIRP Group
22-0018GC	Sutter Health CY 2013 Predicate Facts CIRP Group
22-0286GC	Sutter Health CY 2017 Predicate Facts CIRP Group
22-1300GC	Sutter Health CY 2018 Predicate Facts CIRP Group

On November 7, 2023, the Medicare Contractor filed a challenge to the following fifty-six (56) cases which all share a common lead Medicare Contractor, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E):

19-0355GC	Providence Health CY 2015 PHS Providence Predicate Fact SDA Group CIRP Group
19-1441G	Toyon Associates CY 2014 IPPS Standardized Payment Rate Group
19-1453GC	Adventist Health CY 2014 IPPS Standardized Payment Rate CIRP Group
19-1563G	Toyon Associates CY 2015 IPPS Standardized Payment Rate Group
19-1639G	Toyon Associates CY 2013 IPPS Standardized Payment Rate Group
19-1686G	Toyon Associates CY 2009-2010 IPPS Standardized Payment Rate Group
19-1968GC	Providence Health CY 2017 Predicate Fact SDA CIRP Group

19-2383G	Toyon Associates CY 2016 IPPS Standardized Payment Rate Group
19-2738GC	Adventist Health CY 2015 IPPS Standardized Payment Rate CIRP Group
19-2749GC	Univ of California CY 2012 IPPS Standardized Payment Rate CIRP Group
20-0677GC	Palomar Health CY 2016 Inpatient Prospective Payment System Standardized Payment CIRP Group
20-0902GC	Sutter Health FFY 2020 IPPS Standardized Rate CIRP Group
20-0906G	Toyon Associates FFY 2020 IPPS Standardized Rate Group
20-0957G	Toyon Associates CY 2017 IPPS Standardized Payment Rate Group
20-1109GC	Adventist Health FFY 2020 IPPS Standardized Rate CIRP Group
20-1399G	Toyon Associates CY 2012 IPPS Standardized Payment Rate Group Group
20-2034GC	Univ of California CY 2013 IPPS Standardized Payment Rate CIRP Group
20-2090G	Toyon Associates CY 2015 IPPS Standardized Payment Rate #2 Group
20-2144GC	Univ of California CYs 2010- 2011 IPPS Standardized Payment Rate CIRP Group
21-0246GC	Adventist Health CY 2016 IPPS Standardized Rate CIRP Group
21-0458GC	Sutter Health CY 2012 Predicate Facts CIRP Group
21-0683G	Toyon Associates CY 2016 IPPS Standardized Payment Rate #2 Group
21-0947G	Toyon Associates FFY 2021 Standardized Rate Group
21-0949GC	Adventist Health FFY 2021 IPPS Standardized Rate CIRP Group
21-0951GC	Sutter Health FFY 2021 IPPS Standardized Rate CIRP Group
21-0953GC	Univ of California FFY 2021 IPPS Standardized Rate CIRP Group
21-0954GC	Stanford Health Care FFY 2021 IPPS Standardized Rate CIRP Group
21-1607G	Toyon Associates CY 2018 IPPS Standardized Payment Rate Group
21-1708GC	Palomar Health CY 2017 Inpatient Prospective Payment System Standardized Payment CIRP Group
21-1715GC	Adventist Health CY 2017 Inpatient Prospective Payment System Standardized Payment CIRP Group
21-1794GC	Univ of California CY 2014 IPPS Standardized Payment Rate CIRP Group
22-0146GC	Providence St. Joseph CY 2018 IPPS Standardized Payment Rate CIRP Group
22-0243G	Toyon Associates CY 2017 IPPS Standardized Payment Rate Group
22-0651GC	Stanford Health Care FFY 2022 IPPS Standardized Rate CIRP Group
22-0652GC	Palomar Health FFY 2022 IPPS Standardized Rate CIRP Group
22-0654GC	Univ of California FFY 2022 IPPS Standardized Rate CIRP Group
22-0659GC	Adventist Health FFY 2022 IPPS Standardized Rate CIRP Group
22-0661GC	Sutter Health FFY 2022 IPPS Standardized Rate CIRP Group
22-0662G	Toyon Associates FFY 2022 IPPS Standardized Rate Group
22-0893GC	Alameda Health System FFY 2022 IPPS Standardized Rate CIRP Group
22-0951GC	Sutter Health CY 2014 Predicate Facts CIRP Group
22-1093GC	Stanford Health Care CY 2018 IPPS Standardized Payment Rate CIRP Group
23-0022GC	Adventist Health CY 2018 Inpatient Prospective Payment System Standardized Payment CIRP Group
23-0323GC	Univ of California CY 2015 IPPS Standardized Payment Rate CIRP Group
23-0374GC	Palomar Health CY 2018 Inpatient Prospective Payment System Standardized Payment CIRP Group

23-0392GC	Providence St. Joseph CY 2019 IPPS Standardized Payment Rate CIRP Group
23-0772GC	Alameda Health System FFY 2023 IPPS Standardized Payment Rate CIRP Group
23-0774GC	Palomar Health FFY 2023 IPPS Standardized Payment Rate CIRP Group
23-0775GC	Stanford Health Care FFY 2023 IPPS Standardized Payment Rate CIRP Group
23-0776GC	Sutter Health FFY 2023 IPPS Standardized Payment Rate CIRP Group
23-0777G	Toyon Associates FFY 2023 IPPS Standardized Payment Rate Group
23-0792GC	Univ of California FFY 2023 IPPS Standardized Payment Rate CIRP Group
23-1286GC	Adventist Health CY 2019 Inpatient Prospective Payment System Standardized Payment CIRP Group
23-1331G	Toyon Associates CY 2018 IPPS Standardized Payment Rate Group
23-1592G	Toyon Associates CY 2019 IPPS Standardized Payment Rate Group
23-1616GC	Palomar Health CY 2019 Inpatient Prospective Payment System Standardized Payment CIRP Group

APPENDIX B

The following are examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments and the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i):

a. "Restandardization of base year costs per case used in [the] calculation of Federal rates" for both the labor and non-labor portions to reflect the survey-based wage index as discussed in the FY 1986 IPP Final Rule. 50 Fed. Reg. 35646, 35692 (Sept. 3, 1985).

b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.[64] An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.[65]

c. Budget neutrality adjustments made to the standardized amount designated for urban hospitals and the one designated for rural hospitals when certain urban hospitals were

---

[64] The Secretary confirmed that, beginning in 1991, these adjustments are to be made in a budget neutral manner:

> Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

59 Fed. Reg. 45330, 45348 (Sept. 1, 1994).

[65] 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

> *Comment:* A commenter was concerned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.
>
> *Response:* This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs, inclusion of transfer cases tends to ***increase*** the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.
>
> Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

Id. at 35655-56.

deemed to be urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).[66]

d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)[67] and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).[68]

e. Budget neutrality provision at 42 U.S.C. § 1395ww(d)(3)(A)(vi) that allows Secretary to adjust standardized amount to eliminate the effect of "changes in coding or classification of discharges that do not reflect real changes in case mix."[69]

f. The discretion of the Secretary in 42 U.S.C. § 1395ww(d)(3)(I)(i) to "provide by regulation for such other exceptions and adjustments to such payments amounts under this subsection as the Secretary deems appropriate."

---

[66] *See also* 56 Fed. Reg. 43358, 43373 (Aug. 30, 1991) (stating "Consistent with the prospective payment system for operating costs, the September 1, 1987 capital final rule provided for separate standardized amounts for hospitals located in urban and rural areas. Subsequently, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) provided for a higher update factor for hospitals located in large urban areas than in other urban areas and thereby established three standardized amounts under the prospective payment system for operating costs. Large urban areas are defined as those metropolitan statistical areas (MSAs) with a population of more than 1 million (or New England County metropolitan statistical areas (NECMAs) with a population of more than 970,000). Beginning with discharges on or after April 1,1988 and continuing to FY 1995, the Congress has also established higher update factors for rural hospitals than for urban hospitals. The differential updates have had the effect of substantially reducing the differential between the rural and other urban standardized amounts. Section 4002(c) of Public Law 101-508 provides for the elimination of the separate standardized amounts for rural and other urban hospitals in FY 1995 by equating the rural standardized amount to the other urban standardized amount. The separate standardized amount for large urban hospitals would continue. Currently, the large urban standardized amount under the prospective payment system for operating costs is 1.6 percent higher than the standardized amount for hospitals located in other urban areas.").

[67] *See* 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A); *supra* note 21.

[68] Omnibus Reconciliation Act of 1990, Pub. L. 101-508, § 4002(c), 104 Stat. 1388, 1388-33 – 1388-35 (1990).

[69] For example, the Secretary included the following discussion in the preamble to the FFY 1986 IPPS Final Rule:

> As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year). However, we now have data that indicate that case mix has increased an additional 2.6 percent. Hospitals have been realizing the benefit of that increase through increased payments. Our update factor will be adjusted so as to not pass through in the FY 1987 rates 2.0 percentage points of the increase in case mix. However, the 0.6 percentage points that we estimate to reflect a real increase in case mix will be added to the update factor for FY 1987.

51 Fed. Reg. 31505-06.

g. The subsequent amendments that Congress made in 1994[70] and 1997[71] to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. The Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS.[72]

To illustrate the complex nature of these issues, the Board points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,[73] the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).[74] The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

> Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that developed since they were published. *We believe that it is necessary, **each year**, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries*. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.

---

[70] Social Security Act Amendments of 1994, § 109, Pub. L. 103-432, 108 Stat. 4398, 4408 (1994) placed the then-existing language of 42 U.S.C. § 1395ww(d)(5)(I) into clause (i) and added the following clause (ii): "(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater than or lesser than those that would have otherwise been made in such fiscal year."

[71] Balanced Budget Act of 1997, Pub. L. 105-33, § 4407, 111 Stat. 251, 401 (1997), further revised 42 U.S.C. § 1395ww(d)(5)(I) and added § 1395ww(d)(5)(J).

[72] *See* 60 Fed. Reg. 45778, 45854 (Sept. 1, 1995) ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional payments for transfer cases of $159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.").

[73] 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).

[74] U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

In addition to this general consideration, *the FY 1985 adjusted average standardized amounts* (***Federal rates***) *were required by law* ***to be adjusted to achieve budget neutrality***; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more* ***nor*** *less than* we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years*.

Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were ***higher*** *than necessary to achieve budget neutrality*. Therefore, *we have updated the FY 1985 standardized amounts using a factor that takes into account the* ***overstatement*** *of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts*. To this end, we have identified several factors, ***discussed in section II.A.3.c.***, below, that contributed to the overstatement of the FY 1985 standardized amounts. *We have determined an appropriate percent value for each of them, and have combined them into* ***a proposed composite correction factor*** *for FY 1986 that equals –7.5 percent*.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. **We have combined these values into a composite policy target adjustment factor**, **as discussed in section III.3.e., below**. For FY 1986, this factor equals —1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." *Establishing FY 1986 prospective payment rates based on FY 1985 rates* ***that have been demonstrated to be overstated****, clearly would not comport with the statutory requirement that the rates represent payment for efficiently delivered care*.

> Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes is +.31 percent, it is clear that there is a potential justification of a –4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:
>
> | | Percent |
> |---|---|
> | Forecasted market basket increase.. | +4.27 |
> | Part B costs and FICA taxes..... | +.31 |
> | Composite correction factor..... | –7.5 |
> | Composite policy target adjustment factor..... | –1.5 |
>
> However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.[75]
>
> ****
>
> (3) *Additional causes for the overstatement of FY 1985 Federal rates.* In addition to the factors above, which we believe we must correct, **other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts**.
>
> When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for 1985. After application of the revised market basket, discussed previously, use of these actuarial estimates would reduce the standardized amounts by an additional 1.2 percent.

[75] 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates. The hospital specific rates were set using later (1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. **Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount**. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals" total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.

We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided <u>at this time not</u> to correct the standardized amounts for these factors.**

We received no comments on this issue.

> (4) ***Composite Correction Factor.*** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:
>
> | | *Percent* |
> |---|---|
> | Case mix..... ..... | –6.3 |
> | Market basket..... | –1.2 |
> | Composite correction factor..... | –7.5[76] |

Congress did immediately act on the Secretary's September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 ("EEA-85") to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates (*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).[77] Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

> - Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
>
> - Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
>
> - Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
>
> - Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.[78]

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.[79] As previously discussed above in the decision at Section B.3, in the final rule published on May 6, 1986, the Secretary confirmed that "*the adjusted standardized amounts that were published in the September 3,1985 final rule* (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986"[80] and these FFY 1986 adjusted standardized rates are based on the FFY 1985 budget neutrality-adjusted rates.

---

[76] *Id.* at 35703-04 (bold and underline emphasis added).
[77] Pub. L. 99-107, § 5(a), 99 Stat. 479, 479 (1985). In July 1984, Congress had *already* reduced the 1 percent update factor planned for FFY 1986 to ¼ of a percentage point. Deficit Reduction Act of 1984, Pub. L. 98-369, § 2310(a), 98 Stat. 494, 1075 (1984). As part of the Emergency Extension Act of 1985, Congress further reduced the update factor for FFY 1986, presumably in response to the Secretary's recommendation.
[78] 51 Fed. Reg. 16772, 16772 (May 6, 1986).
[79] *See id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).
[80] 51 Fed. Reg. at 16773.

The examples highlight concerns about how certain future actions and decisions by the Secretary and Congress build upon prior decisions. Here, the Secretary's recommendation to Congress regard the FFY 1986 update factor were based on its analysis of the FFY 1984 and 1985 standardized amounts that had already been adjusted for budget neutrality. To the extent the 1984 standardized amounts had been *further* adjusted (*as **now** proposed by the Providers*), it could have potentially impacted the Secretary's recommendation to Congress for the FFY 1986 update factor as well as Congress' subsequent revisions to the updated factor. Accordingly, this highlights how revisiting and otherwise adjusting the FY 1984 standardized amounts can have ripple effects with the update factor and other adjustments that were made for subsequent years *based on analysis of the prior year(s) and other information*.

APPENDIX C

In its decision, the Board has noted that the Secretary confirmed in the preamble of the FFY 1986 IPPS Final Rule that the FFY budget neutrality-adjusted rates were used in determining the rates for FFY 1986 and would similarly be part of subsequent FFYs rates. The following excerpts from the preambles to IPPS final rules provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates were part of the rate for later FFYs and illustrate how embedded the FFY 1985 budget neutrality-adjusted rates are in the rates used for FFY 1986 and subsequent years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 budget neutrality adjustment*, it is clear that the Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and that the FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

1. In the preamble to the FFY 1986 IPPS Final Rule, the Secretary recognizes that the FFY 1985 budget neutrality adjustment accounted for the removal of nonphysician anesthetist costs from the base rates and no further adjustments were needed relative to those costs since the FFY 1985 budget neutrality-adjusted rates were used in determining the FY 1986 rates and would similarly be used for the 1987 rates:

> c. *Nonphysician anesthetist costs*. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987. We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, **because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts.** (See 49 FR 34794; August 31, 1984). **Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment**. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.[81]

[81] 50 Fed. Reg. at 35708 (Italics emphasis in original and bold and underline emphasis added). In this regard, the Board notes that the FFY 1985 IPPS Final Rule explained how the FFY 1985 budget neutrality adjustment accounted for Anesthetists services:

> *Anesthetists' Services*. Under section 2312 of Pub. L. 98-369, the costs to the hospital of the services of nonphysician anesthetists will be reimbursed in full by Medicare on a reasonable cost basis. In order to ensure that these services will be paid for only once, we must remove their costs from the prospective payment rates.

2. In the preamble to the FFY 1987 IPPS Final Rule, the Secretary explains how her budget neutrality adjustments for FFYs 1984 and 1985 had "already built case-mix increases into the cost-per case assumptions used in deriving the budget neutral prospective rates for FY 1984 and FY 1985" and confirms that "FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year)":

> *Comment*: Several commenters stated that we did not consider real case mix increases in the 1983 to 1984 period, and that we finally are considering real case mix increases for the first time.
>
> *Response*: FY 1984 and FY 1985 were years subject to the requirements for budget neutrality. As required under section 1886(e)(1) of the Act, payments under the prospective payment system were to be equal to what would have been paid under rate-of-increase and peer group limits on reasonable costs under prior law (section 1886(b) of the Act) as if the prospective payment system had never been implemented. Under the rate-of-increase limits and peer group limits, as long as a hospital's cost was lower than that hospital's limits, we paid that cost, regardless of whether real case mix increased or decreased, and regardless of the effect of actual case mix on the cost level for that hospital. . . . Increases in real case mix were built into the cost per case increase assumptions we used to model the rate-of-increase limits. These assumptions took into account estimates of the impact of the rate-of-increase limits and the peer group limits. **Consequently, we considered increases in real case mix in FYs 1984 and 1985.** Moreover, even these assumed increases in cost per case proved to be overstated as we received more recent data against which to evaluate our estimates. To have passed through updated prospective payment case-mix increases for FY 1984 and FY 1985 would have been improper because they would increase program payments over the level that would have been paid under the section 1886(b) limits. **As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.**

For cost reporting periods beginning in FY 1985, we have reduced the adjusted standardized amounts to reflect the removal of these costs **by means of the budget neutrality adjustment methodology**. Our method for doing this is explained in section V.D. of this Addendum. We estimate that FY 1985 payments for anesthetists' services will be about $160 million, or 0.5 percent of Medicare operating costs for hospital accounting years beginning in FY 1985.

> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. **Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year).**

3. In the preamble to the FFY 1988 IPPS Final Rule, the Secretary again recognizes the prior FFY 1985 budget neutrality adjustments to the standardized amounts had already taken into account the removal of nonphysician anesthetist costs and the *FFY 1985 budget neutrality-adjusted rates* ***were reflected in the FFY 1986, 1987, and 1988 rates.***

> c. *Nonphysician Anesthetist Costs*. Section 1886(d)(5)(E) of the Act provides that hospital costs for the services of nonphysician anesthetists are paid in full as a reasonable cost pass-through. Under section 2312(c) of Pub. L. 98-369, this pass-through was made effective for cost reporting periods beginning on or after October 1,1984, and before October 1,1987. Section 9320(a) of Pub. L. 99-509 extended the period of applicability of this pass-through so that services will continue to be paid under reasonable cost for any cost reporting periods (or parts of cost reporting periods) ending before January 1,1989 and struck subsection (E) effective on that date.
>
> In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, it was incorporated in the overall **budget neutrality** adjustment (50 FR 35708). Therefore, **because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived**, we did not propose to make further adjustments to the average standardized amounts for FY 1988.[82]

[82] 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Laura McIntyre
Besler Consulting
116 Village Blvd, Ste. 200
Princeton, NJ 08540

RE: ***Notice of Dismissal – Updated Rationale***
Besler Consulting Standardized Amount CIRP Group Cases
Case Nos. 19-0695GC, *et al.* (*see* **Appendix A** listing 8 group cases)

Dear Ms. McIntyre:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the eight (8) above-referenced common issue related party ("CIRP") *and* optional group cases relating to the standardized amounts used in federal rates for the inpatient prospective payment system ("IPPS") during federal fiscal year ("FFY") 1984, the initial year of IPPS. The Medicare Contractor has filed Jurisdictional Challenges in all of those group cases. The Providers' Representative filed responses to these challenges. As set forth below, the Board has determined that, consistent with 42 U.S.C. §§ 1395ww(d)(7) and 1395oo(g)(2) and 42 C.F.R. § 405.1840(b), it lacks substantive jurisdiction over the appealed issue and is therefore dismissing all eight (8) CIRP and optional group cases in their entirety. This determination is consistent with its prior dismissal determinations in other cases involving the same where the Board found no *substantive* jurisdiction;[1] however, in response to the additional briefing on this issue by other parties, the Board's decision has been updated to clarify and confirm that the federal rates for FFY 1986 and subsequent FFYs used the FFY 1985 budget neutrality-adjusted federal rates.

In summary, the Board finds that it lacks substantive jurisdiction over the issue raised in these appeals. The standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY and the 1984 and 1985 budget neutrality adjustments are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[2] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably*

[1] Prior Board dismissal determination of the issue in the instant group appeals include but are not limited to: Board dec. dated Apr. 6, 2023 (lead case No. 19-0233GC); Board dec. dated Dec. 14, 2023 (lead Case No. 23-0695GC); Board dec. dated Jan. 23, 2024 (lead Case No. 19-1094GC); Board dec. dated Jan. 24, 2024 (lead Case No. 23-1522GC); and Board dec. dated Jan. 31, 2024 (lead Case No. 19-0847GC). These jurisdictional decisions are posted on the Board's website, by the relevant year and month at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/list-prrb/jurisdictional-decisions.

[2] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42

intertwined with those applicable budget neutrality adjustments.[3] Indeed, the standardized amounts were too high for FFYs 1984 and 1985 and the budget neutrality adjustments applied to those years reduced the standardized amounts (reduced by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985) and, thus, these budget neutrality adjustments appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on 1981 data).[4] Because the FFY 1985 budget neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs and because 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments, the Board may not review the standardized amount used for the FFYs appealed as it relates to the common issue in these appeals. In this regard, the Board again notes that the rates for FFY 1986 and subsequent years are based on the budget neutrality adjusted FFY 1985 rates. Accordingly, the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985, *for purposes of future FFYs*,[5] because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.[6]

Background:

Besler Consulting ("Providers' Representative") represents a number of providers in common issue related party ("CIRP") and optional groups which are challenging the IPPS standardized amount. The Medicare Contractor filed four (4) Jurisdictional Challenges covering eight (8) group cases.[7] The Providers' Representative filed responses to these challenges. The group issue statements, jurisdictional challenges, and responses thereto for all eight (8) cases are materially identical and can be considered together.

The group issue presented is:

> The Provider in this group appeal contend that the standardized amount is understated because CMS failed to distinguish between patient discharges and transfers at the time it was first calculated. Because this error has not since been corrected, the Providers are entitled to additional Medicare reimbursement so that they are paid as if the error had not occurred in the

---

U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[3] *See infra* note 57 (citing to decisions that discuss similar circumstances involving Medicare provisions found to be inextricably tied to certain other provisions for which Congress precluded administrative and judicial review).

[4] *See infra* note 41 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

[5] *See also supra* note 2 outlining additional intervening adjustment that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns.

[6] *See also supra* note 2 outlining additional intervening adjustment that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns that could potentially serve as an alternative rationale.

[7] *See* **Appendix A**.

> first instance. *See St. Francis Med. Ctr. V. Azar*, 894 F.3d 290 (D.C. Cir. 2018) ("*St. Francis"*)[8]

Procedural Background:

A. Appealed Issue

In the Providers' preliminary position papers, they explain that the IPPS requires the categorization of different types of discharges (diagnostic related groups, or "DRGs"), and payment rates applicable to each discharge category.[9] The Providers went on to say:

> The problem is that CMS used 1981 cost report data to from the initial base rate and transfers were counted as discharges rather than one because the cost report at the time did not separately quantify transfers. As a result, the additional discharges had the effect of understating the base rate.[10]

CMS opted to use 1981 as a "base year" to calculate these rates, and thus data was collected from hospitals' 1981 cost reports to determine average costs for each discharge category. The data was adjusted for inflation and standardized, but the Providers argue that the initial calculation of this standardized amount continues to serve as the base for all future calculations. Since the Providers allege this initial calculation was understated, they argue that the calculation for each subsequent year has also been understated.[11]

The Providers claim that the data sources used in collecting the 1981 data did not distinguish between patients who were discharged from the hospital, and patients who were transferred to another hospital or facility. They state that CMS views transfers as distinct from discharges, but in calculating the average cost per discharge using the 1981 data, CMS erroneously included transfers in the total number of discharges, thereby inflating the denominator of the cost to discharge ratio. They claim that CMS has acknowledged this error in at least one other context (*i.e.*, during the implementation of the capital PPS), and that this error was the reason for certain DRG weight recalibrations, but that CMS failed to fully correct the flawed Standardized Amount.[12]

In each case, the Providers are challenging the applicable FFY IPPS rates as set forth in the Federal Register.[13] They claim that the average cost per discharge should not include transfers, that CMS has acknowledged this as well as the fact that certain Standardized Amounts

---

[8] *E.g.*, Case 19-0695GC, Issue Presented, Provider's Preliminary Position Paper ("Providers' PPP") at 1 (Sept. 16, 2019).
[9] *See* Providers' PPP at 1.
[10] Statement of Issue – Base Rate (Sept. 16, 2019).
[11] *See* Providers' PPP at 3.
[12] *Id.* at 4-5 (citing 56 Fed. Reg. 43449, 43387 [sic] (Aug. 30, 1991) (related to capital PPS).
[13] *Id*. at 1 ("The Providers submit this preliminary position paper in connection with this appeal from the 2018 Final [IPPS] Rule. Exhibit P2.")

erroneously included transfers, and that this practice violates both the Medicare Act and Administrative Procedure Act.[14] They argue the inclusion of transfers in the calculation of the standardized amount violates the express will of Congress, and thus is not entitled to judicial deference under *Chevron*;[15] and as the Secretary has acknowledged an error but declined to correct the standardized amount on a prospective basis, the agency's interpretation is not entitled to deference as it is "arbitrary, capricious or manifestly contrary to the statute."[16]

B. Jurisdictional Challenges

The Medicare Contractor filed challenges in eight (8) different group cases, and the Providers filed responses in each case.[17] The Medicare Contractor argues that the merits of the appealed issue are illegitimate, but more importantly, that the Board lacks subject matter jurisdiction and need not even address the merits of the issue. It references the Board's April 6, 2023 decision dismissing five (5) different CIRP group appeals concerning the same issue. The Medicare Contractor argues the Board should apply the same rationale and find that 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative review of the base year standardized amounts. It also claims that budget neutrality adjustments after the base year amount was calculated have corrected any potential errors from prior years, and that the data shows the base year was, in fact, initially set too high (rather than understated).

The Providers' responses to these challenges reiterated that the group appeal rests on the fact that each appeal's IPPS payments for the applicable FFY is "improperly understated because the Secretary failed to remove or adjust for patient *transfers* that were included in the 1981 base-year data."[18] They claim that the budget-neutral adjustments and any preclusion provisions do not apply to their IPPS challenges. They ask the Board to deny the Jurisdictional Challenges.

The Providers counter the Medicare Contractor by arguing that budget neutrality adjustments are not applicable to these appeals. The Providers claim they do not seek to challenge the budget neutrality adjustments for FYs 1984 or 1985, rather "the Providers contest the Standardized Amount for FFY 2019 and the methodology by which the Standardized Amount was initially calculated in 1983."[19] They argue that there is a strong presumption in favor of judicial review, and that such a presumption may only be overcome by clear and convincing evidence of a specific legislative intent to preclude review of the matter at issue.[20]

---

[14] *Id*. at 8.
[15] *Id*. at 6-7. Citing *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).
[16] *Id*. at 7. Citing *Lindeen v. Sec. & Exch. Comm'n*, 825 F.3d 646, 656 (D.C. Cir. 2016) (quoting *Chevron*, 467 U.S. at 843-44).
[17] *See* Appendix A for complete list of challenges and cases impacted. As previously noted, the challenges are all materially identical.
[18] *E.g.*, PRRB Case 19-0695GC *et al.*, Providers' Response to MACs' Jurisdictional Challenges at 2 (Dec. 11, 2023).
[19] *Id.* at 7.
[20] *Id.* at 8. Citing *Regeneron Pharms., Inc. v. U.S. Dep't of Health and Human Servs.*, 510 F. Supp. 3d 29, 41-42 (S.D.N.Y. 2020) (citing *Cuzzo Speed Techs. v. Lee*, 136 S.Ct. 2131, 2140 (2016)).

Board Decision:

As described more fully below, the Board finds that it lacks substantive jurisdiction over each of the 8 groups because: (1) the initial IPPS standardized amounts set for FFY 1984,[21] are ***inextricably*** tied to the FFY 1984 and 1985 budget neutrality adjustments to the "applicable percentage increases" for IPPS[22]; (2) the FFY 1985 budget neutrality-adjusted rates were used to determine the rates for FFY 1986 and, thus, became embedded into the rates determined for subsequent FFYs; and (3) 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments. Further, the fact that the Secretary's budget neutrality adjustment to the FY 1984 Federal Rates was 0.970[23] demonstrates that, contrary to the Providers' assertions, the initial standardized amount was ***not*** understated but rather was *overstated* by a factor of 0.030 (*i.e.*, 1.000 – 0.970).

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the IPPS.[24] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[25]

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services."[26] The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain ***base period*** *cost data* be developed and modified in several specified ways (*i.e.*, inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[27] Section 1395ww(d)(2)(A) requires that the Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available:

> (II) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital

[21] The Board notes that, initially, there was not just one standardized amount. Rather there were 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation and each of these 20 rates is further divided into a labor and nonlabor portion. *See* 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[22] 42 U.S.C. § 1395ww(e) is entitled "Proportional adjustments in applicable percentage increases." The 1984 and 1985 budget neutrality adjustments are set forth is § 1395ww(e)(1)(B) which is cross-referenced for 1984 IPPS rates at § 1395ww(d)(2)(F) and for 1985 IPPS rates at § 1395ww(d)(3)(C).
[23] In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970. 49 Fed. Reg. 234, 334 (Jan. 3, 1984).
[24] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[25] *Id.*
[26] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[27] *Id.* (emphasis added).

> services for the hospital for the most recent cost reporting period for which data are available.

Consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the 1984 "base period" operating cost per discharge amount using the 1981 operating costs per discharge amount *updated* by an inflationary factor.[28] The Providers dispute how the Secretary determined "discharges" and allege that the Secretary improperly treated transfers as discharges for purposes of this calculation.

The Secretary then "standardized" the FFY 1984 base period operating cost per discharge using the process prescribed at 42 U.S.C. § 1395ww(d)(2)(c). The standardization process removed the effects of certain variable costs from the cost data, including (but not limited to) excluding costs associated with indirect medical education costs, adjusting for variations in average hospital wage levels, and adjusting for variations in case mix among hospitals.

The initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"), the standardized amount is not adjusted each year simply for inflation.[29] Significantly, some of these annual adjustments were required to be *budget neutral* and are not subject to administrative review and others are discretionary. In particular, 42 U.S.C. § 1395ww(e)(1)(B) provides the budget neutrality adjustment for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

> **(e) Proportional adjustments in *applicable percentage increases***
>
> (1) . . . .
>
> (B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—
>
> (i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),
>
> *are not greater or less than*—

[28] *Id*. at 39763-64.
[29] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

> (ii) the DRG percentage (as defined in subsection (d)(1)(C)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).[30]

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 rate year and 1985 rate year respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

> *(i) Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c) through (h) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of **the payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1984 **under the Social Security Act as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[31]

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

> (v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of the reduced standardized amounts determined under paragraph (c) of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is **not greater or less** than 50 percent of the **payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983**.

---

[30] (Bold emphasis in original and italics and underline emphasis added.) The budget neutrality adjustment at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).
[31] (Italics emphasis in original and bold and underline emphasis added.)

> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[32]

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than* ***or*** *less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e*., reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average payment per case, is prescribed by law to be *no more* ***and*** *no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget neutrality for 1984 and 1985 are ***external*** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.[33] Since these points are ***fixed,*** it also means that it is capped (*i.e*., cannot be increased subsequently outside of the budget neutrality adjustment).

This conclusion is supported by the fact that the normal annual inflation adjustments to the standardized amount provided for in IPPS apply only for FY 1986 forward, as set forth in 42 U.S.C. § 1395ww(b)(3)(B)(3)(i) and cross referenced in § 1395ww(d)(3)(A). Specifically, 42 U.S.C. § 1395ww(b)(3)(B)(i) (2018) defines the term "applicable percentage increase" starting with fiscal year 1986 (as opposed to 1984):

> (B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—

---

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

[33] 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board's pie concept:

> Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.
>
> Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

(I) ***for fiscal year 1986***, 1⁄2 percent,

(II) for fiscal year ***1987***, 1.15 percent,

(III) for fiscal year ***1988***, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,

(IV) for fiscal year ***1989***, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,

(V) for fiscal year ***1990***, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,

(VI) for fiscal year ***1991***, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,

(VII) for fiscal year ***1992***, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,

(VIII) for fiscal year ***1993***, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 1 for hospitals located in a rural area,

(IX) for fiscal year ***1994***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,

(X) for fiscal year ***1995***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),

> (XI) for fiscal year ***1996***, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,
>
> (XII) for fiscal year ***1997***, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,
>
> (XIII) for fiscal year ***1998***, 0 percent,
>
> (XIV) for fiscal year ***1999***, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,
>
> (XV) for fiscal year ***2000***, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,
>
> (XVI) for fiscal year ***2001***, the market basket percentage increase for hospitals in all areas,
>
> (XVII) for fiscal year ***2002***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XVIII) for fiscal year ***2003***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XIX) for each of fiscal years ***2004*** through ***2006***, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and
>
> (XX) ***for each subsequent fiscal year***, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.[34]

The "applicable percentage increase" as defined in § 1395ww(b)(3)(B) is incorporated into § 1395ww(d)(3)(A), as it relates to updating of the standardized amount:

> **(A) UPDATING** PREVIOUS STANDARDIZED AMOUNTS.—
>
> (i) For discharges occurring in a fiscal year beginning ***before*** October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, *equal to the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph*, ***increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B)***. With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital

[34] (Emphasis added.)

> weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).
>
> (ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.
>
> (iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

Thus, while 42 U.S.C. § 1395ww(d)(2) provides the methodology for calculating the standardized amount to be used for each year, and that the amount is subject to the "applicable percentage increase" under subsection (b)(3)(B) *for years after 1984*, it remains that it is not always a simple inflationary or market basket adjustment. In particular, the FFY 1984 and 1985 budget neutrality adjustments (as referenced in § 1395ww(d)(2)(F) and in § 1395ww(d)(3)(C)) were the applicable percentage increases for FFYs 1984 and 1985 and, as described below, those adjustments are not administratively reviewable. Further, as discussed *infra*, it is clear that the Secretary has interpreted 42 U.S.C. § 1395ww(d)(3)(A)(i) to require that the FFY 1985 budget neutrality-adjusted rates be used in determining the rates for FFY 1986 and subsequent FFYs. This is reflected in the following excerpt from 42 C.F.R. § 405.473(c) as initially adopted in the September 3, 1983 final rule:

> (c) *Federal rates for fiscal years after Federal fiscal year 1984.*
>
> ****
>
> (2) *Updating previous standardized amounts*. (i) *For fiscal year 1985*. HCFA will compute an average standardized amount for each group of hospitals described in paragraph (b)(5) of this section . . . equal to the respective adjusted average standardized amount computed for fiscal year 1984 under paragraph (b)(7) of this section—
> (A) Increased for fiscal year 1985 by the applicable percentage increase under § 405.463(c);
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475; and
> (D) **Adjusted for budget neutrality under paragraph (c)(4) of this section.**
> (ii) **For fiscal year 1986** and thereafter, **HCFA will compute an average standardized amount** for each group of hospitals described in paragraph (b)(5) of this section, **equal to the respective adjusted average standardized amounts computed for the previous fiscal year**—
> (A) Increased by the applicable percentage increase determined under paragraph (c)(3) of this section; and
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such

> services must be furnished either directly by hospital or under arrangements.
> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475.
>
> (3) *Determining applicable percentage changes for fiscal year 1986 and following*. The Secretary will determine for each fiscal year (beginning with fiscal year 1986) the applicable percentage change will apply for purposes of paragraph (c)(2)(ii) of this section as the applicable percentage increase for discharges in that fiscal year, and which will take into account amounts the Secretary believes necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In making this determination, the Secretary will consider the recommendations of the Prospective Payment Assessment Commission.[35]

---

[35] 48 Fed. Reg. at 39823 (italics emphasis in original and bold and underline emphasis added). This provision was later moved to 42 C.F.R. § 412.63(c)(2022) which states in pertinent part:

> (c) *Updating previous standardized amounts*.
>
> ****
>
> (2) Each of those amounts is equal to the respective adjusted average standardized amount computed for fiscal year 1984 under §412.62(g)—
> (i) Increased for fiscal year 1985 by the applicable percentage increase in the hospital market basket;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
> (iii) Reduced by a proportion equal to the proportion (estimated by CMS) of the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part; and
> (iv) **Adjusted for budget neutrality under paragraph (h) of this section**.
> (3) ***For fiscal year 1986*** *and thereafter*. CMS computes, for urban and rural hospitals in the United States and for urban and rural hospitals in each region, average standardized amount equal to the respective **adjusted average standardized amounts computed for the previous fiscal year**—
> (i) Increased by the applicable percentage increase determined under paragraphs (d) through (g) of this section;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements; and
> (iii) For discharges occurring on or after October 1, 1985 and before October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part, and for discharges occurring on or after October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments that, based on the total amount of prospective payments for urban hospitals and the total amount of prospective payments for rural hospitals, are additional payments attributable to outlier cases in such hospitals under subpart F of this part.

B. Jurisdictional Findings -- 42 U.S.C. § 1395ww(d)(7)(A) Precludes Administrative Review of the Base Year Standardized Amounts

The Providers essentially are challenging the standardized amount used in the IPPS rates for several FFYs claiming that the Secretary improperly treated transfers as discharges when using 1981 cost report data to determine the initial FFY 1984 base cost per discharge which, in turn, was standardized to arrive at the FFY 1984 standardized amounts. More specifically, the Providers maintain that, the understatement of the standardized amount in the FFY 1984 IPPS Final Rule caused a corresponding underpayment in IPPS payments in FFY 1984 ***and every FFY thereafter*** *because the standardized amount for all IPPS payments for every FFY are based on CMS's calculation of the FFY 1984 standardized amount*.[36]

The published standardized amount for each FFY in these appeals reflects the prior year's standardized amount plus "the applicable percentage increase" as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i) (as referenced in 42 U.S.C. § 1395ww(d)(3)(A)) *as well as other potential adjustments*. Significantly, the "applicable percentage increase[s]" for 1984 forward are ***not*** always simply a cost inflation adjustment or other similar percentage adjustment. To this point, for the first two (2) years of IPPS, Congress mandated that the budget neutrality adjustments for FFYs 1984 and 1985 serve as the "applicable percentage increase" for those years. As a result, the IPPS rates that the Secretary used *for the very first year of IPPS* and then the second year of IPPS were adjusted for budget neutrality. For FFYs 1986 and forward, Congress provided for an "applicable percentage increase" in 42 U.S.C. § 1395ww(b)(3)(B)(i) as referenced in 42 U.S.C. § 1395ww(d)(3)(A). In addition, there are other *permanent* adjustments (*i.e*., adjustments not for that year only but that also apply on a going-forward basis) to the standardized amount that have occurred in other years outside of the "applicable percentage increase."[37] Thus, the standardized amount for a particular year is an amalgamation that builds upon the prior year's standardized amount and then adds additional adjustments for the current year. As noted *supra* and discussed more *infra*, the Secretary has used the FFY 1985 budget neutrality-adjusted rates for determining the FFY 1986 rates and those for subsequent FFYs.

The Providers are, essentially, seeking to peel back the amalgamated standardized amount for each applicable FFY *and, thus, reach back* ***more than 30 years*** to increase the initial FFY 1984 base rate that was used to set the initial FFY 1984 standardized amount***s***. They would then incorporate the alleged increased base rate into the FFY 1984 standardized amount***s*** and then simply carry or flow that *increase forward 35 years*. However, in order to peel the amalgamated standardized amounts for the FFYs at issue (singular[38]) *as used in the IPPS rates for each FFY* back to the initial standardized amount***s*** (plural[39]) used in FFY 1984, and then carry/flow any change forward *to the FFY at issue*, the Providers would have to pass through the FFY 1984 and 1985 budget neutrality adjustments which were the only "applicable percentage increase[s]" for those years. However,

---

[36] *E.g.*, Case No. 19-0695GC *et al.*, Response to MAC Jurisdictional Challenge at 11 ("The Secretary's error caused a ripple-effect of incorrectly calculated Standardized Amounts since 1983 because of the erroneous embedded methodology.").
[37] *See* **Appendix B.**
[38] *See supra* note 21 accompanying text.
[39] *See id.*

they cannot do so because the budget neutrality adjustments had the effect of ***fixing*** the pie for FFYs 1984 and 1985 to (*i.e*., no more ***and*** no less than) the aggregate amounts that would have been paid had IPPS not been implemented.[40] More specifically, the amalgamated standardized payment amount for each FFY at issue reflects the *fixed* FFY 1985 budget neutrality adjustment (and not the initial FFY 1984 standardized amount since the standardized amounts for both FFYs 1984 and 1985 were each adjusted for budget neutrality became *fixed* for purposes of subsequent years as a result of those budget neutrality adjustments). Thus, in the Board's view, the Providers cannot get back to the FFY 1984 standardized amounts without first passing through the FFY 1984 and 1985 budget neutrality adjustments. Regardless, the Providers would not be able to flow forward any adjustments made to the FFY 1984 standardized amounts to FFYs after FFY 1985 because:

> (1) they, again, would not be able to get through the FFY 1984 and 1985 budget neutrality adjustments that Congress otherwise ***fixed*** to an external point (no greater and no less); and
>
> (2) the IPPS rates paid for FFYs 1984 and 1985 are based on standardized amounts that were adjusted downwards as a result of the budget neutrality adjustment for FFY 1984 and also for FFY 1985 (*see* discussion below in Sections B.1 and B.2).[41]

---

[40] *See, e.g.,* 48 Fed. Reg. 39752, 39805 (Sept. 1, 1983) (stating: "Hospital Impact—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20,1983.").

[41] Indeed, the FY 1986 IPPS Final Rule included an example where the Secretary recognized an adjustment to the budget neutrality adjustments would be impacted by the removal of nurse anesthetists costs and confirmed that the adjustments to the standardized amounts had already taken this removal into account:

> c. Nonphysician anesthetist costs. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987.
>
> We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, *because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts*. (See 49 FR 34794; August 31, 1984). ***Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment***. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.

50 Fed. Reg. at 35708 (emphasis added). *See also* 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (stating: "In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, *it was incorporated in the overall* ***budget neutrality adjustment*** (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived, we did not propose to make further adjustments to the average standardized amounts for FY 1988.").

Accordingly, the Board finds that the Providers challenge to the standardized amounts at issue are *inextricably* tied to the budget neutrality adjustments made for FFY 1984 and 1985.[42]

Furthermore, Congress has precluded Board (and judicial) review of the FFY 1984 and 1985 budget neutrality adjustments. Specifically, 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and juridical review of the neutrality adjustment at § 1395ww(e)(1):

> (7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii), . . .[43]

Similarly, the statute governing Board appeals is located at 42 U.S.C. § 1395oo and states in subsection (g)(2):

> The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

The Secretary incorporated the exclusion of the 1984 and 1985 budget neutrality provisions into the Board's governing regulations at 42 C.F.R. § 405.1804 which states in pertinent part:

> Neither administrative nor judicial review is available for controversies about the following matters:

---

[42] The Board notes that the D.C. Circuit's decision in *Saint Francis* is not applicable to the 1984 and 1985 budget neutrality adjustments given the statutory provision precluding administrative and judicial review of those adjustments. Further, *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[43] With regard to implementing this statutory provision, 48 Fed. Reg. 39752, 39785 (Sept. 1, 1983) states:

> Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
> —A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or
> —The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost. It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs. Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98-25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

> (a) The determination of the requirement, or the proportional amount, of the budget neutrality adjustment in the prospective payment rates required under section 1886(e)(1) of the Social Security Act [*i.e.* 42 U.S.C. § 1395ww(e)(1)].[44]

Since the FFY 1984 and 1985 budget neutrality adjustments are based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and are not reviewable, the Board finds that the FFYs 1984 and 1985 budget neutrality adjustments effectively fixed the standardized amounts from that point forward for use in the IPPS system.[45]

Indeed, the Secretary's implementation of the fixed FFY 1984 and 1985 budget neutrality adjustments confirms that the Providers' allegation that the standardized rates for ***each FFY at issue*** are somehow understated due to alleged errors in the FFY 1984 base rate is moot.

1. *The Secretary determined that the initial standardized amounts for FFY 1984 were too high and, therefore, reduced the FFY 1984 standardized amounts through the FFY 1984 budget neutrality adjustment as reflected in the* ***final*** *FFY 1984 IPPS rates*.

In the interim final rule published on September 1, 1983, the Secretary issued a FFY 1984 budget neutrality adjustment to the FFY 1984 standardized amounts of 0.969:

> Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for fiscal years 1984 and 1985, the prospective payment system should be "budget neutral."
>
> Under the Amendments, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Section 1886(e)(1)(A) of the Act requires that aggregate payments for the hospital specific portion should equal the comparable share of estimated reimbursement under prior law. **Similarly, section 1886(e)(1)(B) of the Act requires that aggregate reimbursement for the Federal portion of the prospective payment rates plus any adjustments and special treatment of certain classes of hospitals should equal the corresponding share of estimated outlays prior to the passage of Pub. L. 98--**

[44] The Secretary recently clarified 42 C.F.R. § 405.1804(a) and affirmed that 42 U.S.C. § 1395ww (e)(1) "required that, for cost reporting periods beginning in FYs 1984 and 1985, the IPPS result in aggregate program reimbursement equal to 'what would have been payable' under the reasonable cost-based reimbursement provisions of prior law; that was, for FYs 1984 and 1985, the IPPS would be 'budget neutral.'" 78 Fed. Reg. 74825, 75162 (Dec. 10, 2013) (making technical change to the 42 C.F.R. § 405.1804(a)).

[45] *See, e.g.,* 48 Fed. Reg. 39752, 39765 (Sept. 1, 1983) (stating "We point out that aside from being technically desirable, the effect of standardizing nonlabor hospital costs in Alaska and Hawaii is to decrease the reduction for budget neutrality stemming from the requirements in section 1886(e)(1)(B) of the Act.").

> **21**. Thus, for fiscal year 1984, 75 percent of total projected reimbursement based on the hospital-specific portion should equal 75 percent of total estimated outlays under law as in effect prior to April 20, 1983. Likewise, total estimated prospective payment system outlays deriving from the 25 percent Federal portion, including adjustments and special payment provisions, should equal 25 percent of projected reimbursement under prior laws.
>
> **The adjustment of the Federal portion was determined as follows**:
>
> - *Step 1*—Estimate total incurred payments for inpatient hospital operating costs for fiscal year 1984 that would have been made on a reasonable cost basis under Medicare prior to Pub. L. 98-21.
> - *Step 2*—Multiply total incurred payments by 25 percent, i.e., the Federal portion of total payment amounts for fiscal year 1984.
> - *Step 3*—Estimate the Federal portion of total payments that would have been made without adjusting for budget neutrality, but with the adjustment for outlier payments.
> - *Step 4*—Add an estimate of total adjustments and payments under special payment provisions to the Federal portion (e.g., outliers, indirect medical education).
> - *Step 5*—The difference between the step 2 and step 4 amounts is divided proportionally among the standardized amounts, resulting in the budget neutrality adjusted (standardized) amounts.
>
> **The resulting adjustment factor for the fiscal year 1984 <u>Federal portion</u> is .969**. Payment amounts of hospitals excluded from the prospective payment system (e.g., psychiatric and children's hospitals) and of hospitals not participating in prospective payment because of their participation in demonstrations and studies were not included in the calculations above.[46]

In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970 using the same methodology.[47] Significantly, in the January 1984 final rule, the Secretary suggests that, in calculating the budget neutrality adjustment factor, CMS made no attempt to adjust for transfers under IPPS:

> Regarding additional adjustments recommended by commenters, we made no adjustments to either the adjusted standardized amounts or

[46] 48 Fed. Reg. 39752, 39840-41 (Sept. 1, 1983) (bold, underline emphases added, and italics emphasis in original).
[47] 49 Fed. Reg. 234, 334 (Jan. 3, 1984).

> to the budget neutrality estimates for conditions that could not be quantified on the basis of currently available data, even if there were a likelihood that these conditions might exist under prospective payment. For example, no adjustment was made for the likelihood that admissions would increase more rapidly under prospective payment than under the provisions of Pub. L. 97-248, or for costs that might be disallowed as a result of audit or desk review by the intermediaries. *Likewise, we made no attempt to quantify adjustments* ***for the likelihood of transfers*** *under prospective payment*, emergency room services, and disallowed costs which are successfully appealed.[48]

Accordingly, while the Providers did not appeal the budget neutrality adjustment, the above excerpt suggests that the Providers' concern about the Secretary's alleged mistreatment of transfers may be misplaced and that the treatment of transfers in the in the context of the budget neutrality adjustment for FFY 1984 may have more significance.

Finally, the Secretary also declined to increase the base standardized amount to reflect the increased costs associated with the shift in costs of hospital-based physician services from Part B to Part A, as suggested in a comment. The Secretary noted that such an increase would simply be offset or neutralized by a corresponding increase in the budget neutrality adjustment for FFY 1984:

> Finally, applying such an adjustment to the average standardized amounts (and, by extension, to the per case budget neutrality estimates of Federal rate payments) would not actually increase the level of payments under budget neutrality. If we were to increase the initial standardized amounts to reflect this shift, the budget neutrality adjustment factor would have to be recalculated, would accordingly be increased, and the net result would be virtually identical. As a result, such an adjustment would have no effect on payment levels during FYs 1984 and 1985, which are subject to budget neutrality.[49]

Regardless, the Secretary's application of a 0.970 budget neutrality adjustment factor to the FFY 1984 standardized amounts for the Federal rates confirms that these standardized rates were too high and were reduced by a factor of 0.030. Thus, the ***final*** IPPS payment rates used for the first year of IPPS (*i.e.*, FFY 1984), as published on January 3, 1984, reflect the Secretary's FFY 1984

---

[48] *Id.* at 255 (Emphasis added.) *See also id.* at 331 (stating as part of the discussion on the budget neutrality adjustments: "The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a DRG-adjusted limit on the allowable amount of inpatient operating costs per case and a per case limit on the rate of increase of operating costs of inpatient hospital services. Due to these per case limits, the incentives that influence hospital admission patterns are similar under TEFRA and prospective payment. Accordingly, ***we have assumed that the number of admissions under both prior law and the prospective payment system will be the same***. As a result, the budget neutrality factors can be calculated by comparing reimbursement per discharge for each of the systems, and there is no need to estimate an actual number of hospital admissions." (emphasis added)).

[49] *Id.* at 255.

budget neutrality adjustment. Moreover, as previously noted, since the FFY 1984 budget neutrality adjustment is based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and is not reviewable, the FFY 1984 budget neutrality adjustment effectively ***fixed*** the standardized amounts for FFY 1984 as used from that point forward (*i.e.*, as used both for the FFY 1984 IPPS payment rates and for subsequent years).

2. *The FFY 1985 budget neutrality adjustment also reduced the FFY 1985 standardized amounts, reaffirming that the Secretary's determined that the initial standardized amounts for FFY 1984 were set too high.*

For FFY 1985, the Secretary applied a budget neutrality adjustment of 0.954 to the standardized amounts used for the Federal national rates and 0.950 to the standardized amounts used for the regional rates. The Secretary described these adjustments as follows:

> In accordance with section 1886(e)(1) of the Act, the prospective payment system should result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for FYs 1984 and 1985, the prospective payment system must be "budget neutral".
>
> During the transition period, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. ***Further, effective October 1,1984***, *the Federal portion will be a blend of national and regional rates*. As a result, we must determine three budget neutrality adjustments— one each for both the national and regional rates, and one for the hospital-specific portions. The methodology we are using to make these adjustments is explained in detail in section V. of this addendum.
>
> Based on the data available to date, we have computed the following Federal rate budget neutrality adjustment factors:
>
> Regional—.950
> National—.954[50]
>
> ****

By finalizing an adjustment factor less than 1, the Secretary confirmed that the standardized amounts were too high. Thus, like her budget neutrality adjustments made for FFY 1984, the Secretary again confirmed that the standardized amounts were too high and exercised her discretion to reduce the standardized amounts to be used in the ***final*** FFY 1985 IPPS rates.[51]

[50] 49 Fed. Reg. 34728, 34769 (Aug. 31, 1984).

[51] In the preamble to the FFY 1985 Final Rule, the Secretary "noted that most of the data that the budget neutrality adjustment is based on has already been made available [to the public]. We believe that these data in conjunction with the explanation of the budget neutrality methodology presented in the NPRM (49 FR 27458) should enable individuals to replicate the adjustment factors. . . . In addition, we believe the lengthy and detailed description of the

3. The Secretary has applied the FFY 1985 budget neutrality-adjusted rates to FFY 1986 and subsequent years.

For FFY 1986, the Secretary confirmed that she used the FFY 1985 budget neutrality adjusted federal rates as the basis for determining the FFY 1986 federal rates:

> [T]he FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be ***neither more nor less than*** *we estimated would have been paid under prior legislation for the costs of the same services*. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) ***These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years.***
>
> Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts ***to ensure that accuracy of the FY 1986 standardized amounts***. To this end, we have identified several factors, discussed in section III.A.3.c., below, that contributed to the *overstatement* of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and have combined them into a proposed composite ***correction*** factor for FY 1986 that equals —7.5 percent.[52]

Significantly, in the above excerpt, the Secretary further confirmed that "[t]hese budget neutrality-adjusted rates for FY 1985 are then to be used *as the basis for the determination of rates* ***for later years***."[53] While it is true that the implementation of these rates for FFY 1986 were delayed by Congressional action extending the FFY 1985 rates through April 30, 1986 (as

---

data and the development of rates contained in the **Federal Register**, along with the many examples furnished, afford the reader all the information necessary for an understanding of the prospective payment system. Those individuals, hospitals, or associations desiring additional data and other material, either for verification of rates or for other purposes, may request this date under the Freedom of Information Act." 49 Fed. Reg. at 34771.

[52] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added). *See also* 49 Fed. Reg. at 34767 (stating "We believe the explicit language of section 2310 of Pub. L. 98-369 and section 1886(d)(3)(A) of the Act requires a reduction in the standardized amounts used to compute the Federal rates before adjusting for budget neutrality. . . . Thus, while the Federal rates . . . . have been reduced in this final rule to reflect the inflation factor prescribed by section 2310 of Pub. L. 98-369, we point out that the offset for budget neutrality has also been adjusted. The reduction in the regional and national standardized rates . . . attributable to section 2310 of Pub. L. 98-369 is entirely due to the revised budget neutrality adjustments for 1984 and 1985.").

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

discussed further in **Appendix B**), the Secretary confirmed that it used the rates published in the FFY 1986 IPPS Final Rule plus 1.0 percent modification specified by Congress:

> Section 9101(a) of Pub. L. 99-272 amends section 5(c) of Pub. L. 99-107 to extend the FY 1985 inpatient hospital prospective payment rates through April 30, 1986. Therefore, the DRG classification changes and recalibrated DRG weights that were set forth in the September 3, 1985 final rule (50 FR 35722) are effective for discharges occurring on or after May 1, 1986.
>
> * * * *
>
> In accordance with the provisions of section 9101(b) and (e) of Pub. L. 99-272, the adjusted standardized amounts that were published in the September 3, 1985 final rule (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1, 1986. The revised standardized amounts are set forth in Table 1, below.[54]

Significantly, *a glaring gap in the Providers' response to the Medicare Contractor's jurisdictional challenge* is their failure to discuss or even recognize how the Secretary's interpreted and applied the FFY 1985 budget neutrality adjustment.

The Board has set forth in **Appendix C** excerpts from the preambles of other final rules to provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates applied to later years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 budget neutrality adjustment*, it is clear that:

1. The Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and

2. The FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

Accordingly, the Board finds that the Providers' issue is inextricably tied, at a minimum, to the FFY 1985 budget neutrality adjustments.

* * * * *

In summary, the Providers confirm they do not seek to challenge the FFY 1984 or 195 IPPS payments or the associated FFY 1984 and 1985 budget neutrality adjustments, but rather they "contest the Standardized Amount for [the FFY] and the methodology by which the Standardized Amount was initially calculated in 1983."[55] They also claim that the Budget Neutrality

[54] 87 Fed. Reg. 16772, 16773 (May 6, 1986).
[55] *E.g.,* Case No. 19-0695GC *et al.*, Providers' Response to MAC Jurisdictional Challenge at 7.

Preclusion Provisions are not applicable here because they only bar administrative and judicial review of *a **narrow** category of challenges* to the Secretary's determination of the requirement, or the proportional amount, of any budget neutrality adjustment effected pursuant to 42 U.S.C. § 1395ww(e)(1) in FFYs 1984 and 1985.[56]

The Board disagrees and finds that it lacks substantive jurisdiction over the issue raised in these appeals because the *prospectively-set* standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY and the 1984 and 1985 budget neutrality adjustments are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[57] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably intertwined* with those applicable budget neutrality adjustments.[58] Indeed, the Secretary applied a budget neutrality adjustment to those years to reduce the standardized amounts by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985 and, thus, these budget neutrality adjustments appear to have already automatically accounted for any such alleged errors in

---

[56] *Id*.

[57] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[58] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably intertwined, section 1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and so the shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the "data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is ... a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board notes that the Board erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget neutrality***. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the Board's discussion herein) demonstrates that any adjustment to the FFY 1984 standardized amounts would be *inextricably* tied to the ensuing budget neutrality adjustments made for FFYs 1984 and 1985.

setting the initial base rate (which again was based on *1981 data*).[59] Because the FFY 1985 budget neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs and because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutraily adjustments and the resulting *final* standardized amount for FFY 1985 was carried/flowed forward to FFY 1986 and succeeding FFYs, the Board may not review the standardized amount used for the FFYs being appealed as it relates to the common issue in these appeals. In this regard, the Board again notes that the rates for FFY 1986 and subsequent years are based on the budget neutrality adjusted FFY 1985 rates and the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985, *for purpose of future FFYs*, because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.

Accordingly, the Board finds that: (1) the appealed issue is *inextricably* tied with the FFY 1984 and 1985 budget neutrality adjustments to the standardized amounts *for purposes of future FFYs* under the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), and both 1395ww(d)(2)(F) and 1395ww(d)(3)(C) which reference 1395ww(e)(1)(B), as demonstrated by the fact that the FFY 1985 budget-neutrality adjusted rates were used as the basis for the determination of rates for FFY 1986 and later years; and (2) 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations[60]) prohibit administrative and judicial review of those budget neutrality adjustments. Based on these findings, the Board concludes that it does not have substantive jurisdiction over the issue in the eight (8) CIRP and optional group cases listed in **Appendix A**. Accordingly, the Board hereby closes these eight (8) group cases 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 Participating:

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

For the Board:

2/28/2024

X Clayton J. Nix

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

[59] *See supra* note 41 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).
[60] *See, e.g.*, 42 C.F.R. §§ 405.1804, 405.1840(b)(2).

cc: Pamela VanArsdale, National Government Services, Inc. (J-6)
Danelle Decker, National Government Services, Inc. (J-K)
Judith Cummings, CGS Administrators (J-15)
Michael Redmond, Novitas Solutions, Inc. (J-L)
Wilson Leong, FSS
Jacqueline Vaughn, CMS OAA

APPENDIX A
Jurisdictional Challenges and Responses; Cases at Issue

On September 13, 2023, the Medicare Contractor filed a challenge to the following two (2) cases which all share a common lead Medicare Contractor, National Government Services, Inc. (J-6):

19-0722GC	HealthPartners FFY 2019 Understated Base Rate CIRP Group
19-0876GC	North Memorial Health FFY 2019 Understated Base Rate CIRP Group

On September 14, 2023, the Medicare Contractor filed a challenge to the following two (2) cases which all share a common lead Medicare Contractor, National Government Services, Inc. (J-K):

19-0696G	Besler Consulting FFY 2019 Understated Base Rate Group
19-0699GC	Medisys Health FFY 2019 Understated Base Rate Amount CIRP Group

On November 7, 2023, the Medicare Contractor filed a challenge to the following case with lead Medicare Contractor, CGS Administrators (J-15):

19-0774GC	King' Daughters' Health FFY 2019 Understated Base Rate CIRP Group

On November 14, 2023, the Medicare Contractor filed a challenge to the following three (3) cases which all share a common lead Medicare Contractor, Novitas Solutions, Inc. (J-L):

19-0695GC	Capital Health FFY 2019 Understated Base Rate Amount CIRP Group
19-0712GC	Atlantic Health FFY 2019 Understated Base Rate CIRP Group
19-0729GC	Virtua Health System FFY 2019 Understated Base Rate CIRP Group

APPENDIX B

The following are examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments and the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i):

a. "Restandardization of base year costs per case used in [the] calculation of Federal rates" for both the labor and non-labor portions to reflect the survey-based wage index as discussed in the FY 1986 IPP Final Rule. 50 Fed. Reg. 35646, 35692 (Sept. 3, 1985).

b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.[61] An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.[62]

c. Budget neutrality adjustments made to the standardized amount designated for urban hospitals and the one designated for rural hospitals when certain urban hospitals were

---

[61] The Secretary confirmed that, beginning in 1991, these adjustments are to be made in a budget neutral manner:

> Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

59 Fed. Reg. 45330, 45348 (Sept. 1, 1994).

[62] 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

> *Comment:* A commenter was concerned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.
>
> *Response:* This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs, inclusion of transfer cases tends to ***increase*** the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.
>
> Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

Id. at 35655-56.

deemed to be urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).[63]

d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)[64] and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).[65]

e. Budget neutrality provision at 42 U.S.C. § 1395ww(d)(3)(A)(vi) that allows Secretary to adjust standardized amount to eliminate the effect of "changes in coding or classification of discharges that do not reflect real changes in case mix."[66]

f. The discretion of the Secretary in 42 U.S.C. § 1395ww(d)(3)(I)(i) to "provide by regulation for such other exceptions and adjustments to such payments amounts under this subsection as the Secretary deems appropriate."

---

[63] *See also* 56 Fed. Reg. 43358, 43373 (Aug. 30, 1991) (stating "Consistent with the prospective payment system for operating costs, the September 1, 1987 capital final rule provided for separate standardized amounts for hospitals located in urban and rural areas. Subsequently, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) provided for a higher update factor for hospitals located in large urban areas than in other urban areas and thereby established three standardized amounts under the prospective payment system for operating costs. Large urban areas are defined as those metropolitan statistical areas (MSAs) with a population of more than 1 million (or New England County metropolitan statistical areas (NECMAs) with a population of more than 970,000). Beginning with discharges on or after April 1,1988 and continuing to FY 1995, the Congress has also established higher update factors for rural hospitals than for urban hospitals. The differential updates have had the effect of substantially reducing the differential between the rural and other urban standardized amounts. Section 4002(c) of Public Law 101-508 provides for the elimination of the separate standardized amounts for rural and other urban hospitals in FY 1995 by equating the rural standardized amount to the other urban standardized amount. The separate standardized amount for large urban hospitals would continue. Currently, the large urban standardized amount under the prospective payment system for operating costs is 1.6 percent higher than the standardized amount for hospitals located in other urban areas.").

[64] *See* 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A); *supra* note 21.

[65] Omnibus Reconciliation Act of 1990, Pub. L. 101-508, § 4002(c), 104 Stat. 1388, 1388-33 – 1388-35 (1990).

[66] For example, the Secretary included the following discussion in the preamble to the FFY 1986 IPPS Final Rule:

> As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year). However, we now have data that indicate that case mix has increased an additional 2.6 percent. Hospitals have been realizing the benefit of that increase through increased payments. Our update factor will be adjusted so as to not pass through in the FY 1987 rates 2.0 percentage points of the increase in case mix. However, the 0.6 percentage points that we estimate to reflect a real increase in case mix will be added to the update factor for FY 1987.

51 Fed. Reg. 31505-06.

g. The subsequent amendments that Congress made in 1994[67] and 1997[68] to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. The Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS.[69]

To illustrate the complex nature of these issues, the Board points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,[70] the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).[71] The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

> Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that developed since they were published. *We believe that it is necessary, **each year**, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries*. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.

---

[67] Social Security Act Amendments of 1994, § 109, Pub. L. 103-432, 108 Stat. 4398, 4408 (1994) placed the then-existing language of 42 U.S.C. § 1395ww(d)(5)(I) into clause (i) and added the following clause (ii): "(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater than or lesser than those that would have otherwise been made in such fiscal year."

[68] Balanced Budget Act of 1997, Pub. L. 105-33, § 4407, 111 Stat. 251, 401 (1997), further revised 42 U.S.C. § 1395ww(d)(5)(I) and added § 1395ww(d)(5)(J).

[69] *See* 60 Fed. Reg. 45778, 45854 (Sept. 1, 1995) ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional payments for transfer cases of $159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.").

[70] 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).

[71] U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

In addition to this general consideration, *the FY 1985 adjusted average standardized amounts* (***Federal rates***) *were required by law* ***to be adjusted to achieve budget neutrality***; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more* ***nor*** *less than* we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years*.

Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were ***higher*** *than necessary to achieve budget neutrality*. Therefore, *we have updated the FY 1985 standardized amounts using a factor that takes into account the* ***overstatement*** *of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts*. To this end, we have identified several factors, ***discussed in section II.A.3.c.***, below, that contributed to the overstatement of the FY 1985 standardized amounts. *We have determined an appropriate percent value for each of them, and have combined them into* ***a proposed composite correction factor*** *for FY 1986 that equals –7.5 percent*.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. **We have combined these values into a composite policy target adjustment factor**, **as discussed in section III.3.e., below**. For FY 1986, this factor equals —1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." *Establishing FY 1986 prospective payment rates based on FY 1985 rates* ***that have been demonstrated to be overstated****, clearly would not comport with the statutory requirement that the rates represent payment for efficiently delivered care*.

Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes is +.31 percent, it is clear that there is a potential justification of a –4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:

	Percent
Forecasted market basket increase..	+4.27
Part B costs and FICA taxes.....	+.31
Composite correction factor.....	–7.5
Composite policy target adjustment factor.....	–1.5

However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.[72]

****

(3) *Additional causes for the overstatement of FY 1985 Federal rates.* In addition to the factors above, which we believe we must correct, **other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts**.

When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for 1985. After application of the revised market basket, discussed previously, use of these actuarial estimates would reduce the standardized amounts by an additional 1.2 percent.

[72] 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates. The hospital specific rates were set using later (1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. **Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount**. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals" total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.

We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided <u>at this time not</u> to correct the standardized amounts for these factors.**

We received no comments on this issue.

> (4) ***Composite Correction Factor.*** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:
>
> | | *Percent* |
> |---|---|
> | Case mix..... ..... | –6.3 |
> | Market basket..... | –1.2 |
> | Composite correction factor..... | –7.5[73] |

Congress did immediately act on the Secretary's September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 ("EEA-85") to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates (*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).[74] Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

> - Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
>
> - Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
>
> - Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
>
> - Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.[75]

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.[76] As previously discussed above in the decision at Section B.3, in the final rule published on May 6, 1986, the Secretary confirmed that "*the adjusted standardized amounts that were published in the September 3,1985 final rule* (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986"[77] and these FFY 1986 adjusted standardized rates are based on the FFY 1985 budget neutrality-adjusted rates.

---

[73] *Id.* at 35703-04 (bold and underline emphasis added).
[74] Pub. L. 99-107, § 5(a), 99 Stat. 479, 479 (1985). In July 1984, Congress had *already* reduced the 1 percent update factor planned for FFY 1986 to ¼ of a percentage point. Deficit Reduction Act of 1984, Pub. L. 98-369, § 2310(a), 98 Stat. 494, 1075 (1984). As part of the Emergency Extension Act of 1985, Congress further reduced the update factor for FFY 1986, presumably in response to the Secretary's recommendation.
[75] 51 Fed. Reg. 16772, 16772 (May 6, 1986).
[76] *See id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).
[77] 51 Fed. Reg. at 16773.

The examples highlight concerns about how certain future actions and decisions by the Secretary and Congress build upon prior decisions. Here, the Secretary's recommendation to Congress regard the FFY 1986 update factor were based on its analysis of the FFY 1984 and 1985 standardized amounts that had already been adjusted for budget neutrality. To the extent the 1984 standardized amounts had been *further* adjusted (*as **now** proposed by the Providers*), it could have potentially impacted the Secretary's recommendation to Congress for the FFY 1986 update factor as well as Congress' subsequent revisions to the updated factor. Accordingly, this highlights how revisiting and otherwise adjusting the FY 1984 standardized amounts can have ripple effects with the update factor and other adjustments that were made for subsequent years *based on analysis of the prior year(s) and other information*.

APPENDIX C

In its decision, the Board has noted that the Secretary confirmed in the preamble of the FFY 1986 IPPS Final Rule that the FFY budget neutrality-adjusted rates were used in determining the rates for FFY 1986 and would similarly be part of subsequent FFYs rates. The following excerpts from the preambles to IPPS final rules provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates were part of the rate for later FFYs and illustrate how embedded the FFY 1985 budget neutrality-adjusted rates are in the rates used for FFY 1986 and subsequent years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 budget neutrality adjustment*, it is clear that the Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and that the FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

1. In the preamble to the FFY 1986 IPPS Final Rule, the Secretary recognizes that the FFY 1985 budget neutrality adjustment accounted for the removal of nonphysician anesthetist costs from the base rates and no further adjustments were needed relative to those costs since the FFY 1985 budget neutrality-adjusted rates were used in determining the FY 1986 rates and would similarly be used for the 1987 rates:

> c. *Nonphysician anesthetist costs*. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987. We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, **because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts.** (See 49 FR 34794; August 31, 1984). **Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment**. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.[78]

[78] 50 Fed. Reg. at 35708 (Italics emphasis in original and bold and underline emphasis added). In this regard, the Board notes that the FFY 1985 IPPS Final Rule explained how the FFY 1985 budget neutrality adjustment accounted for Anesthetists services:

> *Anesthetists' Services*. Under section 2312 of Pub. L. 98-369, the costs to the hospital of the services of nonphysician anesthetists will be reimbursed in full by Medicare on a reasonable cost basis. In order to ensure that these services will be paid for only once, we must remove their costs from the prospective payment rates.
> For cost reporting periods beginning in FY 1985, we have reduced the adjusted standardized amounts to reflect the removal of these costs **by means of the budget neutrality adjustment**

2. In the preamble to the FFY 1987 IPPS Final Rule, the Secretary explains how her budget neutrality adjustments for FFYs 1984 and 1985 had "already built case-mix increases into the cost-per case assumptions used in deriving the budget neutral prospective rates for FY 1984 and FY 1985" and confirms that "FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year)":

> *Comment*: Several commenters stated that we did not consider real case mix increases in the 1983 to 1984 period, and that we finally are considering real case mix increases for the first time.
>
> *Response*: FY 1984 and FY 1985 were years subject to the requirements for budget neutrality. As required under section 1886(e)(1) of the Act, payments under the prospective payment system were to be equal to what would have been paid under rate-of-increase and peer group limits on reasonable costs under prior law (section 1886(b) of the Act) as if the prospective payment system had never been implemented. Under the rate-of-increase limits and peer group limits, as long as a hospital's cost was lower than that hospital's limits, we paid that cost, regardless of whether real case mix increased or decreased, and regardless of the effect of actual case mix on the cost level for that hospital. . . . Increases in real case mix were built into the cost per case increase assumptions we used to model the rate-of-increase limits. These assumptions took into account estimates of the impact of the rate-of-increase limits and the peer group limits. **Consequently, we considered increases in real case mix in FYs 1984 and 1985.** Moreover, even these assumed increases in cost per case proved to be overstated as we received more recent data against which to evaluate our estimates. To have passed through updated prospective payment case-mix increases for FY 1984 and FY 1985 would have been improper because they would increase program payments over the level that would have been paid under the section 1886(b) limits. **As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.**
>
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized.

---

methodology. Our method for doing this is explained in section V.D. of this Addendum. We estimate that FY 1985 payments for anesthetists' services will be about $160 million, or 0.5 percent of Medicare operating costs for hospital accounting years beginning in FY 1985.

> In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. **Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year).**

3. In the preamble to the FFY 1988 IPPS Final Rule, the Secretary again recognizes the prior FFY 1985 budget neutrality adjustments to the standardized amounts had already taken into account the removal of nonphysician anesthetist costs and the *FFY 1985 budget neutrality-adjusted rates* ***were reflected in the FFY 1986, 1987, and 1988 rates.***

> c. *Nonphysician Anesthetist Costs*. Section 1886(d)(5)(E) of the Act provides that hospital costs for the services of nonphysician anesthetists are paid in full as a reasonable cost pass-through. Under section 2312(c) of Pub. L. 98-369, this pass-through was made effective for cost reporting periods beginning on or after October 1,1984, and before October 1,1987. Section 9320(a) of Pub. L. 99-509 extended the period of applicability of this pass-through so that services will continue to be paid under reasonable cost for any cost reporting periods (or parts of cost reporting periods) ending before January 1,1989 and struck subsection (E) effective on that date.
>
> In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, it was incorporated in the overall **budget neutrality** adjustment (50 FR 35708). Therefore, **because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived**, we did not propose to make further adjustments to the average standardized amounts for FY 1988.[79]

[79] 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

L. Rene Shannon
Advocate Health
4400 Golf Acres Dr., Bldg. J, Ste. A
Charlotte, NC 28208

RE: ***Notice of Dismissal – Updated Rationale***
Advocate Health Standardized Amount CIRP Group Cases
Case Nos. 19-2181GC, *et al.* (*see* **Appendix A** listing 6 group cases)

Dear Ms. Shannon:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the six (6) above-referenced common issue related party ("CIRP") group cases relating to the standardized amounts used in federal rates for the inpatient prospective payment system ("IPPS") during federal fiscal year ("FFY") 1984, the initial year of IPPS. The Medicare Contractor has filed Jurisdictional Challenges in all of those group cases. The Providers' Representative filed responses to these challenges. As set forth below, the Board has determined that, consistent with 42 U.S.C. §§ 1395ww(d)(7) and 1395oo(g)(2) and 42 C.F.R. § 405.1840(b), it lacks substantive jurisdiction over the appealed issue and is therefore dismissing all six (6) CIRP group cases in their entirety. This determination is consistent with its prior dismissal determinations in other cases involving the same issue finding where the Board found no *substantive* jurisdiction;[1] however, in response to additional brief on this issue by other parties, the Board's decision has been updated to clarify and confirm that the federal rates for FFY 1986 and subsequent FFYs used the FFY 1985 budget neutrality-adjusted federal rates.

In summary, the Board finds that it lacks substantive jurisdiction over the issue raised in these appeals. The standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY and the 1984 and 1985 budget neutrality adjustments are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[2] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably*

[1] Prior Board dismissal determinations of the issue in the instant group appeals include but are not limited to: Board dec. dated Apr. 6, 2023 (lead Case No. 19-0233GC); Board dec. dated Dec. 14, 2023 (lead Case No. 23-0695GC); Board dec. dated Jan. 23, 2024 (lead Case No. 19-1094GC); Board dec. dated Jan. 24, 2024 (lead Case No. 23-1522GC); and Board dec. dated Jan. 31, 2024 (lead Case No. 19-0847GC). These jurisdictional decisions are posted on the Board's website, by the relevant year and month, at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/list-prrb-jurisdictional-decisions.

[2] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42

intertwined with those applicable budget neutrality adjustments.[3] Indeed, the standardized amounts were too high for FFYs 1984 and 1985 and the budget neutrality adjustments applied to those years reduced the standardized amounts (reduced by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985) and, thus, these budget neutrality adjustments appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on 1981 data).[4] Because the FFY 1985 budget neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs and because 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments, the Board may not review the standardized amount used for the FFYs appealed as it relates to the common issue in these appeals. In this regard, the Board again notes that the rates for FFY 1986 and subsequent years are based on the budget neutrality adjusted FFY 1985 rates. Accordingly, the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985, *for purposes of future FFYs*,[5] because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.[6]

Background:

Advocate Health[7] ("Providers' Representative") represents a number of providers in common issue related party ("CIRP") groups which are challenging the IPPS standardized amount. The Medicare Contractor filed a Jurisdictional Challenge covering six (6) group cases.[8] The Providers' Representative filed responses to these challenges. The group issue statements, jurisdictional challenge, and response thereto for all six (6) cases are materially identical and can be considered together.

The group issue presented is:

> Whether the Providers are entitled to an additional payment because inclusion of transfers in the 1981 data used for computing the Medicare Inpatient Prospective Payment System ("IPPS")

U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[3] *See infra* note 57 (citing to decisions that discuss similar circumstances involving Medicare provisions found to be inextricably tied to certain other provisions for which Congress precluded administrative and judicial review).

[4] *See infra* note 41 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

[5] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns.

[6] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns that could potentially serve as an alternative rationale.

[7] Current name of Parent Organization.

[8] *See* **Appendix A.**

standardized amount reduced the Providers' IPPS payment for Fiscal Year 2013?[9]

Procedural Background:

A. Appealed Issue

In the Providers' group issue statements, they explain that the IPPS requires the categorization of different types of discharges (diagnostic related groups, or "DRGs"), and payment rates applicable to each discharge category. Their appeals challenge the latter, arguing that the data used to establish the initial "flat rate" payable per discharge resulted in an understated payment rate. CMS opted to use 1981 as a "base year" to calculate these rates, and thus data was collected from hospitals' 1981 cost reports to determine average costs for each discharge category. The data was adjusted for inflation and standardized, but the Providers argue that the initial calculation of this standardized amount continues to serve as the base for all future calculations. Since the Providers allege this initial calculation was understated, they argue that the calculation for each subsequent year has also been understated.[10]

The Providers claim that the data sources used in collecting the 1981 data did not distinguish between patients who were discharged from the hospital, and patients who were transferred to another hospital or facility. They state that CMS views transfers as distinct from discharges, but in calculating the average cost per discharge using the 1981 data, CMS erroneously included transfers in the total number of discharges, thereby inflating the denominator of the cost to discharge ratio. They claim that CMS has acknowledged this error in at least one other context (*i.e.*, during the implementation of the capital PPS), and that this error was the reason for certain DRG weight recalibrations, but that CMS failed to fully correct the flawed Standardized Amount.[11]

In each case, the Providers are challenging the applicable FFY IPPS rates as set forth in the Federal Register.[12] They argue the appeals are not barred by the "predicate facts" provision of 42 C.F.R. § 405.1885(a)(1)(iii) and that there is no impediment to CMS correcting its erroneous data to remediate the flawed Standardized Amount. They claim that the average cost per discharge should not include transfers, that CMS has acknowledged this as well as the fact that certain Standardized Amounts erroneously included transfers, and that this practice violates both the Medicare Act and Administrative Procedure Act. Finally, they argue that the understated Standardized Amounts and their resulting understated Medicare payments produces cost shifting prohibited by 42 U.S.C. § 1395x(v)(1)(A)(i).[13]

---

[9] *E.g.*, Case 19-2181GC, Group Issue Statement at 1 (Jul. 6, 2019).
[10] *Id.* at 2-3.
[11] *Id.* at 3-4 (citing 56 Fed. Reg. 43449, 43387 [sic] (Aug. 30, 1991) (related to capital PPS) and 60 Fed. Reg. 45791 (Sept. 1, 1995) (related to recalibration of DRG weights to exclude transfers for FY 1996)).
[12] *Id*. at 5 ("The Providers timely appeal within 180 days from the final determination of the Secretary of Health and Human Services as set forth in 83 Fed. Reg. 41782-41783 and Appendix B, Section II.A and Tables 1.A. – 1.E. of the FY 2019 IPPS Final Rule (August 17, 2018; as corrected 83 Fed. Reg. 49836 et seq. and Tables 1.A. – A.E. (October 3, 2018).").
[13] *Id*. at 6.

In their appeal requests, the Providers noted that the Board is bound to implement the "flawed" standardized amount and, as a result, cannot grant the relief they seek. The issue statements indicate that a request for Expedited Judicial Review would be forthcoming, though none were ever filed.[14]

B. Jurisdictional Challenges

The Medicare Contractor filed challenges in six (6) different group cases, and the Providers filed responses in each case.[15] The Medicare Contractor argues that the merits of the appealed issue are illegitimate, but more importantly, that the Board lacks subject matter jurisdiction and need not even address the merits of the issue. It references the Board's April 6, 2023 decision dismissing five (5) different CIRP group appeals concerning the same issue. The Medicare Contractor argues the Board should apply the same rationale and find that 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative review of the base year standardized amounts. It also claims that budget neutrality adjustments after the base year amount was calculated have corrected any potential errors from prior years, and that the data shows the base year was, in fact, initially set too high (rather than understated).

The Providers' responses to these challenges reiterated that the group appeal rests on the fact that each appeal's IPPS payments for the applicable FFY is "improperly understated because the Secretary failed to remove or adjust for patient *transfers* that were included in the 1981 base-year data."[16] They claim that the budget-neutral adjustments and any preclusion provisions do not apply to their IPPS challenges. The ask the Board to find it has jurisdiction over these appeals and that expedited judicial review is warranted.

The Providers counter the Medicare Contractor by arguing that budget neutrality adjustments are not applicable to these appeals. The Providers claim they do not seek to challenge the FFY 1984 or 1985 IPPS payments, but rather they "contest the Standardized Amount for [the applicable FFY] and the methodology by which the Standardized Amount was initially calculated in 1983."[17] The further claim that neither 42 U.S.C. §§ 1395ww(d)(7)(A) nor 1395oo(g)(2) restrict challenges to the methodology deriving from the original Standardized Amount based on the 1981 data.[18] They argue that there is a strong presumption in favor of judicial review, and that in this instance there is not clear indication that Congress intended to preclude review of more recent FFY Standardized Amounts or the predicate facts related to the methodology for calculating the 1983 Standardized Amount.[19] Finally, the Providers conclude that expedited judicial review is appropriate here because the Board is bound to apply the Standardized Amount and, thus, cannot grant the relief sought (*i.e.*, a change to the Standardized Amount).[20]

---

[14] *Id.* at 7.
[15] *See* Appendix A for complete list of challenges and cases impacted. Note, the challenges are all materially identical.
[16] *E.g.*, PRRB Case 19-2181GC *et al.*, Providers' Response to MAC's Jurisdictional Challenge at 2 (Nov. 17, 2023).
[17] *Id.* at 6-7.
[18] *Id.* at 7.
[19] *Id.* at 8.
[20] *Id.* at 9-11. The Providers note that a request for expedited judicial review must be filed separately pursuant to Board Rule 42.2. *Id.* at 11, n.4.

Board Decision:

As described more fully below, the Board finds that it lacks substantive jurisdiction over each of the 6 groups because: (1) the initial IPPS standardized amounts set for FFY 1984[21] are ***inextricably*** tied to the FFY 1984 and 1985 budget neutrality adjustments to the "applicable percentage increases" for IPPS[22]; (2) the FFY 1985 budget neutrality-adjusted rates were used to determine the rates for FFY 1986 and, thus, became imbedded into the rates determined for subsequent FFYs; and (3) 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments. Further, the fact that the Secretary's budget neutrality adjustment to the FY 1984 Federal Rates was 0.970[23] demonstrates that, contrary to the Providers' assertions, the initial standardized amount was ***not*** understated but rather was *overstated* by a factor of 0.030 (*i.e.*, 1.000 – 0.970).

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the IPPS.[24] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[25]

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services."[26] The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain ***base period*** *cost data* be developed and modified in several specified ways (*i.e.*, inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[27] Section 1395ww(d)(2)(A) requires that the Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available:

> (II) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital

---

[21] The Board notes that, initially, there was not just one standardized amount. Rather there were 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation and each of these 20 rates is further divided into a labor and nonlabor portion. *See* 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[22] 42 U.S.C. § 1395ww(e) is entitled "Proportional adjustments in applicable percentage increases." The 1984 and 1985 budget neutrality adjustments are set forth is § 1395ww(e)(1)(B) which is cross-referenced for 1984 IPPS rates at § 1395ww(d)(2)(F) and for 1985 IPPS rates at § 1395ww(d)(3)(C).
[23] In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970. 49 Fed. Reg. 234, 334 (Jan. 3, 1984).
[24] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[25] *Id.*
[26] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[27] *Id.* (emphasis added).

> services for the hospital for the most recent cost reporting period for which data are available.

Consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the 1984 "base period" operating cost per discharge amount using the 1981 operating costs per discharge amount *updated* by an inflationary factor.[28] The Providers dispute how the Secretary determined "discharges" and allege that the Secretary improperly treated transfers as discharges for purposes of this calculation.

The Secretary then "standardized" the FFY 1984 base period operating cost per discharge using the process prescribed at 42 U.S.C. § 1395ww(d)(2)(c). The standardization process removed the effects of certain variable costs from the cost data, including (but not limited to) excluding costs associated with indirect medical education costs, adjusting for variations in average hospital wage levels, and adjusting for variations in case mix among hospitals.

The initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"), the standardized amount is not adjusted each year simply for inflation.[29] Significantly, some of these annual adjustments were required to be *budget neutral* and are not subject to administrative review and others are discretionary. In particular, 42 U.S.C. § 1395ww(e)(1)(B) provides the budget neutrality adjustment for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

> **(e) Proportional adjustments in *applicable percentage increases***
>
> (1) . . . .
>
> (B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—
>
> > (i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),
>
> *are not greater or less than*—

[28] *Id*. at 39763-64.
[29] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

> (ii) the DRG percentage (as defined in subsection (d)(1)(C)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).[30]

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 rate year and 1985 rate year respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

> *(i) Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c) through (h) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of **the payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1984 **under the Social Security Act as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[31]

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

> (v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of the reduced standardized amounts determined under paragraph © of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is **not greater or less** than 50 percent of the **payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983**.

---

[30] (Bold emphasis in original and italics and underline emphasis added.) The budget neutrality adjustment at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).
[31] (Italics emphasis in original and bold and underline emphasis added.)

> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[32]

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than* ***or*** *less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e*., reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average payment per case, is prescribed by law to be *no more* ***and*** *no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget neutrality for 1984 and 1985 are ***external*** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.[33] Since these points are ***fixed,*** it also means that it is capped (*i.e*., cannot be increased subsequently outside of the budget neutrality adjustment).

This conclusion is supported by the fact that the normal annual inflation adjustments to the standardized amount provided for in IPPS apply only for FY 1986 forward, as set forth in 42 U.S.C. § 1395ww(b)(3)(B)(3)(i) and cross referenced in § 1395ww(d)(3)(A). Specifically, 42 U.S.C. § 1395ww(b)(3)(B)(i) (2018) defines the term "applicable percentage increase" starting with fiscal year 1986 (as opposed to 1984):

> (B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—

---

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

[33] 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board's pie concept:

> Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.
>
> Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

(I) ***for fiscal year 1986***, 1⁄2 percent,

(II) for fiscal year ***1987***, 1.15 percent,

(III) for fiscal year ***1988***, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,

(IV) for fiscal year ***1989***, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,

(V) for fiscal year ***1990***, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,

(VI) for fiscal year ***1991***, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,

(VII) for fiscal year ***1992***, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,

(VIII) for fiscal year ***1993***, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 1 for hospitals located in a rural area,

(IX) for fiscal year ***1994***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,

(X) for fiscal year ***1995***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),

> (XI) for fiscal year ***1996***, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,
>
> (XII) for fiscal year ***1997***, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,
>
> (XIII) for fiscal year ***1998***, 0 percent,
>
> (XIV) for fiscal year ***1999***, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,
>
> (XV) for fiscal year ***2000***, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,
>
> (XVI) for fiscal year ***2001***, the market basket percentage increase for hospitals in all areas,
>
> (XVII) for fiscal year ***2002***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XVIII) for fiscal year ***2003***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XIX) for each of fiscal years ***2004*** through ***2006***, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and
>
> (XX) ***for each subsequent fiscal year***, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.[34]

The "applicable percentage increase" as defined in § 1395ww(b)(3)(A) is incorporated into § 1395ww(d)(3)(A), as it relates to updating of the standardized amount:

> **(A) UPDATING** PREVIOUS STANDARDIZED AMOUNTS.—
>
> (i) For discharges occurring in a fiscal year beginning ***before*** October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, *equal to the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph*, ***increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B)***. With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital

[34] (Emphasis added.)

> weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).
>
> (ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.
>
> (iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

Thus, while 42 U.S.C. § 1395ww(d)(2) provides the methodology for calculating the standardized amount to be used for each year, and that the amount is subject to the "applicable percentage increase" under subsection (b)(3)(B) *for years after 1984*, it remains that it is not always a simple inflationary or market basket adjustment. In particular, the FFY 1984 and 1985 budget neutrality adjustments (as referenced in § 1395ww(d)(2)(F) and in § 1395ww(d)(3)(C)) were the applicable percentage increases for FFYs 1984 and 1985 and, as described below, those adjustments are not administratively reviewable. Further, as discussed *infra*, it is clear that the Secretary has interpreted 42 U.S.C. § 1395ww(d)(3)(A)(i) to require that the FFY 1985 budget neutrality-adjusted rates be used in determining the rates for FFY 1986 and subsequent FFYs. This is reflected in the following excerpt from 42 C.F.R. § 405.473(c) as initially adopted in the September 3, 1983 final rule:

> (c) *Federal rates for fiscal years after Federal fiscal year 1984.*
>
> ****
>
> (2) *Updating previous standardized amounts.* (i) *For fiscal year 1985*. HCFA will compute an average standardized amount for each group of hospitals described in paragraph (b)(5) of this section . . . equal to the respective adjusted average standardized amount computed for fiscal year 1984 under paragraph (b)(7) of this section—
> (A) Increased for fiscal year 1985 by the applicable percentage increase under § 405.463(c);
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475; and
> (D) **Adjusted for budget neutrality under paragraph (c)(4) of this section**.
> (ii) **For fiscal year 1986** and thereafter, **HCFA will compute an average standardized amount** for each group of hospitals described in paragraph (b)(5) of this section, **equal to the respective adjusted average standardized amounts computed for the previous fiscal year**—
> (A) Increased by the applicable percentage increase determined under paragraph (c)(3) of this section; and
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such

> services must be furnished either directly by hospitals or under arrangements.
> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475.
>
> (3) *Determining applicable percentage changes for fiscal year 1986 and following*. The Secretary will determine for each fiscal year (beginning with fiscal year 1986) the applicable percentage change which will apply for purposes of paragraph (c)(2)(ii) of this section as the applicable percentage increase for discharges in that fiscal year, and which will take into account amounts the Secretary believes necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In making this determination, the Secretary will consider the recommendations of the Prospective Payment Assessment Commission.[35]

---

[35] 48 Fed. Reg. at 39823 (italics emphasis in original and bold and underline emphasis added). This provision was later moved to 42 C.F.R. § 412.63(c)(2022) which states in pertinent part:

> (c) *Updating previous standardized amounts*.
> ****
> (2) Each of those amounts is equal to the respective adjusted average standardized amount computed for fiscal year 1984 under §412.62(g)—
> (i) Increased for fiscal year 1985 by the applicable percentage increase in the hospital market basket;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
> (iii) Reduced by a proportion equal to the proportion (estimated by CMS) of the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part; and
> (iv) **Adjusted for budget neutrality under paragraph (h) of this section**.
> (3) ***For fiscal year 1986*** *and thereafter*. CMS computes, for urban and rural hospitals in the United States and for urban and rural hospitals in each region, average standardized amount equal to the respective **adjusted average standardized amounts computed for the previous fiscal year**—
> (i) Increased by the applicable percentage increase determined under paragraphs (d) through (g) of this section;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements; and
> (iii) For discharges occurring on or after October 1, 1985 and before October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part, and for discharges occurring on or after October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments that, based on the total amount of prospective payments for urban hospitals and the total amount of prospective payments for rural hospitals, are additional payments attributable to outlier cases in such hospitals under subpart F of this part.

B. Jurisdictional Findings -- 42 U.S.C. § 1395ww(d)(7)(A) Precludes Administrative Review of the Base Year Standardized Amounts

The Providers essentially are challenging the standardized amount used in the IPPS rates for several FFYs claiming that the Secretary improperly treated transfers as discharges when using 1981 cost report data to determine the initial FFY 1984 base cost per discharge which, in turn, was standardized to arrive at the FFY 1984 standardized amounts. More specifically, the Providers maintain that, the understatement of the standardized amount in the FFY 1984 IPPS Final Rule caused a corresponding underpayment in IPPS payments in FFY 1984 ***and every FFY thereafter*** *because the standardized amount for all IPPS payments for every FFY are based on CMS's calculation of the FFY 1984 standardized amount*.[36]

The published standardized amount for each FFY in these appeals reflects the prior year's standardized amount plus "the applicable percentage increase" as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i) (as referenced in 42 U.S.C. § 1395ww(d)(3)(A)) *as well as other potential adjustments*. Significantly, the "applicable percentage increase[s]" for 1984 forward are ***not*** always simply a cost inflation adjustment or other similar percentage adjustment. To this point, for the first two (2) years of IPPS, Congress mandated that the budget neutrality adjustments for FFYs 1984 and 1985 serve as the "applicable percentage increase" for those years. As a result, the IPPS rates that the Secretary used *for the very first year of IPPS* and then the second year of IPPS were adjusted for budget neutrality. For FFYs 1986 and forward, Congress provided for an "applicable percentage increase" in 42 U.S.C. § 1395ww(b)(3)(B)(i) as referenced in 42 U.S.C. § 1395ww(d)(3)(A). In addition, there are other *permanent* adjustments (*i.e*., adjustments not for that year only but that also apply on a going-forward basis) to the standardized amount that have occurred in other years outside of the "applicable percentage increase."[37] Thus, the standardized amount for a particular year is an amalgamation that builds upon the prior year's standardized amount and then adds additional adjustments for the current year. As noted *supra* and discussed more *infra*, the Secretary has used the FFY 1985 budget neutrality-adjusted rates for determining the FFY 1986 rates and those for subsequent FFYs.

The Providers are, essentially, seeking to peel back the amalgamated standardized amount for each applicable FFY *and, thus, reach back* ***more than 30 years*** to increase the initial FFY 1984 base rate that was used to set the initial FFY 1984 standardized amount***s***. They would then incorporate the alleged increased base rate into the FFY 1984 standardized amount***s*** and then simply carry or flow that *increase forward 35 years*. However, in order to peel the amalgamated standardized amounts for the FFYs at issue (singular[38]) *as used in the IPPS rates for each FFY* back to the initial standardized amount***s*** (plural[39]) used in FFY 1984, and then carry/flow any change forward *to the FFY at issue*, the Providers would have to pass through the FFY 1984 and 1985 budget neutrality adjustments which were the only "applicable percentage increase[s]" for those years. However,

---

[36] *E.g.*, PRRB Case 19-2181GC *et al.*, Providers' Response to MACs' Jurisdictional Challenges at 10 ("The Secretary's error caused a ripple-effect of incorrectly calculated Standardized Amounts since 1983 because of the erroneous embedded methodology.").
[37] *See* Appendix B.
[38] *See supra* note 21 accompanying text.
[39] *See id.*

they cannot do so because the budget neutrality adjustments had the effect of ***fixing*** the pie for FFYs 1984 and 1985 to (*i.e*., no more ***and*** no less than) the aggregate amounts that would have been paid had IPPS not been implemented.[40] More specifically, the amalgamated standardized payment amount for each FFY at issue reflects the *fixed* FFY 1985 budget neutrality adjustment (and not the initial FFY 1984 standardized amount since the standardized amounts for FFYs 1984 and 1985 were each adjusted for budget neutrality became *fixed* for purposes of subsequent years as a result of those budget neutrality adjustments). Thus, in the Board's view, the Providers cannot get back to the FFY 1984 standardized amounts without first passing through the FFY 1984 and 1985 budget neutrality adjustments. Regardless, the Providers would not be able to flow forward any adjustments made to the FFY 1984 standardized amounts to FFYs after FFY 1985 because:

> (1) they, again, would not be able to get through the FFY 1984 and 1985 budget neutrality adjustments that Congress otherwise ***fixed*** to an external point (no greater and no less); and
>
> (2) the IPPS rates paid for FFYs 1984 and 1985 are based on standardized amounts that were adjusted downwards as a result of the budget neutrality adjustment for FFY 1984 and also for FFY 1985 (*see* discussion below in Sections B.1 and B.2).[41]

Accordingly, the Board finds that the Providers challenge to the standardized amounts at issue are *inextricably* tied to the budget neutrality adjustments made for FFY 1984 and 1985.[42]

---

[40] *See, e.g.,* 48 Fed. Reg. 39752, 39805 (Sept. 1, 1983) (stating: "Hospital Impact—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20,1983.").

[41] Indeed, the FY 1986 IPPS Final Rule included an example where the Secretary recognized an adjustment to the budget neutrality adjustments would be impacted by the removal of nurse anesthetists costs and confirmed that the adjustments to the standardized amounts had already taken this removal into account:

> c. Nonphysician anesthetist costs. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987.
>
> We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, *because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts*. (See 49 FR 34794; August 31, 1984). ***Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment***. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.

50 Fed. Reg. at 35708 (emphasis added). *See also* 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (stating: "In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, *it was incorporated in the overall* ***budget neutrality adjustment*** (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived, we did not propose to make further adjustments to the average standardized amounts for FY 1988.").

[42] The Board notes that the D.C. Circuit's decision in *Saint Francis* is not applicable to the 1984 and 1985 budget neutrality adjustments given the statutory provision precluding administrative and judicial review of those

Furthermore, Congress has precluded Board (and judicial) review of the FFY 1984 and 1985 budget neutrality adjustments. Specifically, 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and juridical review of the neutrality adjustment at § 1395ww(e)(1):

> (7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii), . . .[43]

Similarly, the statute governing Board appeals is located at 42 U.S.C. § 1395oo and states in subsection (g)(2):

> The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

Since the FFY 1984 and 1985 budget neutrality adjustments are based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and are not reviewable, the Board finds that the FFYs 1984 and 1985 budget neutrality adjustments effectively fixed the standardized amounts from that point forward for use in the IPPS system.[44]

---

adjustments. Further, *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[43] With regard to implementing this statutory provision, 48 Fed. Reg. 39752, 39785 (Sept. 1, 1983) states:

> Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
> —A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or
> —The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost. It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs. Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98-25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

[44] *See, e.g.,* 48 Fed. Reg. 39752, 39765 (Sept. 1, 1983) (stating "We point out that aside from being technically desirable, the effect of standardizing nonlabor hospital costs in Alaska and Hawaii is to decrease the reduction for budget neutrality stemming from the requirements in section 1886(e)(1)(B) of the Act.").

Indeed, the Secretary's implementation of the fixed FFY 1984 and 1985 budget neutrality adjustments confirms that the Providers' allegation that the standardized rates for ***each FFY at issue*** are somehow understated due to alleged errors in the FFY 1984 base rate is moot.

1. *The Secretary determined that the initial standardized amounts for FFY 1984 were too high and, therefore, reduced the FFY 1984 standardized amounts through the FFY 1984 budget neutrality adjustment as reflected in the **final** FFY 1984 IPPS rates*.

In the interim final rule published on September 1, 1983, the Secretary issued a FFY 1984 budget neutrality adjustment to the FFY 1984 standardized amounts of 0.969:

> Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for fiscal years 1984 and 1985, the prospective payment system should be "budget neutral."
>
> Under the Amendments, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Section 1886(e)(1)(A) of the Act requires that aggregate payments for the hospital specific portion should equal the comparable share of estimated reimbursement under prior law. **Similarly, section 1886(e)(1)(B) of the Act requires that aggregate reimbursement for the Federal portion of the prospective payment rates plus any adjustments and special treatment of certain classes of hospitals should equal the corresponding share of estimated outlays prior to the passage of Pub. L. 98-21**. Thus, for fiscal year 1984, 75 percent of total projected reimbursement based on the hospital-specific portion should equal 75 percent of total estimated outlays under law as in effect prior to April 20, 1983. Likewise, total estimated prospective payment system outlays deriving from the 25 percent Federal portion, including adjustments and special payment provisions, should equal 25 percent of projected reimbursement under prior laws.
>
> **The adjustment of the Federal portion was determined as follows**:
>
> - *Step 1*—Estimate total incurred payments for inpatient hospital operating costs for fiscal year 1984 that would have been made on a reasonable cost basis under Medicare prior to Pub. L. 98-21.
> - *Step 2*—Multiply total incurred payments by 25 percent, i.e., the Federal portion of total payment amounts for fiscal year 1984.

> • *Step 3*—Estimate the Federal portion of total payments that would have been made without adjusting for budget neutrality, but with the adjustment for outlier payments.
>
> • *Step 4*—Add an estimate of total adjustments and payments under special payment provisions to the Federal portion (e.g., outliers, indirect medical education).
>
> • *Step 5*—The difference between the step 2 and step 4 amounts is divided proportionally among the standardized amounts, resulting in the budget neutrality adjusted (standardized) amounts.
>
> **The resulting adjustment factor for the fiscal year 1984 <u>Federal portion</u> is .969**. Payment amounts of hospitals excluded from the prospective payment system (e.g., psychiatric and children's hospitals) and of hospitals not participating in prospective payment because of their participation in demonstrations and studies were not included in the calculations above.[45]

In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970 using the same methodology.[46] Significantly, in the January 1984 final rule, the Secretary suggests that, in calculating the budget neutrality adjustment factor, CMS made no attempt to adjust for transfers under IPPS:

> Regarding additional adjustments recommended by commenters, we made no adjustments to either the adjusted standardized amounts or to the budget neutrality estimates for conditions that could not be quantified on the basis of currently available data, even if there were a likelihood that these conditions might exist under prospective payment. For example, no adjustment was made for the likelihood that admissions would increase more rapidly under prospective payment than under the provisions of Pub. L. 97-248, or for costs that might be disallowed as a result of audit or desk review by the intermediaries. *Likewise, we made no attempt to quantify adjustments **for the likelihood of transfers** under prospective payment*, emergency room services, and disallowed costs which are successfully appealed.[47]

---

[45] 48 Fed. Reg. 39752, 39840-41 (Sept. 1, 1983) (bold, underline emphases added, and italics emphasis in original).
[46] 49 Fed. Reg. 234, 334 (Jan. 3, 1984).
[47] *Id.* at 255 (Emphasis added.) *See also id.* at 331 (stating as part of the discussion on the budget neutrality adjustments: "The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a DRG-adjusted limit on the allowable amount of inpatient operating costs per case and a per case limit on the rate of increase of operating costs of inpatient hospital services. Due to these per case limits, the incentives that influence hospital admission patterns are similar under TEFRA and prospective payment. Accordingly, ***we have assumed that the number of admissions under both prior law and the prospective payment system will be the same***. As a result, the budget neutrality factors can be

Accordingly, while the Providers did not appeal the budget neutrality adjustment, the above excerpt suggests that the Providers' concern about the Secretary's alleged mistreatment of transfers may be misplaced and that the treatment of transfers in the in the context of the budget neutrality adjustment for FFY 1984 may have more significance.

Finally, the Secretary also declined to increase the base standardized amount to reflect the increased costs associated with the shift in costs of hospital-based physician services from Part B to Part A, as suggested in a comment. The Secretary noted that such an increase would simply be offset or neutralized by a corresponding increase in the budget neutrality adjustment for FFY 1984:

> Finally, applying such an adjustment to the average standardized amounts (and, by extension, to the per case budget neutrality estimates of Federal rate payments) would not actually increase the level of payments under budget neutrality. If we were to increase the initial standardized amounts to reflect this shift, the budget neutrality adjustment factor would have to be recalculated, would accordingly be increased, and the net result would be virtually identical. As a result, such an adjustment would have no effect on payment levels during FYs 1984 and 1985, which are subject to budget neutrality.[48]

Regardless, the Secretary's application of a 0.970 budget neutrality adjustment factor to the FFY 1984 standardized amounts for the Federal rates confirms that these standardized rates were too high and were reduced by a factor of 0.030. Thus, the ***final*** IPPS payment rates used for the first year of IPPS (*i.e.*, FFY 1984), as published on January 3, 1984, reflect the Secretary's FFY 1984 budget neutrality adjustment. Moreover, as previously noted, since the FFY 1984 budget neutrality adjustment is based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and is not reviewable, the FFY 1984 budget neutrality adjustment effectively ***fixed*** the standardized amounts for FFY 1984 as used from that point forward (*i.e.*, as used both for the FFY 1984 IPPS payment rates and for subsequent years).

2. *The FFY 1985 budget neutrality adjustment also reduced the FFY 1985 standardized amounts, reaffirming that the Secretary's determined that the initial standardized amounts for FFY 1984 were set too high.*

For FFY 1985, the Secretary applied a budget neutrality adjustment of 0.954 to the standardized amounts used for the Federal national rates and 0.950 to the standardized amounts used for the regional rates. The Secretary described these adjustments as follows:

> In accordance with section 1886(e)(1) of the Act, the prospective payment system should result in aggregate program reimbursement equal to "what would have been payable" under the reasonable

calculated by comparing reimbursement per discharge for each of the systems, and there is no need to estimate an actual number of hospital admissions." (emphasis added)).

[48] *Id.* at 255.

> cost provisions of prior law; that is, for FYs 1984 and 1985, the prospective payment system must be "budget neutral".
>
> During the transition period, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. ***Further, effective October 1,1984***, *the Federal portion will be a blend of national and regional rates*. As a result, we must determine three budget neutrality adjustments— one each for both the national and regional rates, and one for the hospital-specific portions. The methodology we are using to make these adjustments is explained in detail in section V. of this addendum.
>
> Based on the data available to date, we have computed the following Federal rate budget neutrality adjustment factors:
>
> Regional—.950
> National—.954[49]

By finalizing an adjustment factor less than 1, the Secretary confirmed that the standardized amounts were too high. Thus, like her budget neutrality adjustments made for FFY 1984, the Secretary again confirmed that the standardized amounts were too high and exercised her discretion to reduce the standardized amounts to be used in the ***final*** FFY 1985 IPPS rates.[50]

3. *The Secretary has applied the FFY 1985 budget neutrality-adjusted rates to FFY 1986 and subsequent years.*

For FFY 1986, the Secretary confirmed that she used the FFY 1985 budget neutrality adjusted federal rates as the basis for determining the FFY 1986 federal rates:

> [T]he FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be ***neither more nor less than*** *we estimated would have been paid under prior legislation for the costs of the same services*. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule

[49] 49 Fed. Reg. 34728, 34769 (Aug. 31, 1984).

[50] In the preamble to the FFY 1985 Final Rule, the Secretary "noted that most of the data that the budget neutrality adjustment is based on has already been made available [to the public]. We believe that these data in conjunction with the explanation of the budget neutrality methodology presented in the NPRM (49 FR 27458) should enable individuals to replicate the adjustment factors. . . . In addition, we believe the lengthy and detailed description of the data and the development of rates contained in the **Federal Register**, along with the many examples furnished, afford the reader all the information necessary for an understanding of the prospective payment system. Those individuals, hospitals, or associations desiring additional data and other material, either for verification of rates or for other purposes, may request this date under the Freedom of Information Act." 49 Fed. Reg. at 34771.

> (49 FR 34791).) ***These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years***.
>
> Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts ***to ensure that accuracy of the FY 1986 standardized amounts***. To this end, we have identified several factors, discussed in section III.A.3.c., below, that contributed to the *overstatement* of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and have combined them into a proposed composite ***correction*** factor for FY 1986 that equals —7.5 percent.[51]

Significantly, in the above excerpt, the Secretary further confirmed that "[t]hese budget neutrality-adjusted rates for FY 1985 are then to be used *as the basis for the determination of rates* ***for later years***."[52] While it is true that the implementation of these rates for FFY 1986 were delayed by Congressional action extending the FFY 1985 rates through April 30, 1986 (as discussed further in **Appendix B**), the Secretary confirmed that it used the rates published in the FFY 1986 IPPS Final Rule plus a 1.0 percent modification specified by Congress:

> Section 9101(a) of Pub. L. 99-272 amends section 5(c) of Pub. L. 99-107 to extend the FY 1985 inpatient hospital prospective payment rates through April 30,1986. Therefore, the DRG classification changes and recalibrated DRG weights that were set forth in the September 3,1985 final rule (50 FR 35722) are effective for discharges occurring on or after May 1,1986.
>
> ****
>
> In accordance with the provisions of section 9101(b) and (e) of Pub. L. 99-272, the adjusted standardized amounts that were published in the September 3,1985 final rule (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986. The revised standardized amounts are set forth in Table 1, below.[53]

---

[51] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added). *See also* 49 Fed. Reg. at 34767 (stating "We believe the explicit language of section 2310 of Pub. L. 98-369 and section 1886(d)(3)(A) of the Act requires a reduction in the standardized amounts used to compute the Federal rates before adjusting for budget neutrality. . .. Thus, while the Federal rates. . .. have been reduced in this final rule to reflect the inflation factor prescribed by section 2310 of Pub. L. 98-369, we point out that the offset for budget neutrality has also been adjusted. The reduction in the regional and national standardized rates . . . attributable to section 2310 of Pub. L. 98-369 is entirely due to the revised budget neutrality adjustments for 1984 and 1985.").

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

[53] 87 Fed. Reg. 16772, 16773 (May 6, 986).

Significantly, *a glaring gap in the Providers' response to the Medicare Contractor's jurisdictional challenge* is their failure discuss or even recognize how the Secretary interpreted and applied the FFY 1985 budget neutrality adjustment.

The Board has set forth in **Appendix C** excerpts from the preamble of other final rules to provide additional contexts where the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates to later years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to 1985 budget neutrality adjustment*, it is clear that:

1. The Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and

2. The FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

Accordingly, the Board finds that the Providers' issue is inextricably tied, at a minimum, to the FFY 1985 budget neutrality adjustments.

* * * * *

In summary, the Providers confirm they do not seek to challenge the FFY 1984 or 1985 IPPS payments or the associated FFY 1984 and 1985 budget neutrality adjustments, but rather they "contest the Standardized Amount for [the applicable FFY] and the methodology by which the Standardized Amount was initially calculated in 1983."[54] They also claim that the Budget Neutrality Preclusion Provisions are not applicable here because they only bar administrative and judicial review of *a **narrow** category of challenges* to the Secretary's determination of the requirement, or the proportional amount, of any budget neutrality adjustment effected pursuant to 42 U.S.C. § 1395ww(e)(1) in FFYs 1984 and 1985.[55]

The Board disagrees and finds that it lacks substantive jurisdiction over the issue raised in these appeals because the *prospectively-set* standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY and the 1984 and 1985 budget neutrality adjustments are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[56] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably intertwined* with those applicable budget neutrality adjustments.[57] Indeed, the

---

[54] *E.g.*, PRRB Case Nos. 19-2181GC, *et al.*, Providers' Response to MACs' Jurisdictional Challenges at 6-7.
[55] *Id.* at 9.
[56] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts
[57] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably intertwined, section 1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As

Secretary applied a budget neutrality adjustment to those years to reduce the standardized amounts by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985 and, thus, these budget neutrality adjustments appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on *1981 data*).[58] Because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of those adjustments and the resulting *final* standardized amounts for FFY 1985 was carried/flowed forward, the Board may not review the standardized amount used for the FFYs being appealed as they relate to the issue in these appeals, *i.e.*, the alleged inaccuracies in the standardized amounts used for FFY 1985 as carried/flowed forward for all years following FFY 1985 to the FFYs being appealed. In this regard, the Board notes that the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985 because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.

Accordingly, the Board finds that: (1) the appealed issue is *inextricably* intertwined with the FFY 1984 and 1985 budget neutrality adjustments to the standardized amounts *for purposes of future FFYs* under the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), and both 1395ww(d)(2)(F) and 1395ww(d)(3)(C) which reference 1395ww(e)(1)(B), as demonstrated by the fact that the FFY 1985 budget-neutrality adjusted rates were used as the basis for the

---

both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and so the shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the "data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is ... a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board notes that the Board erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget neutrality***. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the Board's discussion herein) demonstrate that any adjustment to the FFY 1984 standardized amounts would be *inextricably* tied to the ensuing budget neutrality adjustments made for FFYs 1984 and 1985.

[58] *See supra* note 41 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

determination of rates for FFY 1986 and later years; and (2) 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations[59]) prohibit administrative and judicial review of those budget neutrality adjustments, Based on these findings, the Board concludes that it does not have substantive jurisdiction over the issue in the six (6) CIRP group cases listed in **Appendix A**. Accordingly, the Board hereby closes these six (6) group cases 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 Participating:

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

For the Board:

2/28/2024

X Clayton J. Nix

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

cc: Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Wilson Leong, FSS
Jacqueline Vaughn, CMS OAA

[59] *See, e.g.*, 42 C.F.R. §§ 405.1804, 405.1840(b)(2).

APPENDIX A
Jurisdictional Challenge and Response; Cases at Issue

On September 19, 2023, the Medicare Contractor filed a challenge to the following six (6) cases which all share a common lead Medicare Contractor, Palmetto GBA c/o National Government Services, Inc. (J-M):

19-2181GC	Carolinas Health CY 2013 Atrium Health IPPS Standardized Amount CIRP Group
19-2243GC	Carolinas Health CY 2014 Atrium Health IPPS Standardized Amount CIRP Group
19-2299GC	Carolinas Health CY 2012 IPPS Standardized Amount CIRP Group
19-2490GC	Carolinas Health CY 2015 Atrium Health IPPS Standardized Amount CIRP Group
21-1007GC	Atrium Health CY 2016 IPPS Standardized Amount CIRP Group
22-1145GC	Atrium Health FFY 2018 IPPS Standardized Amount CIRP Group

APPENDIX B

The following are examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments and the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i):

a. "Restandardization of base year costs per case used in [the] calculation of Federal rates" for both the labor and non-labor portions to reflect the survey-based wage index as discussed in the FY 1986 IPP Final Rule. 50 Fed. Reg. 35646, 35692 (Sept. 3, 1985).

b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.[60] An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.[61]

c. Budget neutrality adjustments made to the standardized amount designated for urban hospitals and the one designated for rural hospitals when certain urban hospitals were

---

[60] The Secretary confirmed that, beginning in 1991, these adjustments are to be made in a budget neutral manner:

> Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

59 Fed. Reg. 45330, 45348 (Sept. 1, 1994).

[61] 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

> *Comment:* A commenter was concerned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.
>
> *Response:* This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs, inclusion of transfer cases tends to ***increase*** the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.
>
> Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

Id. at 35655-56.

deemed to be urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).[62]

d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)[63] and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).[64]

e. Budget neutrality provision at 42 U.S.C. § 1395ww(d)(3)(A)(vi) that allows Secretary to adjust standardized amount to eliminate the effect of "changes in coding or classification of discharges that do not reflect real changes in case mix."[65]

f. The discretion of the Secretary in 42 U.S.C. § 1395ww(d)(3)(I)(i) to "provide by regulation for such other exceptions and adjustments to such payments amounts under this subsection as the Secretary deems appropriate."

---

[62] *See also* 56 Fed. Reg. 43358, 43373 (Aug. 30, 1991) (stating "Consistent with the prospective payment system for operating costs, the September 1, 1987 capital final rule provided for separate standardized amounts for hospitals located in urban and rural areas. Subsequently, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) provided for a higher update factor for hospitals located in large urban areas than in other urban areas and thereby established three standardized amounts under the prospective payment system for operating costs. Large urban areas are defined as those metropolitan statistical areas (MSAs) with a population of more than 1 million (or New England County metropolitan statistical areas (NECMAs) with a population of more than 970,000). Beginning with discharges on or after April 1,1988 and continuing to FY 1995, the Congress has also established higher update factors for rural hospitals than for urban hospitals. The differential updates have had the effect of substantially reducing the differential between the rural and other urban standardized amounts. Section 4002(c) of Public Law 101-508 provides for the elimination of the separate standardized amounts for rural and other urban hospitals in FY 1995 by equating the rural standardized amount to the other urban standardized amount. The separate standardized amount for large urban hospitals would continue. Currently, the large urban standardized amount under the prospective payment system for operating costs is 1.6 percent higher than the standardized amount for hospitals located in other urban areas.").

[63] *See* 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A); *supra* note 21.

[64] Omnibus Reconciliation Act of 1990, Pub. L. 101-508, § 4002(c), 104 Stat. 1388, 1388-33 – 1388-35 (1990).

[65] For example, the Secretary included the following discussion in the preamble to the FFY 1986 IPPS Final Rule:

> As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year). However, we now have data that indicate that case mix has increased an additional 2,6 percent. Hospitals have been realizing the benefit of that increase through increased payments. Our update factor will be adjusted so as to not pass through in the FY 1987 rates 2.0 percentage points of the increase in case mix. However, the 0.6 percentage points that we estimate to reflect a real increase in case mix will be added to the update factor for FY 1987.

51 Fed. Reg. 31505-06.

g. The subsequent amendments that Congress made in 1994[66] and 1997[67] to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. The Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS.[68]

To illustrate the complex nature of these issues, the Board points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,[69] the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).[70] The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

> Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that developed since they were published. *We believe that it is necessary, **each year**, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries*. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.

---

[66] Social Security Act Amendments of 1994, § 109, Pub. L. 103-432, 108 Stat. 4398, 4408 (1994) placed the then-existing language of 42 U.S.C. § 1395ww(d)(5)(I) into clause (i) and added the following clause (ii): "(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater than or lesser than those that would have otherwise been made in such fiscal year."

[67] Balanced Budget Act of 1997, Pub. L. 105-33, § 4407, 111 Stat. 251, 401 (1997), further revised 42 U.S.C. § 1395ww(d)(5)(I) and added § 1395ww(d)(5)(J).

[68] *See* 60 Fed. Reg. 45778, 45854 (Sept. 1, 1995) ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional payments for transfer cases of $159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.").

[69] 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).

[70] U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

In addition to this general consideration, *the FY 1985 adjusted average standardized amounts* (***Federal rates***) *were required by law* ***to be adjusted to achieve budget neutrality***; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more* ***nor*** *less than* we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years*.

Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were ***higher*** *than necessary to achieve budget neutrality*. Therefore, *we have updated the FY 1985 standardized amounts using a factor that takes into account the* ***overstatement*** *of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts*. To this end, we have identified several factors, ***discussed in section II.A.3.c.***, below, that contributed to the overstatement of the FY 1985 standardized amounts. *We have determined an appropriate percent value for each of them, and have combined them into* ***a proposed composite correction factor*** *for FY 1986 that equals –7.5 percent*.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. **We have combined these values into a composite policy target adjustment factor**, **as discussed in section III.3.e., below**. For FY 1986, this factor equals —1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." *Establishing FY 1986 prospective payment rates based on FY 1985 rates* ***that have been demonstrated to be overstated****, clearly would not comport with the statutory requirement that the rates represent payment for efficiently delivered care*.

Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes is +.31 percent, it is clear that there is a potential justification of a –4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:

	Percent
Forecasted market basket increase..	+4.27
Part B costs and FICA taxes.....	+.31
Composite correction factor.....	–7.5
Composite policy target adjustment factor.....	–1.5

However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.[71]

****

(3) *Additional causes for the overstatement of FY 1985 Federal rates.* In addition to the factors above, which we believe we must correct, **other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts**.

When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for 1985. After application of the revised market basket, discussed previously, use of these actuarial estimates would reduce the standardized amounts by an additional 1.2 percent.

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the

[71] 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

Federal rates. The hospital specific rates were set using later (1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. **Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount**. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals" total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.

We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided <u>at this time not</u> to correct the standardized amounts for these factors.**

We received no comments on this issue.

(4) ***Composite Correction Factor.*** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:

	Percent
Case mix.....	–6.3
Market basket.....	–1.2
Composite correction factor.....	–7.5[72]

Congress did immediately act on the Secretary's September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 ("EEA-85") to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates (*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).[73] Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

> - Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
>
> - Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
>
> - Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
>
> - Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.[74]

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.[75] As previously discussed above in the decision at Section B.3, in the final rule published on May 6, 1986, the Secretary confirmed that "*the adjusted standardized amounts that were published in the September 3,1985 final rule* (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986"[76] and these FFY 1986 adjusted standardized rates are based on the FFY 1985 budget neutrality-adjusted rates.

The examples highlight concerns about how certain future actions and decisions by the Secretary and Congress build upon prior decisions. Here, the Secretary's recommendation to Congress

---

[72] *Id.* at 35703-04 (bold and underline emphasis added).
[73] Pub. L. 99-107, § 5(a), 99 Stat. 479, 479 (1985). In July 1984, Congress had *already* reduced the 1 percent update factor planned for FFY 1986 to ¼ of a percentage point. Deficit Reduction Act of 1984, Pub. L. 98-369, § 2310(a), 98 Stat. 494, 1075 (1984). As part of the Emergency Extension Act of 1985, Congress further reduced the update factor for FFY 1986, presumably in response to the Secretary's recommendation.
[74] 51 Fed. Reg. 16772, 16772 (May 6, 1986).
[75] *See id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).
[76] 51 Fed. Reg. at 16773.

regard the FFY 1986 update factor were based on its analysis of the FFY 1984 and 1985 standardized amounts that had already been adjusted for budget neutrality. To the extent the 1984 standardized amounts had been *further* adjusted (*as **now** proposed by the Providers*), it could have potentially impacted the Secretary's recommendation to Congress for the FFY 1986 update factor as well as Congress' subsequent revisions to the updated factor. Accordingly, this highlights how revisiting and otherwise adjusting the FY 1984 standardized amounts can have ripple effects with the update factor and other adjustments that were made for subsequent years *based on analysis of the prior year(s) and other information*.

APPENDIX C

In its decision, the Board has noted that the Secretary confirmed in the preamble of the FFY 1986 IPPS Final Rule that the FFY budget neutrality-adjusted rates were used in determining the rates for FFY 1986 and would be similarly be part of subsequent FFYs. The following excerpts from the preambles to IPPS final rules provide additional contexts where the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates were part of the rate for later FFYs and illustrate how imbedded the FFY 1985 budget neutrality-adjusted rates are in the rates used for FFY 1986 and subsequent years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to 1985 budget neutrality adjustment*, it is clear that the Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and that the FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

1. In the preamble to the FFY 1986 IPPS Final Rule, the Secretary recognizes that the FFY 1985 budget neutrality adjustment accounted for the removal of nonphysician anesthetist costs from the base rates and no further adjustments were needed relative to those costs since the FFY 1985 budget neutrality-adjusted rates were used in determining the FY 1986 rates and would similarly be used for the 1987 rates:

> c. *Nonphysician anesthetist costs*. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987. We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, **because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts.** (See 49 FR 34794; August 31, 1984). **Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment**. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.[77]

---

[77] 50 Fed. Reg. at 35708 (Italics emphasis in original and bold and underline emphasis added). In this regard, the Board notes that the FFY 1985 IPPS Final Rule explained how the FFY 1985 budget neutrality adjustment accounted for Anesthetists services:

> *Anesthetists' Services*. Under section 2312 of Pub. L. 98-369, the costs to the hospital of the services of nonphysician anesthetists will be reimbursed in full by Medicare on a reasonable cost basis. In order to ensure that these services will be paid for only once, we must remove their costs from the prospective payment rates.
>
> For cost reporting periods beginning in FY 1985, we have reduced the adjusted standardized amounts to reflect the removal of these costs **by means of the budget neutrality adjustment methodology**. Our method for doing this is explained in section V.D. of this Addendum. We

2. In the preamble to the FFY 1987 IPPS Final Rule, the Secretary explains how her budget neutrality adjustments for FFYs 1984 and 1985 had "already built case-mix increases into the cost-per case assumptions used in deriving the budget neutral prospective rates for FY 1984 and FY 1985" and confirms that "FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year)":

> *Comment*: Several commenters stated that we did not consider real case mix increases in the 1983 to 1984 period, and that we finally are considering real case mix increases for the first time.
>
> *Response*: FY 1984 and FY 1985 were years subject to the requirements for budget neutrality. As required under section 1886(e)(1) of the Act, payments under the prospective payment system were to be equal to what would have been paid under rate-of-increase and peer group limits on reasonable costs under prior law (section 1886(b) of the Act) as if the prospective payment system had never been implemented. Under the rate-of-increase limits and peer group limits, as long as a hospital's cost was lower than that hospital's limits, we paid that cost, regardless of whether real case mix increased or decreased, and regardless of the effect of actual case mix on the cost level for that hospital. . . . Increases in real case mix were built into the cost per case increase assumptions we used to model the rate-of-increase limits. These assumptions took into account estimates of the impact of the rate-of-increase limits and the peer group limits. **Consequently, we considered increases in real case mix in FYs 1984 and 1985.** Moreover, even these assumed increases in cost per case proved to be overstated as we received more recent data against which to evaluate our estimates. To have passed through updated prospective payment case-mix increases for FY 1984 and FY 1985 would have been improper because they would increase program payments over the level that would have been paid under the section 1886(b) limits. **As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.**
>
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals

---

estimate that FY 1985 payments for anesthetists services will be about $160 million, or 0.5 percent of Medicare operating costs for hospital accounting years beginning in FY 1985.

> realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. **Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year).**

3. In the preamble to the FFY 1988 IPPS Final Rule, the Secretary again recognizes the prior FFY 1985 budget neutrality adjustments to the standardized amounts had already taken into account the removal of nonphysician anesthetist costs and the FFY 1985 budget neutrality-adjusted rates were reflected in the FFY 1986, 1987, and 1988 rates.

> c. *Nonphysician Anesthetist Costs*. Section 1886(d)(5)(E) of the Act provides that hospital costs for the services of nonphysician anesthetists are paid in full as a reasonable cost pass-through. Under section 2312(c) of Pub. L. 98-369, this pass-through was made effective for cost reporting periods beginning on or after October 1,1984, and before October 1,1987. Section 9320(a) of Pub. L. 99-509 extended the period of applicability of this pass-through so that services will continue to be paid under reasonable cost for any cost reporting periods (or parts of cost reporting periods) ending before January 1,1989 and struck subsection (E) effective on that date.
>
> In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, it was incorporated in the overall **budget neutrality** adjustment (50 FR 35708). Therefore, **because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived**, we did not propose to make further adjustments to the average standardized amounts for FY 1988.[78]

[78] 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Mr. Michael Sorber
M. S. Hall & Associates, LLC
One Lincoln Center
110 West Fayette Street
Syracuse, NY 13202

Ms. Danelle Decker
National Government Services, Inc. (J-K)
Mail point INA102-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: ***Dismissal Due to No Final Determination***
Unity Hospital of Rochester, Prov. No. 33-0226,
FYE 12/31/2019
Case No. 24-1229

Dear Mr. Sorber and Ms. Decker:

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

BACKGROUND:

On February 5, 2024, the Provider, by way of its representative of record, M.S. Hall & Associates, filed an appeal request for the Provider's Fiscal Year End ("FYE") 12/31/2019. The appeal request identified the final determination being appeal as a ***Tentative Settlement*** dated December 7, 2020, issued by National Government Services, the Medicare Contractor ("MAC") and, accordingly, uploaded: (1) a copy of that Tentative Settlement as the "final determination" document; and (2) a copy of the tentative settlement calculation summary worksheet dated August 31, 2020 as the "audit adjustment" document. The subject appeal was filed 1,155 days after December 7, 2020, *i.e.*, the date of this "tentative" settlement. Significantly, the December 7, 2020 Tentative Settlement did ***not*** include any appeal rights.

Another defect in the appeal request is the fact that is does not include an Issue Statement describing the issue(s) being appeal. Instead, the document filed as the Issue Statement is a request for reopening, addressed to the MAC, dated February 5, 2024, the same date the appeal was filed with the Board. Specifically, the reopening request asked the Medicare Contractor "to formally reopen the … FYE 12/31/2019 Medicare cost report for the inclusion of reimbursable Medicare bad debts in the amount of $1,075,643." The reopening request does not describe why it is dissatisfied (*e.g*, why these bad debts were not included with the as-filed or in the settled cost report).

Finally, the Board notes that the calculation support spreadsheet contained Protected Health Information/Personally Identifiable Information ("PHI/PII") that was unredacted, notwithstanding Board Rule 1.4 which prohibits submission of PHI/PII unless permission from the Board is granted:

> **1.4 Confidential Information**
>
> The Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule requires a covered entity and its business associates to make reasonable efforts to limit use, disclosure of, and requests for protected health information ("PHI") or other personally identifiable information ("PII") to the minimum necessary to accomplish the intended purpose. While the Privacy Rule permits uses and disclosures for litigation, subject to certain conditions, such information is generally not necessary for documentation submitted to the Board.
>
> Because the record in Board proceedings may be disclosed to the public, the parties must carefully review their documents to ensure that they do not contain patient names, health insurance or social security numbers, addresses, or other information that identifies individuals. If the parties need to include materials with patient names, numbers, or other identifying information, they must redact (i.e., untraceably remove) the names and numbers and replace them with non-identifying sequential numbers. If the confidential information itself is necessary to support your position, you must file a request seeking permission from the Board to submit unredacted PHI or PII with the Board, at least **fourteen (14) days** prior to the document deadline. If permission is granted, the Board will instruct how the PHI or PII should be submitted (i.e., in OH CDMS or in hard copy as necessary). A redacted version of the document should also be filed in OH CDMS. Any documentation submitted with unredacted PHI or PII (not submitted under seal) will be permanently removed from the record and will not be considered by the Board.[1]

RULES/REGULATIONS:

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

[1] (Bold and italics emphasis in original and underline emphasis added.)

42 C.F.R. § 405.1801(a) defines Contractor determination as follows:

> (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.[2]

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

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

[2] (Emphasis added.)

> each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.
>
> (3) **A copy of the final contractor or Secretary determination under appeal** and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section.[3]

Board Rules 7 and 8 address requirements related to support for the appealed final determination, availability of Issue-related information, and basis for dissatisfaction. Per Board Rule 6.1, the Board will dismiss appeal requests that do not meet the *minimum* filing requirements as identified in 42 C.F.R. § 405.1835(b).

BOARD DETERMINATION:

The Board has determined that the Provider's appeal request is fatally flawed as it was not filed in accordance with the regulations at 42 C.F.R. §§ 405.1801(a) and 405.1835(b) and with the Board Rules.

First, the Provider filed the subject appeal based on a ***Tentative Settlement*** dated December 7, 2020 as confirmed by the fact that this determination is described in OH CDMS as the determination being appeal and that a copy of the Tentative Settlement was attached as the "final determination" being appealed. However, the *Tentative* Settlement is not a ***final*** determination as demonstrated by the fact that it is "tentative" and no appeal rights were included within that document. Accordingly, the Board finds it is not appealable. By failing to appeal from a final determination, it is clear that the Provider has failed to demonstrate that the provider satisfies the requirements for a Board hearing.

Second, the Provider's appeal request failed to include an issue statement consistent with the appeal request content requirements in 42 C.F.R. § 405.1835(b) and Board Rule 7.2, describing what issue the Provider was appealing and why the Provider was dissatisfied. In lieu of an issue statement, the Provider submitted a Notice of Reopening, addressed to the MAC, that was concurrently dated with the submission of this appeal. Reopenings are governed by 42 C.F.R. § 405.1885 and are not under the purview of the Board. The reopening notice cannot be considered an issue statement since it was not prepared for the Board appeal and does not describe the Provider's dissatisfaction with the bad debts at issue consistent with § 405.1835(b)(2) and Board Rule 7.2, 7.3 and 8.

Accordingly, the Board hereby dismisses Case No. 24-1229 since the appeal request is fatally flawed and does not meet the *minimum* filing requirements as outlined above.

[3] (Bold and italics emphasis in original and underline emphasis added.)

Finally, *the Board **admonishes** **the Provider** for including with its appeal request certain PHI/PII information in its "Calculation Support" document without obtaining prior approval from the Board as described in Board Rule 4.1*. As Board Rule 4.1 explains, a party appearing before the Board may not include PHI/PII in any filing without express prior-approval from the Board. Accordingly, the Board has ***permanently*** removed the offending "calculation support" document from the record because Board 1.4 specifies that "[a]ny documentation submitted with unredacted PHI or PII (not submitted under seal) will be permanently removed from the record and will not be considered by the Board." *The Board directs the Provider to review Board Rule 1.4 and come into compliance with that Rule and ensure that, for any future filings, it redacts all confidential information in accordance with Board Rule 1.4*.

The Board closes this case and removes it from its docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

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

FOR THE BOARD:

2/29/2024

X Clayton J. Nix

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

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Gregory Etzel, Esq.
Morgan, Lewis & Bockius LLP
1000 Louisiana St., Ste. 4000
Houston, TX 77002

RE: ***Notice of Dismissal – Updated Rationale***
Morgan Lewis Standardized Amount CIRP Group Cases
Case Nos. 19-0212G, *et al.* (*see* **Appendix A** listing 119 group cases)

Dear Mr. Etzel:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the one hundred and nineteen (119) above-referenced common issue related party ("CIRP") group cases relating to the standardized amounts used in federal rates for the inpatient prospective payment system ("IPPS") during federal fiscal year ("FFY") 1984, the initial year of IPPS. The Medicare Contractor has filed Jurisdictional Challenges in all of those group cases. The Providers' Representative filed responses to these challenges. As set forth below, the Board has determined that, consistent with 42 U.S.C. §§ 1395ww(d)(7) and 1395oo(g)(2) and 42 C.F.R. § 405.1840(b), it lacks substantive jurisdiction over the appealed issue and is therefore dismissing all one hundred and nineteen (119) CIRP group cases in their entirety. This determination is consistent with its prior dismissal determinations in other cases involving the same issue where the Board found no *substantive* jurisdiction;[1] however, in response to the additional briefing on this issue by other parties, the Board's decision has been updated to clarify and confirm that the federal rates for FFY 1986 and subsequent FFYs used the FFY 1985 budget neutrality-adjusted federal rates.

In summary, the Board finds that it lacks substantive jurisdiction over the issue raised in these appeals because the standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY and the 1984 and 1985 budget neutrality adjustments are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[2] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably*

[1] Prior Board dismissal determinations of the issue in the instant group appeals include but are not limited to: Board dec. dated Apr. 6, 2023 (lead Case No. 19-0233GC); Board dec. dated Dec. 14, 2023 (lead Case No. 23-0695GC); Board dec. dated Jan. 23, 2024 (lead Case No. 19-1094GC); Board dec. dated Jan. 24, 2024 (lead Case No. 23-1522GC); and Board dec. dated Jan. 31, 2024 (lead Case No. 19-0847GC). These jurisdictional decisions are posted on the Board's website, by the relevant year and month, at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/list-prrb-jurisdictional-decisions.

[2] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and

intertwined with those applicable budget neutrality adjustments.[3] Indeed, the standardized amounts were too high for FFYs 1984 and 1985 and the budget neutrality adjustments applied to those years reduced the standardized amounts (reduced by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985) and, thus, these budget neutrality adjustments appear to have automatically accounted for any such alleged errors in setting the initial base rate (which again was based on 1981 data).[4] Because the FFY 1985 budget neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs and because 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments, the Board may not review the standardized amount used for the FFYs appealed as it relates to the common issue in these appeals. In this regard, the Board again notes that the rates for FFY 1986 and subsequent years are based on the budget neutrality adjusted FFY 1985 rates. Accordingly, the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985, *for purposes of future FFYs*,[5] because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.[6]

Background:

Morgan, Lewis & Bockius LLP ("Providers' Representative") represents a number of providers in common issue related party ("CIRP") and optional groups which are challenging the IPPS standardized amount. The Medicare Contractor filed five (5) Jurisdictional Challenges covering one hundred and nineteen (119) group cases.[7] The Providers' Representative filed responses to these challenges. The group issue statements, jurisdictional challenges, and responses thereto for all one hundred and nineteen (119) cases are materially identical and can be considered together.

The group issue statement presented is:

> Whether the Secretary's failure to distinguish between patient discharges and transfers during the implementation of the inpatient prospective payment system resulted in an understatement of the Federal DRG

2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[3] *See infra* note 55 (citing to decisions that discuss similar circumstances involving Medicare provisions found to be inextricably tied to certain other provisions for which Congress precluded administrative and judicial review).

[4] *See infra* 39 note (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

[5] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns.

[6] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns that could potentially serve as an alternative rationale.

[7] *See* **Appendix A**.

Prospective Payment Amounts paid to the Providers in the fiscal year at issue.[8]

Procedural Background:

A. Appealed Issue

In the Providers' group issue statements, they explain that the IPPS requires the categorization of different types of discharges (diagnostic related groups, or "DRGs"), and payment rates applicable to each discharge category. Their appeals challenge the latter, arguing that the data used to establish the initial "flat rate" payable per discharge resulted in an understated payment rate. CMS opted to use 1981 as a "base year" to calculate these rates, and thus data was collected from hospitals' 1981 cost reports to determine average costs for each discharge category. The data was adjusted for inflation and standardized, but the Providers argue that the initial calculation of this standardized amount continues to serve as the base for all future calculations. Since the Providers allege this initial calculation was understated, they argue that the calculation for each subsequent year has also been understated.[9]

The Providers claim that the data sources used in collecting the 1981 data did not distinguish between patients who were discharged from the hospital, and patients who were transferred to another hospital or facility. They state that CMS views transfers as distinct from discharges, but in calculating the average cost per discharge using the 1981 data, CMS erroneously included transfers in the total number of discharges, thereby inflating the denominator of the cost to discharge ratio. They claim that CMS has acknowledged this error in at least one other context (*i.e.*, during the implementation of the capital PPS), and that this error was the reason for certain DRG weight recalibrations, but that CMS failed to fully correct the flawed Standardized Amount.[10]

In each case, the Providers are challenging the applicable FFY IPPS rates as set forth in the Federal Register.[11] They argue the appeals are not barred by the "predicate facts" provision of 42 C.F.R. § 405.1885(a)(1)(iii) and that there is no impediment to CMS correcting its erroneous data to remediate the flawed Standardized Amount. They claim that the average cost per discharge should not include transfers, that CMS has acknowledged this as well as the fact that certain Standardized Amounts erroneously included transfers. Finally, they argue that the understated Standardized Amounts and their resulting understated Medicare payments produces cost shifting prohibited by 42 U.S.C. § 1395x(v)(1)(A)(i).[12]

---

[8] *E.g.*, Case 19-0212G, Group Issue Statement at 1 (Nov. 2, 2018).
[9] *Id*.
[10] *E.g.,* PRRB Case No. 19-0212G, Providers' Preliminary Position Paper at 11-12 (citing 56 Fed. Reg. 43449, 43387 (Aug. 30, 1991) (related to capital PPS) and 60 Fed. Reg. 45791 (Sept. 1, 1995) (related to recalibration of DRG weights to exclude transfers for FY 1996)).
[11] *See id.* at 8 ("The Secretary's original calculation of the Standardized Amount in 1983 still directly impacts Medicare reimbursement under IPPS for the fiscal year at issue in this appeal.").
[12] *Id.* at 13-14.

B. Jurisdictional Challenges

The Medicare Contractor filed challenges in one hundred-nineteen (119) different group cases, and the Providers filed a response in each case.[13] The Medicare Contractor argues that the merits of the appealed issue are illegitimate, but more importantly, that the Board lacks subject matter jurisdiction and need not even address the merits of the issue. It references the Board's April 6, 2023 decision dismissing five (5) different CIRP group appeals concerning the same issue. The Medicare Contractor argues the Board should apply the same rationale and find that 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative review of the base year standardized amounts. It also claims that budget neutrality adjustments after the base year amount was calculated have corrected any potential errors from prior years, and that the data shows the base year was, in fact, initially set too high (rather than understated).

The Providers' responses to these challenges reiterated that the group appeal rests on the fact that each appeal's IPPS payments for the applicable FFY are understated as "[t]he DRG Payment Amount formula for fiscal year 1986, and all years following it, still includes a calculation of the standardized amount with the same embedded Discharge Calculation error."[14] The ask the Board to find it has jurisdiction over these appeals.

The Providers counter the Medicare Contractor by arguing that the plain language of 42 U.S.C. § 1395ww(d)(7)(A) "does not contain any limitation to the administrative or judicial review of the Secretary's determination of the standardized amount. . ."[15] The Providers claim they do not seek to challenge the FFY 1984 or 1985 IPPS payments, and the Providers' challenge is not "inextricably tied" with the budget neutrality adjustment subject to judicial preclusion.[16] The Providers also argue that the Board was in error when it labeled the 1984-1985 budget neutrality adjustments as the "applicable percentage increase", as that term started with fiscal year 1986.[17] They argue that there is a strong presumption in favor of judicial review, and that in this instance there is not clear indication that Congress intended to preclude review of more recent FFY Standardized Amounts or the predicate facts related to the methodology for calculating the 1983 Standardized Amount.[18]

Board Decision:

As described more fully below, the Board finds that it lacks substantive jurisdiction over each of the 119 groups because: (1) the initial IPPS standardized amounts set for FFY 1984[19] are ***inextricably*** tied to the FFY 1984 and 1985 budget neutrality adjustments to the "applicable

---

[13] *See* **Appendix A** for a complete list of challenges and cases impacted. As previously noted, the challenges are all materially identical.
[14] *E.g.*, PRRB Case No. 19-0212G, Providers' Response to MAC Jurisdictional Challenge at 4 (Feb. 10, 2024).
[15] *Id*. at 6.
[16] *Id.* at 8.
[17] *Id*. at 16.
[18] *Id.* at 22.
[19] The Board notes that, initially, there was not just one standardized amount. Rather there were 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation and each of these 20 rates is further divided into a labor and nonlabor portion. *See* 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).

percentage increases" for IPPS[20]; (2) the FFY 1985 budget neutrality-adjusted rates were used to determine the rates for FFY 1986 and, thus, became embedded into the rates determined for subsequent FFYs; and (3) 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments. Further, the fact that the Secretary's budget neutrality adjustment to the FY 1984 Federal Rates was 0.970[21] demonstrates that, contrary to the Providers' assertions, the initial standardized amount was ***not*** understated but rather was *overstated* by a factor of 0.030 (*i.e*., 1.000 – 0.970).

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the IPPS.[22] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[23]

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services."[24] The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain ***base period*** *cost data* be developed and modified in several specified ways (*i.e.*, inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[25] Section 1395ww(d)(2)(A) requires that the Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available:

> (II) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

Consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the 1984 "base period" operating cost per discharge amount using the 1981 operating costs per discharge amount *updated* by an inflationary factor.[26]

---

[20] 42 U.S.C. § 1395ww(e) is entitled "Proportional adjustments in applicable percentage increases." The 1984 and 1985 budget neutrality adjustments are set forth is § 1395ww(e)(1)(B) which is cross-referenced for 1984 IPPS rates at § 1395ww(d)(2)(F) and for 1985 IPPS rates at § 1395ww(d)(3)(C).
[21] In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970. 49 Fed. Reg. 234, 334 (Jan. 3, 1984).
[22] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[23] *Id.*
[24] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[25] *Id.* (emphasis added).
[26] *Id*. at 39763-64.

The Providers dispute how the Secretary determined "discharges" and allege that the Secretary improperly treated transfers as discharges for purposes of this calculation.

The Secretary then "standardized" the FFY 1984 base period operating cost per discharge using the process prescribed at 42 U.S.C. § 1395ww(d)(2)(c). The standardization process removed the effects of certain variable costs from the cost data, including (but not limited to) excluding costs associated with indirect medical education costs, adjusting for variations in average hospital wage levels, and adjusting for variations in case mix among hospitals.

The initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"), the standardized amount is not adjusted each year simply for inflation.[27] Significantly, some of these annual adjustments were required to be *budget neutral* and are not subject to administrative review and others are discretionary. In particular, 42 U.S.C. § 1395ww(e)(1)(B) provides the budget neutrality adjustment for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

> **(e) Proportional adjustments in *applicable percentage increases***
>
> (1) . . . .
>
> (B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—
>
> > (i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),
>
> *are not greater or less than*—
>
> > (ii) the DRG percentage (as defined in subsection (d)(1)(C)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).[28]

[27] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[28] (Bold emphasis in original and italics and underline emphasis added.) The budget neutrality adjustment at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 rate year and 1985 rate year respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

> (i) *Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c) through (h) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of **the payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1984 **under the Social Security Act as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[29]

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

> (v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of the reduced standardized amounts determined under paragraph (c) of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is **not greater or less** than 50 percent of the **payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[30]

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

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than* ***or*** *less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e*., reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average payment per case, is prescribed by law to be *no more* ***and*** *no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget neutrality for 1984 and 1985 are ***external*** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.[31] Since these points are ***fixed,*** it also means that it is capped (*i.e*., cannot be increased subsequently outside of the budget neutrality adjustment).

This conclusion is supported by the fact that the normal annual inflation adjustments to the standardized amount provided for in IPPS apply only for FY 1986 forward, as set forth in 42 U.S.C. § 1395ww(b)(3)(B)(3)(i) and cross referenced in § 1395ww(d)(3)(A). Specifically, 42 U.S.C. § 1395ww(b)(3)(B)(i) (2018) defines the term "applicable percentage increase" starting with fiscal year 1986 (as opposed to 1984):

> (B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—
>
> (I) ***for fiscal year 1986***, 1⁄2 percent,
>
> (II) for fiscal year ***1987***, 1.15 percent,
>
> (III) for fiscal year ***1988***, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as

[31] 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board's pie concept:

> Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.
>
> Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,

(IV) for fiscal year ***1989***, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,

(V) for fiscal year ***1990***, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,

(VI) for fiscal year ***1991***, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,

(VII) for fiscal year ***1992***, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,

(VIII) for fiscal year ***1993***, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 1 for hospitals located in a rural area,

(IX) for fiscal year ***1994***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,

(X) for fiscal year ***1995***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),

(XI) for fiscal year ***1996***, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,

(XII) for fiscal year ***1997***, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,

> (XIII) for fiscal year ***1998***, 0 percent,
>
> (XIV) for fiscal year ***1999***, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,
>
> (XV) for fiscal year ***2000***, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,
>
> (XVI) for fiscal year ***2001***, the market basket percentage increase for hospitals in all areas,
>
> (XVII) for fiscal year ***2002***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XVIII) for fiscal year ***2003***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XIX) for each of fiscal years ***2004*** through ***2006***, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and
>
> (XX) ***for each subsequent fiscal year***, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.[32]

The "applicable percentage increase" as defined in § 1395ww(b)(3)(B) is incorporated into § 1395ww(d)(3)(A), as it relates to updating of the standardized amount:

> **(B) UPDATING** PREVIOUS STANDARDIZED AMOUNTS.—(i) For discharges occurring in a fiscal year beginning ***before*** October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, ***equal to*** *the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph*, ***increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B)***. With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).

[32] (Emphasis added.)

> (ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.
>
> (iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

Thus, while 42 U.S.C. § 1395ww(d)(2) provides the methodology for calculating the standardized amount to be used for each year, and that the amount is subject to the "applicable percentage increase" under subsection (b)(3)(B) *for years after 1984*, it remains that it is not always a simple inflationary or market basket adjustment. In particular, the FFY 1984 and 1985 budget neutrality adjustments (as referenced in § 1395ww(d)(2)(F) and in § 1395ww(d)(3)(C))

were the applicable percentage increases for FFYs 1984 and 1985 and, as described below, those adjustments are not administratively reviewable. Further, as discussed *infra*, it is clear that the Secretary has interpreted 42 U.S.C. § 1395ww(d)(3)(A)(i) to require the FFY 1985 budget neutrality-adjusted rates be used in determining the rates for FFY 1986 and subsequent FFYs. This is reflected in the following excerpt from 42 C.F.R. § 405.473(c) as initially adopted in the September 3, 1983 final rule:

> (c) *Federal rates for fiscal years after Federal fiscal year 1984.*
>
> ****
>
> (2) *Updating previous standardized amounts.*
>
> (i) *For fiscal year 1985*. HCFA will compute an average standardized amount for each group of hospitals described in paragraph (b)(5) of this section . . . equal to the respective adjusted average standardized amount computed for fiscal year 1984 under paragraph (b)(7) of this section—
>
> (A) Increased for fiscal year 1985 by the applicable percentage increase under § 405.463(c);
>
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
>
> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475; and
>
> (D) **Adjusted for budget neutrality under paragraph (c)(4) of this section**.
>
> (ii) **For fiscal year 1986** and thereafter, **HCFA will compute an average standardized amount** for each group of hospitals described in paragraph (b)(5) of this section, **equal to the respective adjusted average standardized amounts computed for the previous fiscal year**—
>
> (A) Increased by the applicable percentage increase determined under paragraph (c)(3) of this section; and

> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements.
>
> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475.
>
> (3) *Determining applicable percentage changes for fiscal year 1986 and following*. The Secretary will determine for each fiscal year (beginning with fiscal year 1986) the applicable percentage change which will apply for purposes of paragraph (c)(2)(ii) of this section as the applicable percentage increase for discharges in that fiscal year, and which will take into account amounts the Secretary believes necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In making this determination, the Secretary will consider the recommendations of the Prospective Payment Assessment Commission.[33]

---

[33] 48 Fed. Reg. at 39823 (italics emphasis in original and bold and underline emphasis added). This provision was later moved to 42 C.F.R. § 412.63(c)(2022) which states in pertinent part:

> (c) *Updating previous standardized amounts*.
>
> ****
>
> (2) Each of those amounts is equal to the respective adjusted average standardized amount computed for fiscal year 1984 under §412.62(g)—
> (i) Increased for fiscal year 1985 by the applicable percentage increase in the hospital market basket;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
> (iii) Reduced by a proportion equal to the proportion (estimated by CMS) of the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part; and
> (iv) **Adjusted for budget neutrality under paragraph (h) of this section**.
> (3) ***For fiscal year 1986*** *and thereafter*. CMS computes, for urban and rural hospitals in the United States and for urban and rural hospitals in each region, average standardized amount equal to the respective **adjusted average standardized amounts computed for the previous fiscal year**—
> (i) Increased by the applicable percentage increase determined under paragraphs (d) through (g) of this section;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements; and
> (iii) For discharges occurring on or after October 1, 1985 and before October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments based on the total amount of

B. Jurisdictional Findings -- 42 U.S.C. § 1395ww(d)(7)(A) Precludes Administrative Review of the Base Year Standardized Amounts

The Providers essentially are challenging the standardized amount used in the IPPS rates for several FFYs claiming that the Secretary improperly treated transfers as discharges when using 1981 cost report data to determine the initial FFY 1984 base cost per discharge which, in turn, was standardized to arrive at the FFY 1984 standardized amounts. More specifically, the Providers maintain that, the understatement of the standardized amount in the FFY 1984 IPPS Final Rule caused a corresponding underpayment in IPPS payments in FFY 1984 ***and every FFY thereafter*** *because the standardized amount for all IPPS payments for every FFY are based on CMS's calculation of the FFY 1984 standardized amount*.[34]

The published standardized amount for each FFY in these appeals reflects the prior year's standardized amount plus "the applicable percentage increase" as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i) (as referenced in 42 U.S.C. § 1395ww(d)(3)(A)) as well *as other potential adjustments*. Significantly, the "applicable percentage increase[s]" for 1984 forward are ***not*** always simply a cost inflation adjustment or other similar percentage adjustment. To this point, for the first two (2) years of IPPS, Congress mandated that the budget neutrality adjustments for FFYs 1984 and 1985 serve as the "applicable percentage increase" for those years. As a result, the IPPS rates that the Secretary used *for the very first year of IPPS* and then the second year of IPPS were adjusted for budget neutrality. For FFYs 1986 and forward, Congress provided for an "applicable percentage increase" in 42 U.S.C. § 1395ww(b)(3)(B)(i) as referenced in 42 U.S.C. § 1395ww(d)(3)(A). In addition, there are other *permanent* adjustments (*i.e*., adjustments not for that year only but that also apply on a going-forward basis) to the standardized amount that have occurred in other years outside of the "applicable percentage increase."[35] Thus, the standardized amount for a particular year is an amalgamation that builds upon the prior year's standardized amount and then adds additional adjustments for the current year. As noted *supra* and discussed more *infra*, the Secretary has used the FFY 1985 budget neutrality-adjusted rates for determining the FFY 1986 rates and those for subsequent FFYs.

The Providers are, essentially, seeking to peel back the amalgamated standardized amount for each applicable FFY *and, thus, reach back* ***more than 30 years*** to increase the initial FFY 1984 base rate that was used to set the initial FFY 1984 standardized amount**s**. They would then incorporate the alleged increased base rate into the FFY 1984 standardized amount**s** and then simply carry or flow that *increase forward 35 years*. However, in order to peel the amalgamated standardized amounts for the FFYs at issue (singular[36]) *as used in the IPPS rates for each FFY* back to the

---

prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part, and for discharges occurring on or after October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments that, based on the total amount of prospective payments for urban hospitals and the total amount of prospective payments for rural hospitals, are additional payments attributable to outlier cases in such hospitals under subpart F of this part.

[34] *See e.g.*, PRRB Case No. 19-0212G, Providers' Response to MAC Jurisdictional Challenge at 21 (Feb. 10, 2024).

[35] *See* **Appendix B.**

[36] *See supra* note 19 accompanying text.

initial standardized amount***s*** (plural[37]) used in FFY 1984, and then carry/flow any change forward *to the FFY at issue*, the Providers would have to pass through the FFY 1984 and 1985 budget neutrality adjustments which were the only "applicable percentage increase[s]" for those years. However, they cannot do so because the budget neutrality adjustments had the effect of ***fixing*** the pie for FFYs 1984 and 1985 to (*i.e.*, no more ***and*** no less than) the aggregate amounts that would have been paid had IPPS not been implemented.[38] More specifically, the amalgamated standardized payment amount for each FFY at issue reflects the *fixed* FFY 1985 budget neutrality adjustment (and not the initial FFY 1984 standardized amount since the standardized amounts for FFYs 1984 and 1985 were each adjusted for budget neutrality and became *fixed* for purposes of subsequent years as a result of those budget neutrality adjustments). Thus, in the Board's view, the Providers cannot get back to the FFY 1984 standardized amounts without first passing through the FFY 1984 and 1985 budget neutrality adjustments. Regardless, the Providers would not be able to flow forward any adjustments made to the FFY 1984 standardized amounts to FFYs after FFY 1985 because:

> (1) they, again, would not be able to get through the FFY 1984 and 1985 budget neutrality adjustments that Congress otherwise ***fixed*** to an external point (no greater and no less); and
>
> (2) the IPPS rates paid for FFYs 1984 and 1985 are based on standardized amounts that were adjusted downwards as a result of the budget neutrality adjustment for FFY 1984 and also for FFY 1985 (*see* discussion below in Sections B.1 and B.2).[39]

---

[37] *See id.*

[38] *See, e.g.,* 48 Fed. Reg. 39752, 39805 (Sept. 1, 1983) (stating: "Hospital Impact—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20,1983.").

[39] Indeed, the FY 1986 IPPS Final Rule included an example where the Secretary recognized an adjustment to the budget neutrality adjustments would be impacted by the removal of nurse anesthetists costs and confirmed that the adjustments to the standardized amounts had already taken this removal into account:

> c. Nonphysician anesthetist costs. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987.
>
> We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, *because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts*. (See 49 FR 34794; August 31, 1984). ***Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment***. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.

50 Fed. Reg. at 35708 (emphasis added). *See also* 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (stating: "In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, *it was incorporated in the overall* ***budget neutrality adjustment*** (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived, we did not propose to make further adjustments to the average standardized amounts for FY 1988.").

Accordingly, the Board finds that the Providers challenge to the standardized amounts at issue are *inextricably* tied to the budget neutrality adjustments made for FFY 1984 and 1985.[40]

Furthermore, Congress has precluded Board (and judicial) review of the FFY 1984 and 1985 budget neutrality adjustments. Specifically, 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and juridical review of the neutrality adjustment at § 1395ww(e)(1):

> (7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii), . . .[41]

Similarly, the statute governing Board appeals is located at 42 U.S.C. § 1395oo and states in subsection (g)(2):

> The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

Since the FFY 1984 and 1985 budget neutrality adjustments are based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and are not reviewable, the

---

[40] The Board notes that the D.C. Circuit's decision in *Saint Francis* is not applicable to the 1984 and 1985 budget neutrality adjustments given the statutory provision precluding administrative and judicial review of those adjustments. Further, *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[41] With regard to implementing this statutory provision, 48 Fed. Reg. 39752, 39785 (Sept. 1, 1983) states:

> Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
> —A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or
> —The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost. It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs. Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98-25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

Board finds that the FFYs 1984 and 1985 budget neutrality adjustments effectively fixed the standardized amounts that point forward for use in the IPPS system.[42]

Indeed, the Secretary's implementation of the fixed FFY 1984 and 1985 budget neutrality adjustments confirms that the Providers' allegation that the standardized rates for ***each FFY at issue*** are somehow understated due to alleged errors in the FFY 1984 base rate is moot.

1. *The Secretary determined that the initial standardized amounts for FFY 1984 were too high and, therefore, reduced the FFY 1984 standardized amounts through the FFY 1984 budget neutrality adjustment as reflected in the **final** FFY 1984 IPPS rates*.

In the interim final rule published on September 1, 1983, the Secretary issued a FFY 1984 budget neutrality adjustment to the FFY 1984 standardized amounts of 0.969:

> Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for fiscal years 1984 and 1985, the prospective payment system should be "budget neutral."
>
> Under the Amendments, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Section 1886(e)(1)(A) of the Act requires that aggregate payments for the hospital specific portion should equal the comparable share of estimated reimbursement under prior law. **Similarly, section 1886(e)(1)(B) of the Act requires that aggregate reimbursement for the Federal portion of the prospective payment rates plus any adjustments and special treatment of certain classes of hospitals should equal the corresponding share of estimated outlays prior to the passage of Pub. L. 98--21**. Thus, for fiscal year 1984, 75 percent of total projected reimbursement based on the hospital-specific portion should equal 75 percent of total estimated outlays under law as in effect prior to April 20, 1983. Likewise, total estimated prospective payment system outlays deriving from the 25 percent Federal portion, including adjustments and special payment provisions, should equal 25 percent of projected reimbursement under prior laws.
>
> **The adjustment of the Federal portion was determined as follows**:

[42] *See, e.g.,* 48 Fed. Reg. 39752, 39765 (Sept. 1, 1983) (stating "We point out that aside from being technically desirable, the effect of standardizing nonlabor hospital costs in Alaska and Hawaii is to decrease the reduction for budget neutrality stemming from the requirements in section 1886(e)(1)(B) of the Act.").

> • *Step 1*—Estimate total incurred payments for inpatient hospital operating costs for fiscal year 1984 that would have been made on a reasonable cost basis under Medicare prior to Pub. L. 98-21.
>
> • *Step 2*—Multiply total incurred payments by 25 percent, i.e., the Federal portion of total payment amounts for fiscal year 1984.
>
> • *Step 3*—Estimate the Federal portion of total payments that would have been made without adjusting for budget neutrality, but with the adjustment for outlier payments.
>
> • *Step 4*—Add an estimate of total adjustments and payments under special payment provisions to the Federal portion (e.g., outliers, indirect medical education).
>
> • *Step 5*—The difference between the step 2 and step 4 amounts is divided proportionally among the standardized amounts, resulting in the budget neutrality adjusted (standardized) amounts.
>
> **The resulting adjustment factor for the fiscal year 1984 <u>Federal portion</u> is .969**. Payment amounts of hospitals excluded from the prospective payment system (e.g., psychiatric and children's hospitals) and of hospitals not participating in prospective payment because of their participation in demonstrations and studies were not included in the calculations above.[43]

In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970 using the same methodology.[44] Significantly, in the January 1984 final rule, the Secretary suggests that, in calculating the budget neutrality adjustment factor, CMS made no attempt to adjust for transfers under IPPS:

> Regarding additional adjustments recommended by commenters, we made no adjustments to either the adjusted standardized amounts or to the budget neutrality estimates for conditions that could not be quantified on the basis of currently available data, even if there were a likelihood that these conditions might exist under prospective payment. For example, no adjustment was made for the likelihood that admissions would increase more rapidly under prospective payment than under the provisions of Pub. L. 97-248, or for costs that might be disallowed as a result of audit or desk review by the intermediaries. *Likewise, we made no attempt to quantify adjustments **for the***

[43] 48 Fed. Reg. 39752, 39840-41 (Sept. 1, 1983) (bold, underline emphases added, and italics emphasis in original).
[44] 49 Fed. Reg. 234, 334 (Jan. 3, 1984).

> ***likelihood of transfers*** *under prospective payment*, emergency room services, and disallowed costs which are successfully appealed.[45]

Accordingly, while the Providers did not appeal the budget neutrality adjustment, the above excerpt suggests that the Providers' concern about the Secretary's alleged mistreatment of transfers may be misplaced and that the treatment of transfers in the in the context of the budget neutrality adjustment for FFY 1984 may have more significance.

Finally, the Secretary also declined to increase the base standardized amount to reflect the increased costs associated with the shift in costs of hospital-based physician services from Part B to Part A, as suggested in a comment. The Secretary noted that such an increase would simply be offset or neutralized by a corresponding increase in the budget neutrality adjustment for FFY 1984:

> Finally, applying such an adjustment to the average standardized amounts (and, by extension, to the per case budget neutrality estimates of Federal rate payments) would not actually increase the level of payments under budget neutrality. If we were to increase the initial standardized amounts to reflect this shift, the budget neutrality adjustment factor would have to be recalculated, would accordingly be increased, and the net result would be virtually identical. As a result, such an adjustment would have no effect on payment levels during FYs 1984 and 1985, which are subject to budget neutrality.[46]

Regardless, the Secretary's application of a 0.970 budget neutrality adjustment factor to the FFY 1984 standardized amounts for the Federal rates confirms that these standardized rates were too high and were reduced by a factor of 0.030. Thus, the ***final*** IPPS payment rates as used for the first year of IPPS (*i.e.*, FFY 1984), as finalized on January 3, 1984, reflect the Secretary's FFY 1984 budget neutrality adjustment. Moreover, as previously noted, since the FFY 1984 budget neutrality adjustment is based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and is not reviewable, the FFY 1984 budget neutrality adjustment effectively ***fixed*** the standardized amounts for FFY 1984 as used from that point forward (*i.e.*, as used both for the FFY 1984 IPPS payment rates and for subsequent years).

2. *The FFY 1985 budget neutrality adjustment also reduced the FFY 1985 standardized amounts, reaffirming that the Secretary's determined that the initial standardized amounts for FFY 1984 were set too high.*

---

[45] *Id.* at 255 (Emphasis added.) *See also id.* at 331 (stating as part of the discussion on the budget neutrality adjustments: "The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a DRG-adjusted limit on the allowable amount of inpatient operating costs per case and a per case limit on the rate of increase of operating costs of inpatient hospital services. Due to these per case limits, the incentives that influence hospital admission patterns are similar under TEFRA and prospective payment. Accordingly, ***we have assumed that the number of admissions under both prior law and the prospective payment system will be the same***. As a result, the budget neutrality factors can be calculated by comparing reimbursement per discharge for each of the systems, and there is no need to estimate an actual number of hospital admissions." (emphasis added)).

[46] *Id.* at 255.

For FFY 1985, the Secretary applied a budget neutrality adjustment of 0.954 to the standardized amounts used for the Federal national rates and 0.950 to the standardized amounts used for the regional rates. The Secretary described these adjustments as follows:

> In accordance with section 1886(e)(1) of the Act, the prospective payment system should result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for FYs 1984 and 1985, the prospective payment system must be "budget neutral".
>
> During the transition period, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. ***Further, effective October 1,1984***, *the Federal portion will be a blend of national and regional rates*. As a result, we must determine three budget neutrality adjustments— one each for both the national and regional rates, and one for the hospital-specific portions. The methodology we are using to make these adjustments is explained in detail in section V. of this addendum.
>
> Based on the data available to date, we have computed the following Federal rate budget neutrality adjustment factors:
>
> Regional—.950
> National—.954[47]
>
> ****

By finalizing an adjustment factor less than 1, the Secretary confirmed that the standardized amounts were too high. Thus, like her budget neutrality adjustments made for FFY 1984, the Secretary again confirmed that the standardized amounts were too high and exercised her discretion to reduce the standardized amounts to be used in the ***final*** FFY 1985 IPPS rates.[48]

3. *The Secretary has applied the FFY 1985 budget neutrality-adjusted rates to FFY 1986 and subsequent years.*

For FFY 1986, the Secretary confirmed that she used the FFY 1985 budget neutrality adjusted federal rates as the basis for determining the FFY 1986 federal rates:

---

[47] 49 Fed. Reg. 34728, 34769 (Aug. 31, 1984).

[48] In the preamble to the FFY 1985 Final Rule, the Secretary "noted that most of the data that the budget neutrality adjustment is based on has already been made available [to the public]. We believe that these data in conjunction with the explanation of the budget neutrality methodology presented in the NPRM (49 FR 27458) should enable individuals to replicate the adjustment factors. . . . In addition, we believe the lengthy and detailed description of the data and the development of rates contained in the **Federal Register**, along with the many examples furnished, afford the reader all the information necessary for an understanding of the prospective payment system. Those individuals, hospitals, or associations desiring additional data and other material, either for verification of rates or for other purposes, may request this date under the Freedom of Information Act." 49 Fed. Reg. at 34771.

> [T]he FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be ***neither more nor less than*** *we estimated would have been paid under prior legislation for the costs of the same services*. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) ***These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years***.
>
> Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts ***to ensure that accuracy of the FY 1986 standardized amounts***. To this end, we have identified several factors, discussed in section III.A.3.c., below, that contributed to the *overstatement* of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and have combined them into a proposed composite ***correction*** factor for FY 1986 that equals —7.5 percent.[49]

Significantly, in the above excerpt, the Secretary further confirmed that "[t]hese budget neutrality-adjusted rates for FY 1985 are then to be used *as the basis for the determination of rates* ***for later years***."[50] While it is true that the implementation of these rates for FFY 1986 were delayed by Congressional action extending the FFY 1985 rates through April 30, 1986 (as discussed further in **Appendix B**), the Secretary confirmed that it used the rates published in the FFY 1986 IPPS Final Rule plus a 1.0 percent modification specified by Congress:

> Section 9101(a) of Pub. L. 99-272 amends section 5(c) of Pub. L. 99-107 to extend the FY 1985 inpatient hospital prospective payment rates through April 30,1986. Therefore, the DRG classification changes and recalibrated DRG weights that were set

[49] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added). *See also* 49 Fed. Reg. at 34767 (stating "We believe the explicit language of section 2310 of Pub. L. 98-369 and section 1886(d)(3)(A) of the Act requires a reduction in the standardized amounts used to compute the Federal rates before adjusting for budget neutrality. . .. Thus, while the Federal rates. . .. have been reduced in this final rule to reflect the inflation factor prescribed by section 2310 of Pub. L. 98-369, we point out that the offset for budget neutrality has also been adjusted. The reduction in the regional and national standardized rates . . . attributable to section 2310 of Pub. L. 98-369 is entirely due to the revised budget neutrality adjustments for 1984 and 1985.").
[50] *Id.* (emphasis added).

> forth in the September 3,1985 final rule (50 FR 35722) are effective for discharges occurring on or after May 1, 1986.
>
> ****
>
> In accordance with the provisions of section 9101(b) and (e) of Pub. L. 99-272, the adjusted standardized amounts that were published in the September 3,1985 final rule (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986. The revised standardized amounts are set forth in Table 1, below.[51]

Significantly, *a glaring gap in the Providers' response to the Medicare Contractor's jurisdictional challenge* is their failure discuss or even recognize how the Secretary interpreted and applied the FFY 1985 budget neutrality adjustment.

The Board has set forth in **Appendix C** excerpts from the preambles of other final rules to provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates applied to later years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 budget neutrality adjustment*, it is clear that:

1. The Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and

2. The FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

Accordingly, the Board finds that the Providers' issue is inextricably tied, at a minimum, to the FFY 1985 budget neutrality adjustments.

* * * * *

In summary, the Providers confirm that they do not seek to challenge the FFY 1984 or 1985 IPPS payments or the associated FFY 1984 and 1985 budget neutrality adjustments, but rather "are challenging an entirely separate factor in the calculation of the DRG Payment Amounts (i.e., the base rate calculation of the standardized amount). . ."[52] They also claim that the Budget Neutrality Preclusion Provisions are not applicable here because they only bar administrative and judicial review of *a **narrow** category of challenges* to the Secretary's determination of the requirement, or the proportional amount, of any budget neutrality adjustment effected pursuant to 42 U.S.C. § 1395ww(e)(1) in FFYs 1984 and 1985.[53]

The Board disagrees and finds that it lacks substantive jurisdiction over the issue raised in these appeals because the *prospectively-set* standardized amounts used for IPPS rates for FFYs 1984 and

---

[51] 87 Fed. Reg. 16772, 16773 (May 6, 1986).
[52] Case No. 19-0212G *et al*., Providers' Response to MAC Jurisdictional Challenge at 21.
[53] *See e.g., id*. at 7.

FFY 1985 are each based on the budget neutrality adjustment made for that FFY and the 1984 and 1985 budget neutrality adjustments are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[54] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably intertwined* with those applicable budget neutrality adjustments.[55] Indeed, the Secretary applied a budget neutrality adjustment to those years to reduce the standardized amounts by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985 and, thus, these budget neutrality adjustments appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on *1981 data*).[56] Because the FFY 1985 budget neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs and because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments and the resulting *final* standardized amount for FFY 1985 was carried/flowed forward to FFY 1986 and succeeding FFYs, the Board may not review the standardized amount used for the FFYs being appealed as it relates to the common issue in these appeals. In this regard, the Board again notes that the rates for

---

[54] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[55] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably intertwined, section 1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and so the shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the "data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is ... a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board notes that the Board erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget neutrality***. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the Board's discussion herein) demonstrates that any adjustment to the FFY 1984 standardized amounts would be *inextricably* tied to the ensuing budget neutrality adjustments made for FFYs 1984 and 1985.

[56] *See supra* note 39 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

FFY 1986 and subsequent years are based on the budget neutrality adjusted FFY 1985 rates and the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985, *for purpose of future FFYs*, because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.

Accordingly, the Board finds that: (1) the appealed issue is *inextricably* intertwined with the FFY 1984 and 1985 budget neutrality adjustments to the standardized amounts *for purposes of future FFYs* under the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), and both 1395ww(d)(2)(F) and 1395ww(d)(3)(C) which reference 1395ww(e)(1)(B), as demonstrated by the fact that the FFY 1985 budget-neutrality adjusted rates were used as the basis for the determination of rates for FFY 1986 and later years; and (2) 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations[57]) prohibit administrative and judicial review of those budget neutrality adjustments. Based on these findings, the Board concludes that it does not have substantive jurisdiction over the issue in the one hundred and nineteen (119) CIRP and optional group cases listed in **Appendix A**. Accordingly, the Board hereby closes these one hundred and nineteen (119) groups cases 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 Participating:

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

For the Board:

2/29/2024

X Clayton J. Nix

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

cc: Danelle Decker, National Government Services, Inc. (J-K)
Michael Redmond, Novitas Solutions, Inc. (J-L)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Pamela VanArsdale, National Government Services, Inc. (J-6)
John Bloom, Noridian Healthcare Solutions (J-F)
Wilson Leong, FSS
Jacqueline Vaughn, CMS OAA

[57] *See, e.g.*, 42 C.F.R. §§ 405.1804, 405.1840(b)(2).

APPENDIX A
Jurisdictional Challenges and Responses; Cases at Issue

On September 13, 2023, the Medicare Contractor filed a challenge to the following case with Medicare Contractor, National Government Services, Inc. (J-6):

20-2057GC	Catholic Health CY 2017 Understated Base Rate CIRP Group

On September 14, 2023, the Medicare Contractor filed a challenge to the following ninety-three (93) cases which all share a common lead Medicare Contractor, National Government Services, Inc. (J-K):

19-0212G	Morgan, Lewis & Bockius CY 2015 Understated Base Rate Group
19-0237GC	Catholic Health System CY 2015 NY Understated Base Rate CIRP Group
19-0413G	Morgan, Lewis & Bockius CY 2014 Understated Base Rate Group
19-0521GC	Univ of Rochester CY 2014 University of Rochester MC 2014 Understated Base Rate CIRP Group
19-0592GC	Northwell Health CY 2014 2014 Understated Base Rate CIRP Group
19-0751GC	Catholic Health System FFY 2019 Understated Base Rate in Final IPPS Rule CIRP Group
19-0776GC	Kaleida Health FFY 2019 Understated Base Rate in the Final IPPS Rule CIRP Group
19-0777GC	Univ of Rochester FFY 2019 Understated Base Rate in the Final IPPS Rule CIRP Group
19-0778GC	Rochester Regional Health FFY 2019 Understated Base Rate in the Final IPPS Rule CIRP Group
19-0822GC	Montefiore Health FFY 2019 Understated Base Rate in the Final IPPS Rule CIRP Group
19-0827GC	Catholic Health LI FFY 2019 Understated Base Rate in the Final IPPS Rule CIRP Group
19-0830GC	Northwell Health FFY 2019 Understated Base Rate in the Final IPPS Rule CIRP Group
19-0834G	Morgan, Lewis & Bockius FFY 2019 Understated Base Rate in Final IPPS Rule Group
19-1157GC	One Brooklyn Health Syste FFY 2019 Understated Base Rate in the Final IPPS Rule CIRP Group
19-1243GC	Catholic Health LI CY 2015 Understated Base Rate CIRP Group
19-1291GC	One Brooklyn CY 2015 One Brooklyn Health System Understated Base Rate CIRP Group
19-1323GC	Rochester Regional Health CY 2012, 2015 Understated Base Rate CIRP Group
19-1356GC	Montefiore Health CY 2013 – 2015 Understated Base Rate CIRP Group
19-1570GC	Northwell Health CY 2013 Understated Base Rate CIRP Group
19-1571GC	Northwell Health CY 2015 Understated Base Rate CIRP Group
19-2023G	Morgan, Lewis & Bockius CY 2009 – 2010 Understate Base Rate Group
19-2068GC	Univ of Rochester CY 2015 Understated Base Rate CIRP Group
19-2356GC	Northwell Health CY 2016 Understated Base Rate CIRP Group
20-1007GC	Univ of Rochester CY 2016 Understated Base Rate CIRP Group
20-1008GC	Stony Brook Medicine CY 2015 Understated Base Rate CIRP Group
20-1009GC	Catholic Health FFY 2020 Understated Base Rate in 2020 Final IPPS Rule CIRP Group
20-1010GC	Rochester Regional Health FFY 2020 Understated Base Rate in the 2020 Final IPPS Rule CIRP Group
20-1024GC	Montefiore Health FFY 2020 Understated Base Rate in Final IPPS Rule CIRP Group
20-1027GC	Catholic Health LI FFY 2020 Understated Base Rate in Final Rule CIRP Group

20-1028GC	Univ of Rochester FFY 2020 Understated Base Rate in Final Rule CIRP Group
20-1029GC	Northwell Health FFY 2020 Understated Base Rate in Final Rule CIRP Group
20-1030GC	Kaleida Health FFY 2020 Understated Base Rate in Final Rule CIRP Group
20-1075GC	One Brooklyn FFY 2020 Understated Base Rate in the Final Rule CIRP Group
20-1135GC	Albany Medical Center FFY 2020 Understated Base Rate in the Final Rule CIRP Group
20-1157G	Morgan, Lewis & Bockius FFY 2020 Understated Base Rate in the Final Rule Group
20-1405G	Morgan, Lewis & Bockius CY 2016 Understated Base Rate Group
20-1407GC	Upper Allegheny Health Sy CY 2016 Understated Base Rate CIRP Group
20-1409GC	One Brooklyn CY 2016 Understated Base Rate CIRP Group
20-1427GC	Catholic Health LI CY 2016 Understated Base Rate CIRP Group
20-1484GC	Catholic Health CY 2016 Understated Base Rate CIRP Group
20-1489GC	Rochester Regional Health CY 2016 Understated Base Rate CIRP Group
20-1537GC	Albany Medical Center CY 2016 Understated Base Rate CIRP Group
20-1755GC	Montefiore Health CY 2016 Understated Base Rate CIRP Group
20-1933GC	Catholic Health LI CY 2017 Understated Base Rate CIRP Group
20-1980GC	Montefiore Health CY 2017 Understated Base Rate CIRP Group
20-2026GC	Stony Brook Medicine CY 2016 Understated Base Rate CIRP Group
20-2042GC	Univ of Rochester CY 2017 Understated Base Rate CIRP Group
20-2078G	Morgan, Lewis & Bockius CY 2017 Understated Base Rate Group
20-2158GC	Kaleida Health CY 2017 Understated Base Rate CIRP Group
21-0283GC	Stony Brook Medicine CY 2017 Understated Base Rate CIRP Group
21-0295GC	Albany Medical Center CY 2017 Understated Base Rate CIRP Group
21-0450GC	Northwell Health CY 2017 Understated Base Rate CIRP Group
21-0741GC	Rochester Regional Health CY 2017 Understated Base Rate CIRP Group
21-0742GC	One Brooklyn CY 2017 Understated Base Rate CIRP Group
21-1039GC	Northwell Health FFY 2021 Understated Base Rate in 2021 Final IPPS Rule CIRP Group
21-1044GC	Albany Medical Center FFY 2021 Understated Base Rate in the 2021 Final IPPS Rule CIRP Group
21-1046GC	Rochester Regional Health FFY 2021 Understated Base Rate in the Final 2021 IPPS Rule CIRP Group
21-1057GC	Univ of Rochester FFY 2021 Understated Base Rate in 2021 Final IPPS Rule CIRP Group
21-1058GC	Catholic Health FFY 2021 Understated Base Rate in 2021 Final IPPS Rule CIRP Group
21-1081GC	Montefiore Health FFY 2021 Understated Base Rate in 2021 Final IPPS Rule CIRP Group
21-1082GC	One Brooklyn FFY 2021 Understated Base Rate in 2021 Final IPPS Rule CIRP Group
21-1084GC	Kaleida Health FFY 2021 Understated Base Rate in 2021 Final IPPS Rule CIRP Group
21-1093G	Morgan, Lewis & Bockius FFY 2021 Understated Base Rate in 2021 Final IPPS Rule Group
21-1096GC	Catholic Health LI FFY 2021 Understated Base Rate in 2021 Final IPPS Rule CIRP Group
21-1423GC	Univ of Rochester CY 2018 Understated Base Rate CIRP Group
21-1427GC	Rochester Regional Health CY 2018 Understated Base Rate CIRP Group
21-1618G	Morgan, Lewis & Bockius CY 2018 Understated Base Rate Group
21-1629GC	Kaleida Health CY 2018 Understated Base Rate CIRP Group
21-1645GC	Catholic Health LI CY 2018 Understated Base Rate CIRP Group
21-1648GC	Catholic Health CY 2018 Understated Base Rate CIRP Group

21-1660GC	Montefiore Health CY 2018 Understated Base Rate CIRP Group
21-1673GC	Albany Medical Center CY 2018 Understated Base Rate CIRP Group
22-0137GC	Northwell Health CY 2018 Understated Base Rate CIRP Group
22-0186GC	One Brooklyn CY 2018 Understated Base Rate CIRP Group
22-0666GC	Northwell Health FFY 2022 Understated Base Rate in the 2022 Final IPPS Rule CIRP Group
22-0667GC	Montefiore Health FFY 2022 Understated Base Rate in the 2022 Final IPPS Rule CIRP Group
22-0668GC	Albany Medical Center FFY 2022 Understated Base Rate in 2022 Final IPPS Rule CIRP Group
22-0698GC	Rochester Regional Health FFY 2022 Understated Base Rate in the 2022 Final IPPS Rule CIRP Group
22-0709GC	Univ of Rochester FFY 2022 Understated Base Rate in the 2022 Final IPPS Rule CIRP Group
22-0717G	Morgan, Lewis & Bockius FFY 2022 Understated Base Rate in the 2022 Final IPPS Rule Group
22-0743GC	Kaleida Health FFY 2022 Understated Base Rate in the 2022 Final IPPS Rule CIRP Group
22-1158G	Morgan, Lewis & Bockius CY 2017 Understated Base Rate Optional Group II Group
22-1359GC	Univ of Rochester CY 2019 Understated Base Rate CIRP Group
23-0379GC	Albany Medical Center CY 2019 Understated Base Rate CIRP Group
23-0692GC	Albany Medical Center FFY 2023 Understated Base Rate CIRP Group
23-0693GC	Catholic Health LI FFY 2023 Understated Base Rate in 2023 IPPS Final Rule CIRP Group
23-0694GC	Catholic Health FFY 2023 Understated Base Rate in 2023 IPPS Final Rule CIRP Group
23-0757GC	Kaleida Health FFY 2023 Understated Base Rate in 2023 IPPS Final Rule CIRP Group
23-0763GC	Montefiore Health FFY 2023 Understated Base Rate in 2023 Final IPPS Rule CIRP Group
23-0780GC	Northwell Health FFY 2023 Understated Base Rate in the 2023 IPPS Final Rule CIRP Group
23-0786GC	Rochester Regional Health FFY 2023 Understated Base Rate in the 2023 IPPS Final Rule CIRP Group
23-0804GC	Univ of Rochester FFY 2023 Understated Base Rate in the 2023 IPPS Final Rule CIRP Group
23-0805G	Morgan, Lewis & Bockius FFY 2023 Understate Base Rate in the 2023 IPPS Final Rule Group

On September 19, 2023, the Medicare Contractor filed a challenge to the following seven (7) cases which all share a common lead Medicare Contractor, Palmetto GBA c/o National Government Services, Inc. (J-M):

19-2246GC	Duke University CY 2012 Understated Base Rate CIRP Group
20-0114GC	Duke University CY 2013 Understated Base Rate CIRP Group
20-1026GC	Duke University FFY 2020 Understated Base Rate in Final Rule CIRP Group
21-1095GC	Duke University FFY 2021 Understated Base Rate in 2021 Final IPPS Rule CIRP Group
22-0712GC	Duke University FFY 2022 Understated Base Rate in the 2022 Final IPPS Rule CIRP Group
23-0468GC	Duke University CY 2015 Understated Base Rate CIRP Group
23-0723GC	Duke University FFY 2023 Understated Base Rate in the 2023 Final IPPS Rule CIRP Group

On September 22, 2023, the Medicare Contractor filed a challenge to the following case with Medicare Contractor, Noridian Healthcare Solutions, LLC (J-F):

22-1061G	Morgan Lewis & Bockius CYs 2013 & 2016 Understated Base Rate (Optional Group II) Group

On October 19, 2023, the Medicare Contractor filed a challenge to the following seventeen (17) cases which all share a common lead Medicare Contractor, Novitas Solutions, LLC (J-L):

19-0726GC	CarePoint Health FFY 2019 Understated Base Rate in Final IPPS Rule CIRP Group
19-0763GC	Geisinger Health CY 2015 – 2016 Understated Base Rate CIRP Group
19-0816GC	Geisinger Health FFY 2019 Understated Base Rate in the Final IPPS Rule CIRP Group
19-1292GC	Geisinger Health CY 2017 Understated Base Rate CIRP Group
19-2279GC	CarePoint Health CY 2015 Understated Base Rate CIRP Group
20-1025GC	CarePoint Health FFY 2020 Understated Base Rate in Final IPPS Rule CIRP Group
20-1068GC	Geisinger Health FFY 2020 Understated Base Rate in Final Rule CIRP Group
20-1893GC	CarePoint Health CY 2016 Understated Base Rate CIRP Group
20-1958GC	Geisinger Health CY 2011 Understated Base Rate CIRP Group
21-0703GC	CarePoint Health CY 2017 Understated Base Rate CIRP Group
21-1045GC	Geisinger Health FFY 2021 Understated Base Rate in the 2021 Final IPPS Rule CIRP Group
21-1052GC	CarePoint Health FFY 2021 Understated Base Rate in 2021 Final IPPS Rule CIRP Group
21-1456GC	Geisinger Health CY 2018 Understated Base Rate CIRP Group
22-0714GC	Geisinger Health FFY 2022 Understated Base Rate in the 2022 Final IPPS Rule CIRP Group
22-0997GC	CarePoint Health CY 2018 Understated Base Rate CIRP Group
23-0756GC	Geisinger Health FFY 2023 Understated Base Rate in 2023 IPPS Final Rule CIRP Group
23-1044GC	Geisinger Health CY 2019 Understated Base Rate (NPR) CIRP Group

APPENDIX B

The following are examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments and the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i):

a. "Restandardization of base year costs per case used in [the] calculation of Federal rates" for both the labor and non-labor portions to reflect the survey-based wage index as discussed in the FY 1986 IPP Final Rule. 50 Fed. Reg. 35646, 35692 (Sept. 3, 1985).

b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.[58] An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.[59]

c. Budget neutrality adjustments made to the standardized amount designated for urban hospitals and the one designated for rural hospitals when certain urban hospitals were

---

[58] The Secretary confirmed that, beginning in 1991, these adjustments are to be made in a budget neutral manner:

> Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

59 Fed. Reg. 45330, 45348 (Sept. 1, 1994).

[59] 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

> *Comment:* A commenter was concerned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.
>
> *Response:* This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs, inclusion of transfer cases tends to ***increase*** the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.
>
> Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

Id. at 35655-56.

deemed to be urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).[60]

d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)[61] and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).[62]

e. Budget neutrality provision at 42 U.S.C. § 1395ww(d)(3)(A)(vi) that allows Secretary to adjust standardized amount to eliminate the effect of "changes in coding or classification of discharges that do not reflect real changes in case mix."[63]

f. The discretion of the Secretary in 42 U.S.C. § 1395ww(d)(3)(I)(i) to "provide by regulation for such other exceptions and adjustments to such payments amounts under this subsection as the Secretary deems appropriate."

---

[60] *See also* 56 Fed. Reg. 43358, 43373 (Aug. 30, 1991) (stating "Consistent with the prospective payment system for operating costs, the September 1, 1987 capital final rule provided for separate standardized amounts for hospitals located in urban and rural areas. Subsequently, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) provided for a higher update factor for hospitals located in large urban areas than in other urban areas and thereby established three standardized amounts under the prospective payment system for operating costs. Large urban areas are defined as those metropolitan statistical areas (MSAs) with a population of more than 1 million (or New England County metropolitan statistical areas (NECMAs) with a population of more than 970,000). Beginning with discharges on or after April 1,1988 and continuing to FY 1995, the Congress has also established higher update factors for rural hospitals than for urban hospitals. The differential updates have had the effect of substantially reducing the differential between the rural and other urban standardized amounts. Section 4002(c) of Public Law 101-508 provides for the elimination of the separate standardized amounts for rural and other urban hospitals in FY 1995 by equating the rural standardized amount to the other urban standardized amount. The separate standardized amount for large urban hospitals would continue. Currently, the large urban standardized amount under the prospective payment system for operating costs is 1.6 percent higher than the standardized amount for hospitals located in other urban areas.").

[61] *See* 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A); *supra* note 21.

[62] Omnibus Reconciliation Act of 1990, Pub. L. 101-508, § 4002(c), 104 Stat. 1388, 1388-33 – 1388-35 (1990).

[63] For example, the Secretary included the following discussion in the preamble to the FFY 1986 IPPS Final Rule:

> As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year). However, we now have data that indicate that case mix has increased an additional 2.6 percent. Hospitals have been realizing the benefit of that increase through increased payments. Our update factor will be adjusted so as to not pass through in the FY 1987 rates 2.0 percentage points of the increase in case mix. However, the 0.6 percentage points that we estimate to reflect a real increase in case mix will be added to the update factor for FY 1987.

51 Fed. Reg. 31505-06.

g. The subsequent amendments that Congress made in 1994[64] and 1997[65] to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. The Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS.[66]

To illustrate the complex nature of these issues, the Board points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,[67] the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).[68] The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

> Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that developed since they were published. *We believe that it is necessary, **each year**, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries*. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.

---

[64] Social Security Act Amendments of 1994, § 109, Pub. L. 103-432, 108 Stat. 4398, 4408 (1994) placed the then-existing language of 42 U.S.C. § 1395ww(d)(5)(I) into clause (i) and added the following clause (ii): "(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater than or lesser than those that would have otherwise been made in such fiscal year."

[65] Balanced Budget Act of 1997, Pub. L. 105-33, § 4407, 111 Stat. 251, 401 (1997), further revised 42 U.S.C. § 1395ww(d)(5)(I) and added § 1395ww(d)(5)(J).

[66] *See* 60 Fed. Reg. 45778, 45854 (Sept. 1, 1995) ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional payments for transfer cases of $159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.").

[67] 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).

[68] U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

In addition to this general consideration, *the FY 1985 adjusted average standardized amounts* (***Federal rates***) *were required by law* ***to be adjusted to achieve budget neutrality***; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more* ***nor*** *less than* we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years*.

Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were ***higher*** *than necessary to achieve budget neutrality*. Therefore, *we have updated the FY 1985 standardized amounts using a factor that takes into account the* ***overstatement*** *of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts*. To this end, we have identified several factors, ***discussed in section II.A.3.c.***, below, that contributed to the overstatement of the FY 1985 standardized amounts. *We have determined an appropriate percent value for each of them, and have combined them into* ***a proposed composite correction factor*** *for FY 1986 that equals –7.5 percent*.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. **We have combined these values into a composite policy target adjustment factor**, **as discussed in section III.3.e., below**. For FY 1986, this factor equals —1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." *Establishing FY 1986 prospective payment rates based on FY 1985 rates* ***that have been demonstrated to be overstated****, clearly would not comport with the statutory requirement that the rates represent payment for efficiently delivered care*.

> Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes is +.31 percent, it is clear that there is a potential justification of a –4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:
>
> | | Percent |
> |---|---|
> | Forecasted market basket increase.. | +4.27 |
> | Part B costs and FICA taxes..... | +.31 |
> | Composite correction factor..... | –7.5 |
> | Composite policy target adjustment factor..... | –1.5 |
>
> However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.[69]
>
> ****
>
> (3) *Additional causes for the overstatement of FY 1985 Federal rates.* In addition to the factors above, which we believe we must correct, **other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts**.
>
> When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for 1985. After application of the revised market basket, discussed previously, use of these actuarial estimates would reduce the standardized amounts by an additional 1.2 percent.

[69] 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates. The hospital specific rates were set using later (1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. **Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount**. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals" total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.

We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided <u>at this time not</u> to correct the standardized amounts for these factors.**

We received no comments on this issue.

> (4) ***Composite Correction Factor.*** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:
>
> | | *Percent* |
> |---|---|
> | Case mix..... ..... | –6.3 |
> | Market basket..... | –1.2 |
> | Composite correction factor..... | –7.5[70] |

Congress did immediately act on the Secretary's September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 ("EEA-85") to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates (*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).[71] Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

> - Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
>
> - Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
>
> - Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
>
> - Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.[72]

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.[73] As previously discussed above in the decision at Section B.3, in the final rule published on May 6, 1986, the Secretary confirmed that "*the adjusted standardized amounts that were published in the September 3,1985 final rule* (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986"[74] and these FFY 1986 adjusted standardized rates are based on the FFY 1985 budget neutrality-adjusted rates.

---

[70] *Id.* at 35703-04 (bold and underline emphasis added).
[71] Pub. L. 99-107, § 5(a), 99 Stat. 479, 479 (1985). In July 1984, Congress had *already* reduced the 1 percent update factor planned for FFY 1986 to ¼ of a percentage point. Deficit Reduction Act of 1984, Pub. L. 98-369, § 2310(a), 98 Stat. 494, 1075 (1984). As part of the Emergency Extension Act of 1985, Congress further reduced the update factor for FFY 1986, presumably in response to the Secretary's recommendation.
[72] 51 Fed. Reg. 16772, 16772 (May 6, 1986).
[73] *See id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).
[74] 51 Fed. Reg. at 16773.

The examples highlight concerns about how certain future actions and decisions by the Secretary and Congress build upon prior decisions. Here, the Secretary's recommendation to Congress regard the FFY 1986 update factor were based on its analysis of the FFY 1984 and 1985 standardized amounts that had already been adjusted for budget neutrality. To the extent the 1984 standardized amounts had been *further* adjusted (*as **now** proposed by the Providers*), it could have potentially impacted the Secretary's recommendation to Congress for the FFY 1986 update factor as well as Congress' subsequent revisions to the updated factor. Accordingly, this highlights how revisiting and otherwise adjusting the FY 1984 standardized amounts can have ripple effects with the update factor and other adjustments that were made for subsequent years *based on analysis of the prior year(s) and other information*.

APPENDIX C

In its decision, the Board has noted that the Secretary confirmed in the preamble of the FFY 1986 IPPS Final Rule that the FFY budget neutrality-adjusted rates were used in determining the rates for FFY 1986 and would similarly be part of subsequent FFYs rates. The following excerpts from the preambles to IPPS final rules provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates were part of the rate for later FFYs and illustrate how embedded the FFY 1985 budget neutrality-adjusted rates are in the rates used for FFY 1986 and subsequent years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 budget neutrality adjustment*, it is clear that the Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and that the FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

1. In the preamble to the FFY 1986 IPPS Final Rule, the Secretary recognizes that the FFY 1985 budget neutrality adjustment accounted for the removal of nonphysician anesthetist costs from the base rates and no further adjustments were needed relative to those costs since the FFY 1985 budget neutrality-adjusted rates were used in determining the FY 1986 rates and would similarly be used for the 1987 rates:

> c. *Nonphysician anesthetist costs*. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987. We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, **because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts.** (See 49 FR 34794; August 31, 1984). **Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment**. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.[75]

[75] 50 Fed. Reg. at 35708 (Italics emphasis in original and bold and underline emphasis added). In this regard, the Board notes that the FFY 1985 IPPS Final Rule explained how the FFY 1985 budget neutrality adjustment accounted for Anesthetists services:

> *Anesthetists' Services*. Under section 2312 of Pub. L. 98-369, the costs to the hospital of the services of nonphysician anesthetists will be reimbursed in full by Medicare on a reasonable cost basis. In order to ensure that these services will be paid for only once, we must remove their costs from the prospective payment rates.

2. In the preamble to the FFY 1987 IPPS Final Rule, the Secretary explains how her budget neutrality adjustments for FFYs 1984 and 1985 had "already built case-mix increases into the cost-per case assumptions used in deriving the budget neutral prospective rates for FY 1984 and FY 1985" and confirms that "FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year)":

> *Comment*: Several commenters stated that we did not consider real case mix increases in the 1983 to 1984 period, and that we finally are considering real case mix increases for the first time.
>
> *Response*: FY 1984 and FY 1985 were years subject to the requirements for budget neutrality. As required under section 1886(e)(1) of the Act, payments under the prospective payment system were to be equal to what would have been paid under rate-of-increase and peer group limits on reasonable costs under prior law (section 1886(b) of the Act) as if the prospective payment system had never been implemented. Under the rate-of-increase limits and peer group limits, as long as a hospital's cost was lower than that hospital's limits, we paid that cost, regardless of whether real case mix increased or decreased, and regardless of the effect of actual case mix on the cost level for that hospital. . . . Increases in real case mix were built into the cost per case increase assumptions we used to model the rate-of-increase limits. These assumptions took into account estimates of the impact of the rate-of-increase limits and the peer group limits. **Consequently, we considered increases in real case mix in FYs 1984 and 1985.** Moreover, even these assumed increases in cost per case proved to be overstated as we received more recent data against which to evaluate our estimates. To have passed through updated prospective payment case-mix increases for FY 1984 and FY 1985 would have been improper because they would increase program payments over the level that would have been paid under the section 1886(b) limits. **As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.**

For cost reporting periods beginning in FY 1985, we have reduced the adjusted standardized amounts to reflect the removal of these costs **by means of the budget neutrality adjustment methodology**. Our method for doing this is explained in section V.D. of this Addendum. We estimate that FY 1985 payments for anesthetists' services will be about $160 million, or 0.5 percent of Medicare operating costs for hospital accounting years beginning in FY 1985.

> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. **Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year).**

3. In the preamble to the FFY 1988 IPPS Final Rule, the Secretary again recognizes the prior FFY 1985 budget neutrality adjustments to the standardized amounts had already taken into account the removal of nonphysician anesthetist costs and the *FFY 1985 budget neutrality-adjusted rates* ***were reflected in the FFY 1986, 1987, and 1988 rates.***

> c. *Nonphysician Anesthetist Costs*. Section 1886(d)(5)(E) of the Act provides that hospital costs for the services of nonphysician anesthetists are paid in full as a reasonable cost pass-through. Under section 2312(c) of Pub. L. 98-369, this pass-through was made effective for cost reporting periods beginning on or after October 1,1984, and before October 1,1987. Section 9320(a) of Pub. L. 99-509 extended the period of applicability of this pass-through so that services will continue to be paid under reasonable cost for any cost reporting periods (or parts of cost reporting periods) ending before January 1,1989 and struck subsection (E) effective on that date.
>
> In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, it was incorporated in the overall **budget neutrality** adjustment (50 FR 35708). Therefore, **because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived**, we did not propose to make further adjustments to the average standardized amounts for FY 1988.[76]

[76] 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Barbara Williams, Esq.
Powers, Pyles, Sutter & Verville, PC
1501 M Street, NW, 7th Floor
Washington, DC 20005

RE: ***Notice of Dismissal – Updated Rationale***
Powers Pyles Standardized Amount CIRP Group Cases
Case Nos. 19-0456GC, *et al.* (*see* **Appendix A** listing 5 group cases)

Dear Ms. Williams:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the five (5) above-referenced common issue related party ("CIRP") group cases relating to the standardized amounts used in federal rates for the inpatient prospective payment system ("IPPS") during federal fiscal year ("FFY") 1984, the initial year of IPPS. The Medicare Contractor has filed Jurisdictional Challenges in all of those group cases. The Providers' Representative filed responses to these challenges. As set forth below, the Board has determined that, consistent with 42 U.S.C. §§ 1395ww(d)(7) and 1395oo(g)(2) and 42 C.F.R. § 405.1840(b), it lacks substantive jurisdiction over the appealed issue and is therefore dismissing all five (5) CIRP group cases in their entirety. This determination is consistent with its prior dismissal determinations in other cases involving the same issue where the Board found no *substantive* jurisdiction;[1] however, in response to the additional briefing on this issue by other parties, the Board's decision has been updated to clarify and confirm that the federal rates for FFY 1986 and subsequent FFYs used the FFY 1985 budget neutrality-adjusted federal rates.

In summary, the Board finds that it lacks substantive jurisdiction over the issue raised in these appeals because the standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY and the 1984 and 1985 budget neutrality adjustments are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[2] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably*

[1] Prior Board dismissal determinations of the issue in the instant group appeals include but are not limited to: Board dec. dated Apr. 6, 2023 (lead Case No. 19-0233GC); Board dec. dated Dec. 14, 2023 (lead Case No. 23-0695GC); Board dec. dated Jan. 23, 2024 (lead Case No. 19-1094GC); Board dec. dated Jan. 24, 2024 (lead Case No. 23-1522GC); and Board dec. dated Jan. 31, 2024 (lead Case No. 19-0847GC). These jurisdictional decisions are posted on the Board's website, by the relevant year and month, at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/list-prrb-jurisdictional-decisions.

[2] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress'

intertwined with those applicable budget neutrality adjustments.[3] Indeed, the standardized amounts were too high for FFYs 1984 and 1985 and the budget neutrality adjustments applied to those years reduced the standardized amounts (reduced by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985) and, thus, these budget neutrality adjustments already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on 1981 data).[4] Because the FFY 1985 budget neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs and because 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments, the Board may not review for the FFYs appealed as it relates to the common issue in these appeals. In this regard, the Board again notes that the rates for FFY 1986 and subsequent years are based on the budget neutrality adjusted FFY 1985 rates. Accordingly, the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985, *for purposes of future FFYs*,[5] because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.[6]

Background:

Powers, Pyles, Sutter & Verville, PC ("Providers' Representative") represents a number of providers in common issue related party ("CIRP") groups which are challenging the IPPS standardized amount. The Medicare Contractor filed a Jurisdictional Challenge covering five (5) group cases.[7] The Providers' Representative filed responses to this challenge. The group issue statements, jurisdictional challenge, and response thereto for all five (5) cases are materially identical and can be considered together.

The group issue statement presented is:

> Whether the Secretary of Health and Human Services must recalculate the inpatient prospective payment system (IPPS) standardized amount to exclude transfers from the number of discharges in the 1983 IPPS base year?[8]

---

decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[3] *See infra* note 57 (citing to decisions that discuss similar circumstances involving Medicare provisions found to be inextricably tied to certain other provisions for which Congress precluded administrative and judicial review).

[4] *See infra* note 40 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

[5] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns.

[6] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns that could potentially serve as an alternative rationale.

[7] *See* **Appendix A**.

[8] *E.g.*, Case 19-0456GC, Group Issue Statement at 1 (Dec. 4, 2018).

Procedural Background:

A. Appealed Issue

In the Providers' preliminary position papers, they explain that:

> [T]he inpatient operating costs of hospitals are reimbursed based on prospectively-determined rates for each patient discharge, rather than on the reasonable operating costs for providing the services. 42 U.S.C. § 1395ww(d). Payments are made to hospitals via lump-sum amounts assigned to specific diagnosis-related groups ("DRGs") determined by a patient's diagnosis at the time of discharge. . .
>
> A hospital caring for a Medicare beneficiary who is assigned a given DRG receives a standardized amount for that patient . . . regardless of the actual costs of caring for that patient. . . In calculating the standardized amount, the Medicare statute directs the Secretary to "determined the allowable operating costs per *discharge* of inpatient hospital services for the hospital for the most recent cost reporting period for which data is available."[9]

CMS opted to use 1983 as a "base year" to calculate these rates, and thus data was collected from hospitals' 1981 cost reports to determine average costs for each discharge category. The data was adjusted for inflation and standardized, but the Providers argue that the initial calculation of this standardized amount continues to serve as the base for all future calculations. Since the Providers allege this initial calculation was understated, they argue that the calculation for each subsequent year has also been understated.[10]

The Providers claim that the data sources used in collecting the 1981 data did not distinguish between patients who were discharged from the hospital, and patients who were transferred to another hospital or facility. They state that CMS views transfers as distinct from discharges, but in calculating the average cost per discharge using the 1981 data, CMS erroneously included transfers in the total number of discharges. They claim that CMS has acknowledged this error in at least one other context (*i.e.*, during the implementation of the capital PPS), and that this error was the reason for certain DRG weight recalibrations, but that CMS failed to fully correct the flawed Standardized Amount.[11]

---

[9] *E.g.* PRRB Case No. 19-0456GC, Providers' Preliminary Position Paper ("Providers' PPP") at 4 (Sept. 20, 2019).
[10] *See id*. at 11.
[11] *Id.* at 13 (citing 56 Fed. Reg. 43358, 43386 (Aug. 30, 1991) (related to capital PPS)).

In each case, the Providers are challenging the applicable FFY IPPS rates as set forth in the Federal Register.[12] They argue the appeals are not barred by the "predicate facts" provision of 42 C.F.R. § 405.1885 and that there is no impediment to CMS correcting its erroneous data to remediate the flawed Standardized Amount. They claim that the average cost per discharge should not include transfers, that CMS has acknowledged this as well as the fact that certain Standardized Amounts erroneously included transfers. They also argue that hospitals have not been permitted to appeal the rate under CMS' improper interpretation of 42 C.F.R. 405.1885.[13]

B. Jurisdictional Challenges

The Medicare Contractor filed a challenges in the five (5) different group cases, and the Providers filed a response in each case.[14] The Medicare Contractor argues that the merits of the appealed issue are illegitimate, but more importantly, that the Board lacks subject matter jurisdiction and need not even address the merits of the issue. It references the Board's April 6, 2023 decision dismissing five (5) different CIRP group appeals concerning the same issue. The Medicare Contractor argues the Board should apply the same rationale and find that 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative review of the base year standardized amounts. It also claims that budget neutrality adjustments after the base year amount was calculated have corrected any potential errors from prior years, and that the data shows the base year was, in fact, initially set too high (rather than understated).

The Providers' responses to these challenges reiterated that the group appeal rests on the fact that each appeal's IPPS payments for the applicable FFY are understated as "the calculation of the 1983 "base year" standardized amount violates the Medicare statute because it improperly includes patient transfers as discharges."[15] They claim that the budget-neutral adjustments and any preclusion provisions do not apply to their IPPS challenges. The ask the Board to find it has jurisdiction over these appeals.

The Providers counter the Medicare Contractor by arguing that "the Budget Neutrality Preclusion Statute does not foreclose the Board from reviewing the Providers' appeals."[16] The Providers claim they do not seek to challenge the FFY 1984 or 1985 IPPS payments, "and the Providers' challenge is not "inextricably intertwined" with the budget neutrality adjustment subject to judicial preclusion."[17] The further claim that neither 42 U.S.C. §§ 1395ww(d)(7)(A) nor 1395oo(g)(2) restrict challenges to the statutory provision governing the challenged "costs per discharge" calculation.[18] They argue that there is a strong presumption in favor of judicial

---

[12] *See id*. at 11 ("Providers challenge the flawed computation of the 1983 "base year" standardized amount used to determine the Providers' IPPS payment for FY 2016. This miscalculation affected the Providers' FY 2016 IPPS payments because CMS uses the 1983 standardized amount, updated for inflation, to determine IPPS payments in that year.")
[13] *Id*. at 9-10.
[14] *See* **Appendix A** for a complete list of challenges and cases impacted. As previously noted, the challenges are all materially identical.
[15] Provider's Motion to Dismiss MAC's Jurisdictional Challenge at 8 (Nov. 30, 2023).
[16] *Id*. at 11.
[17] *Id.* at 7.
[18] *Id.* at 10.

review, and that in this instance there is not clear indication that Congress intended to preclude review of more recent FFY Standardized Amounts or the predicate facts related to the methodology for calculating the 1983 Standardized Amount.[19]

Board Decision:

As described more fully below, the Board finds that it lacks substantive jurisdiction over each of the 5 groups because: (1) the initial IPPS standardized amounts set for FFY 1984[20] are ***inextricably*** tied to the FFY 1984 and 1985 budget neutrality adjustments to the "applicable percentage increases" for IPPS[21]; (2) the FFY 1985 budget neutrality-adjusted rates were used to determine the rates for FFY 1986 and, thus, became embedded into the rates determined for subsequent FFYs; and (3) 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments. Further, the fact that the Secretary's budget neutrality adjustment to the FY 1984 Federal Rates was 0.970[22] demonstrates that, contrary to the Providers' assertions, the initial standardized amount was ***not*** understated but rather was *overstated* by a factor of 0.030 (*i.e.*, 1.000 – 0.970).

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the IPPS.[23] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[24]

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services."[25] The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain ***base period*** *cost data* be developed and modified in several specified ways (*i.e.*, inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[26] Section 1395ww(d)(2)(A) requires that the Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available:

---

[19] *Id.* at 6.
[20] The Board notes that, initially, there was not just one standardized amount. Rather there were 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation and each of these 20 rates is further divided into a labor and nonlabor portion. *See* 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[21] 42 U.S.C. § 1395ww(e) is entitled "Proportional adjustments in applicable percentage increases." The 1984 and 1985 budget neutrality adjustments are set forth is § 1395ww(e)(1)(B) which is cross-referenced for 1984 IPPS rates at § 1395ww(d)(2)(F) and for 1985 IPPS rates at § 1395ww(d)(3)(C).
[22] In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970. 49 Fed. Reg. 234, 334 (Jan. 3, 1984).
[23] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[24] *Id.*
[25] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[26] *Id.* (emphasis added).

> (II) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

Consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the 1984 "base period" operating cost per discharge amount using the 1981 operating costs per discharge amount *updated* by an inflationary factor.[27] The Providers dispute how the Secretary determined "discharges" and allege that the Secretary improperly treated transfers as discharges for purposes of this calculation.

The Secretary then "standardized" the FFY 1984 base period operating cost per discharge using the process prescribed at 42 U.S.C. § 1395ww(d)(2)(c). The standardization process removed the effects of certain variable costs from the cost data, including (but not limited to) excluding costs associated with indirect medical education costs, adjusting for variations in average hospital wage levels, and adjusting for variations in case mix among hospitals.

The initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"), the standardized amount is not adjusted each year simply for inflation.[28] Significantly, some of these annual adjustments were required to be *budget neutral* and are not subject to administrative review and others are discretionary. In particular, 42 U.S.C. § 1395ww(e)(1)(B) provides the budget neutrality adjustment for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

> **(e) Proportional adjustments in *applicable percentage increases***
>
> (1) . . . .
>
> (B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—
>
> (i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals

[27] *Id*. at 39763-64.
[28] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

> (excluding payments made under section 1395cc(a)(1)(F) of this title),
>
> *are not greater or less than*—
>
> (ii) the DRG percentage (as defined in subsection (d)(1)(C)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).[29]

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 rate year and 1985 rate year respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

> (i) *Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c) through (h) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of **the payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1984 **under the Social Security Act as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[30]

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

> (v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of the reduced standardized amounts determined under paragraph (c) of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus

[29] (Bold emphasis in original and italics and underline emphasis added.) The budget neutrality adjustment at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).
[30] (Italics emphasis in original and bold and underline emphasis added.)

> any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is **not greater or less** than 50 percent of the **payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[31]

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than **or** less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e*., reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average payment per case, is prescribed by law to be *no more **and** no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget neutrality for 1984 and 1985 are ***external*** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.[32] Since these points are ***fixed,*** it also means that it is capped (*i.e*., cannot be increased subsequently outside of the budget neutrality adjustment).

This conclusion is supported by the fact that the normal annual inflation adjustments to the standardized amount provided for in IPPS apply only for FY 1986 forward, as set forth in 42 U.S.C. § 1395ww(b)(3)(B)(3)(i) and cross referenced in § 1395ww(d)(3)(A). Specifically, 42

---

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

[32] 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board's pie concept:

> Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.
>
> Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

U.S.C. § 1395ww(b)(3)(B)(i) (2018) defines the term "applicable percentage increase" starting with fiscal year 1986 (as opposed to 1984):

> (B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—
>
> (I) ***for fiscal year 1986***, 1⁄2 percent,
>
> (II) for fiscal year ***1987***, 1.15 percent,
>
> (III) for fiscal year ***1988***, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,
>
> (IV) for fiscal year ***1989***, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,
>
> (V) for fiscal year ***1990***, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,
>
> (VI) for fiscal year ***1991***, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,
>
> (VII) for fiscal year ***1992***, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,
>
> (VIII) for fiscal year ***1993***, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 1 for hospitals located in a rural area,
>
> (IX) for fiscal year ***1994***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,

> (X) for fiscal year ***1995***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),
>
> (XI) for fiscal year ***1996***, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,
>
> (XII) for fiscal year ***1997***, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,
>
> (XIII) for fiscal year ***1998***, 0 percent,
>
> (XIV) for fiscal year ***1999***, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,
>
> (XV) for fiscal year ***2000***, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,
>
> (XVI) for fiscal year ***2001***, the market basket percentage increase for hospitals in all areas,
>
> (XVII) for fiscal year ***2002***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XVIII) for fiscal year ***2003***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XIX) for each of fiscal years ***2004*** through ***2006***, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and
>
> (XX) ***for each subsequent fiscal year***, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.[33]

The "applicable percentage increase" as defined in § 1395ww(b)(3)(A) is incorporated into § 1395ww(d)(3)(A), as it relates to updating of the standardized amount:

> **(A) UPDATING** PREVIOUS STANDARDIZED AMOUNTS.—
>
> (i) For discharges occurring in a fiscal year beginning ***before*** October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a

[33] (Emphasis added.)

rural area within each region, *equal to the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph*, ***increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B)***. With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).

(ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.

(iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

> (II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

Thus, while 42 U.S.C. § 1395ww(d)(2) provides the methodology for calculating the standardized amount to be used for each year, and that the amount is subject to the "applicable percentage increase" under subsection (b)(3)(B) *for years after 1984*, it remains that it is not always a simple inflationary or market basket adjustment. In particular, the FFY 1984 and 1985 budget neutrality adjustments (as referenced in § 1395ww(d)(2)(F) and in § 1395ww(d)(3)(C)) were the applicable percentage increases for FFYs 1984 and 1985 and, as described below, those adjustments are not administratively reviewable. Further, as discussed *infra*, it is clear that the Secretary has interpreted 42 U.S.C. § 1395ww(d)(3)(A)(i) to require the FFY 1985 budget neutrality-adjusted rates be used in determining the rates for FFY 1986 and subsequent FFYs. This is reflected in the following excerpt from 42 C.F.R. § 405.473(c) as initially adopted in the September 3, 1983 final rule:

> (c) *Federal rates for fiscal years after Federal fiscal year 1984.*
>
> ****
>
> (2) *Updating previous standardized amounts.*
>
> (i) *For fiscal year 1985*. HCFA will compute an average standardized amount for each group of hospitals described in paragraph (b)(5) of this section . . . equal to the respective adjusted average standardized amount computed for fiscal year 1984 under paragraph (b)(7) of this section—
>
> (A) Increased for fiscal year 1985 by the applicable percentage increase under § 405.463(c);
>
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
>
> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the total amount of prospective payments which are additional payment amounts attributable to outlier cases

under § 405.475; and

(D) **Adjusted for budget neutrality under paragraph (c)(4) of this section**.

(ii) **For fiscal year 1986** and thereafter, **HCFA will compute an average standardized amount** for each group of hospitals described in paragraph (b)(5) of this section, **equal to the respective adjusted average standardized amounts computed for the previous fiscal year**—

(A) Increased by the applicable percentage increase determined under paragraph (c)(3) of this section; and

(B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements.

(C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475.

(3) *Determining applicable percentage changes for fiscal year 1986 and following*. The Secretary will determine for each fiscal year (beginning with fiscal year 1986) the applicable percentage change which will apply for purposes of paragraph (c)(2)(ii) of this section as the applicable percentage increase for discharges in that fiscal year, and which will take into account amounts the Secretary believes necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In making this determination, the Secretary will consider the recommendations of the Prospective Payment Assessment Commission.[34]

---

[34] 48 Fed. Reg. at 39823 (italics emphasis in original and bold and underline emphasis added). This provision was later moved to 42 C.F.R. § 412.63(c)(2022) which states in pertinent part:

(c) *Updating previous standardized amounts*.

****

(2) Each of those amounts is equal to the respective adjusted average standardized amount computed for fiscal year 1984 under §412.62(g)—

(i) Increased for fiscal year 1985 by the applicable percentage increase in the hospital market basket;

B. Jurisdictional Findings -- 42 U.S.C. § 1395ww(d)(7)(A) Precludes Administrative Review of the Base Year Standardized Amounts

The Providers essentially are challenging the standardized amount used in the IPPS rates for several FFYs claiming that the Secretary improperly treated transfers as discharges when using 1981 cost report data to determine the initial FFY 1984 base cost per discharge which, in turn, was standardized to arrive at the FFY 1984 standardized amounts. More specifically, the Providers maintain that, the understatement of the standardized amount in the FFY 1984 IPPS Final Rule caused a corresponding underpayment in IPPS payments in FFY 1984 ***and every FFY thereafter*** *because the standardized amount for all IPPS payments for every FFY are based on CMS's calculation of the FFY 1984 standardized amount*.[35]

The published standardized amount for each FFY in these appeals reflects the prior year's standardized amount plus "the applicable percentage increase" as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i) (as referenced in 42 U.S.C. § 1395ww(d)(3)(A)) as well as other potential adjustments. Significantly, the "applicable percentage increase[s]" for 1984 forward are ***not*** always simply a cost inflation adjustment or other similar percentage adjustment. To this point, for the first two (2) years of IPPS, Congress mandated that the budget neutrality adjustments for FFYs 1984 and 1985 serve as the "applicable percentage increase" for those years. As a result, the IPPS rates that the Secretary used *for the very first year of IPPS* and then the second year of IPPS were adjusted for budget neutrality. For FFYs 1986 and forward, Congress provided for an "applicable percentage increase" in 42 U.S.C. § 1395ww(b)(3)(B)(i) as referenced in 42 U.S.C.

> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
> (iii) Reduced by a proportion equal to the proportion (estimated by CMS) of the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part; and
> (iv) **Adjusted for budget neutrality under paragraph (h) of this section**.
> (3) ***For fiscal year 1986*** *and thereafter*. CMS computes, for urban and rural hospitals in the United States and for urban and rural hospitals in each region, average standardized amount equal to the respective **adjusted average standardized amounts computed for the previous fiscal year**—
> (i) Increased by the applicable percentage increase determined under paragraphs (d) through (g) of this section;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements; and
> (iii) For discharges occurring on or after October 1, 1985 and before October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part, and for discharges occurring on or after October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments that, based on the total amount of prospective payments for urban hospitals and the total amount of prospective payments for rural hospitals, are additional payments attributable to outlier cases in such hospitals under subpart F of this part.

[35] *E.g.*, PRRB Case 19-0456GC *et al.*, Providers' PPP at 4 ("Therefore, errors contained in the 1983 "base year" standardized amount calculation are carried forward year after year.").

§ 1395ww(d)(3)(A). In addition, there are other *permanent* adjustments (*i.e.*, adjustments not for that year only but that also apply on a going-forward basis) to the standardized amount that have occurred in other years outside of the "applicable percentage increase."[36] Thus, the standardized amount for a particular year is an amalgamation that builds upon the prior year's standardized amount and then adds additional adjustments for the current year. As noted *supra* and discussed more *infra*, the Secretary has used the FFY 1985 budget neutrality-adjusted rates for determining the FFY 1986 rates and those for subsequent FFYs.

The Providers are, essentially, seeking to peel back the amalgamated standardized amount for each applicable FFY *and, thus, reach back* ***more than 30 years*** to increase the initial FFY 1984 base rate that was used to set the initial FFY 1984 standardized amount***s***. They would then incorporate the alleged increased base rate into the FFY 1984 standardized amount***s*** and then simply carry or flow that *increase forward 35 years*. However, in order to peel the amalgamated standardized amounts for the FFYs at issue (singular[37]) *as used in the IPPS rates for each FFY* back to the initial standardized amount***s*** (plural[38]) used in FFY 1984, and then carry/flow any change forward *to the FFY at issue*, the Providers would have to pass through the FFY 1984 and 1985 budget neutrality adjustments which were the only "applicable percentage increase[s]" for those years. However, they cannot do so because the budget neutrality adjustments had the effect of ***fixing*** the pie for FFYs 1984 and 1985 to (*i.e.*, no more ***and*** no less than) the aggregate amounts that would have been paid had IPPS not been implemented.[39] More specifically, the amalgamated standardized payment amount for each FFY at issue reflects the *fixed* FFY 1985 budget neutrality adjustment (and not the initial FFY 1984 standardized amount since the standardized amounts for FFYs 1984 and 1985 were each adjusted for budget neutrality and became *fixed* for purposes of subsequent years as a result of those budget neutrality adjustments). Thus, in the Board's view, the Providers cannot get back to the FFY 1984 standardized amounts without first passing through the FFY 1984 and 1985 budget neutrality adjustments. Regardless, the Providers would not be able to flow forward any adjustments made to the FFY 1984 standardized amounts to FFYs after FFY 1985 because:

> (1) they, again, would not be able to get through the FFY 1984 and 1985 budget neutrality adjustments that Congress otherwise ***fixed*** to an external point (no greater and no less); and
>
> (2) the IPPS rates paid for FFYs 1984 and 1985 are based on standardized amounts that were adjusted downwards as a result of

---

[36] *See* **Appendix B.**
[37] *See supra* note 20 accompanying text.
[38] *See id.*
[39] *See, e.g.,* 48 Fed. Reg. 39752, 39805 (Sept. 1, 1983) (stating: "Hospital Impact—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20,1983.").

> the budget neutrality adjustment for FFY 1984 and also for FFY 1985 (*see* discussion below in Sections B.1 and B.2).[40]

Accordingly, the Board finds that the Providers challenge to the standardized amounts at issue are *inextricably* tied to the budget neutrality adjustments made for FFY 1984 and 1985.[41]

Furthermore, Congress has precluded Board (and judicial) review of the FFY 1984 and 1985 budget neutrality adjustments. Specifically, 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and juridical review of the neutrality adjustment at § 1395ww(e)(1):

> (7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii), . . .[42]

---

[40] Indeed, the FY 1986 IPPS Final Rule included an example where the Secretary recognized an adjustment to the budget neutrality adjustments would be impacted by the removal of nurse anesthetists costs and confirmed that the adjustments to the standardized amounts had already taken this removal into account:

> c. Nonphysician anesthetist costs. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987.
>
> We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, *because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts*. (See 49 FR 34794; August 31, 1984). ***Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment***. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.

50 Fed. Reg. at 35708 (emphasis added). *See also* 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (stating: "In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, *it was incorporated in the overall* ***budget neutrality adjustment*** (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived, we did not propose to make further adjustments to the average standardized amounts for FY 1988.").

[41] The Board notes that the D.C. Circuit's decision in *Saint Francis* is not applicable to the 1984 and 1985 budget neutrality adjustments given the statutory provision precluding administrative and judicial review of those adjustments. Further, *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[42] With regard to implementing this statutory provision, 48 Fed. Reg. 39752, 39785 (Sept. 1, 1983) states:

> Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
>
> —A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or
>
> —The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost. It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs.

Similarly, the statute governing Board appeals is located at 42 U.S.C. § 1395oo and states in subsection (g)(2):

> The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

Similarly, the statute governing Board appeals is located at 42 U.S.C. § 1395oo and states in subsection (g)(2):

> The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

Since the FFY 1984 and 1985 budget neutrality adjustments are based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and are not reviewable, the Board finds that the FFYs 1984 and 1985 budget neutrality adjustments effectively fixed the standardized amounts from that point forward for use in the IPPS system.[43]

Indeed, the Secretary's implementation of the fixed FFY 1984 and 1985 budget neutrality adjustments confirms that the Providers' allegation that the standardized rates for ***each FFY at issue*** are somehow understated due to alleged errors in the FFY 1984 base rate is moot.

1. *The Secretary determined that the initial standardized amounts for FFY 1984 were too high and, therefore, reduced the FFY 1984 standardized amounts through the FFY 1984 budget neutrality adjustment as reflected in the **final** FFY 1984 IPPS rates*.

In the interim final rule published on September 1, 1983, the Secretary issued a FFY 1984 budget neutrality adjustment to the FFY 1984 standardized amounts of 0.969:

> Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal

---

Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98-25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

[43] *See, e.g.,* 48 Fed. Reg. 39752, 39765 (Sept. 1, 1983) (stating "We point out that aside from being technically desirable, the effect of standardizing nonlabor hospital costs in Alaska and Hawaii is to decrease the reduction for budget neutrality stemming from the requirements in section 1886(e)(1)(B) of the Act.").

to "what would have been payable" under the reasonable cost provisions of prior law; that is, for fiscal years 1984 and 1985, the prospective payment system should be "budget neutral."

Under the Amendments, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Section 1886(e)(1)(A) of the Act requires that aggregate payments for the hospital specific portion should equal the comparable share of estimated reimbursement under prior law. **Similarly, section 1886(e)(1)(B) of the Act requires that aggregate reimbursement for the Federal portion of the prospective payment rates plus any adjustments and special treatment of certain classes of hospitals should equal the corresponding share of estimated outlays prior to the passage of Pub. L. 98-21**. Thus, for fiscal year 1984, 75 percent of total projected reimbursement based on the hospital-specific portion should equal 75 percent of total estimated outlays under law as in effect prior to April 20, 1983. Likewise, total estimated prospective payment system outlays deriving from the 25 percent Federal portion, including adjustments and special payment provisions, should equal 25 percent of projected reimbursement under prior laws.

The adjustment of the Federal portion was determined as follows:

- *Step 1*—Estimate total incurred payments for inpatient hospital operating costs for fiscal year 1984 that would have been made on a reasonable cost basis under Medicare prior to Pub. L. 98-21.
- *Step 2*—Multiply total incurred payments by 25 percent, i.e., the Federal portion of total payment amounts for fiscal year 1984.
- *Step 3*—Estimate the Federal portion of total payments that would have been made without adjusting for budget neutrality, but with the adjustment for outlier payments.
- *Step 4*—Add an estimate of total adjustments and payments under special payment provisions to the Federal portion (e.g., outliers, indirect medical education).
- *Step 5*—The difference between the step 2 and step 4 amounts is divided proportionally among the standardized amounts, resulting in the budget neutrality adjusted (standardized) amounts.

The resulting adjustment factor for the fiscal year 1984 Federal portion is .969. Payment amounts of hospitals excluded from the prospective payment system (e.g., psychiatric and children's

> hospitals) and of hospitals not participating in prospective payment because of their participation in demonstrations and studies were not included in the calculations above.[44]

In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970 using the same methodology.[45] Significantly, in the January 1984 final rule, the Secretary suggests that, in calculating the budget neutrality adjustment factor, CMS made no attempt to adjust for transfers under IPPS:

> Regarding additional adjustments recommended by commenters, we made no adjustments to either the adjusted standardized amounts or to the budget neutrality estimates for conditions that could not be quantified on the basis of currently available data, even if there were a likelihood that these conditions might exist under prospective payment. For example, no adjustment was made for the likelihood that admissions would increase more rapidly under prospective payment than under the provisions of Pub. L. 97-248, or for costs that might be disallowed as a result of audit or desk review by the intermediaries. *Likewise, we made no attempt to quantify adjustments* ***for the likelihood of transfers*** *under prospective payment*, emergency room services, and disallowed costs which are successfully appealed.[46]

Accordingly, while the Providers did not appeal the 1984 or 1985 budget neutrality adjustments, the above excerpt suggests that the Providers' concern about the Secretary's alleged mistreatment of transfers may be misplaced and that the treatment of transfers in the in the context of the budget neutrality adjustment for FFY 1984 may have more significance.

Finally, the Secretary also declined to increase the base standardized amount to reflect the increased costs associated with the shift in costs of hospital-based physician services from Part B to Part A, as suggested in a comment. The Secretary noted that such an increase would simply be offset or neutralized by a corresponding increase in the budget neutrality adjustment for FFY 1984:

> Finally, applying such an adjustment to the average standardized amounts (and, by extension, to the per case budget neutrality estimates of Federal rate payments) would not actually increase the

---

[44] 48 Fed. Reg. 39752, 39840-41 (Sept. 1, 1983) (bold, underline emphases added, and italics emphasis in original).
[45] 49 Fed. Reg. 234, 334 (Jan. 3, 1984).
[46] *Id.* at 255 (Emphasis added.) *See also id.* at 331 (stating as part of the discussion on the budget neutrality adjustments: "The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a DRG-adjusted limit on the allowable amount of inpatient operating costs per case and a per case limit on the rate of increase of operating costs of inpatient hospital services. Due to these per case limits, the incentives that influence hospital admission patterns are similar under TEFRA and prospective payment. Accordingly, ***we have assumed that the number of admissions under both prior law and the prospective payment system will be the same***. As a result, the budget neutrality factors can be calculated by comparing reimbursement per discharge for each of the systems, and there is no need to estimate an actual number of hospital admissions." (emphasis added)).

> level of payments under budget neutrality. If we were to increase the initial standardized amounts to reflect this shift, the budget neutrality adjustment factor would have to be recalculated, would accordingly be increased, and the net result would be virtually identical. As a result, such an adjustment would have no effect on payment levels during FYs 1984 and 1985, which are subject to budget neutrality.[47]

Regardless, the Secretary's application of a 0.970 budget neutrality adjustment factor to the FFY 1984 standardized amounts ***prospectively set*** for the Federal rates for FFY 1984 confirms that these standardized rates were too high and were reduced by a factor of 0.030. Thus, the ***final*** IPPS payment rates as used for the first year of IPPS (*i.e.*, FFY 1984), as finalized on January 3, 1984, reflect the Secretary's FFY 1984 budget neutrality adjustment. Moreover, as previously noted, since the FFY 1984 budget neutrality adjustment is based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and is not reviewable, the FFY 1984 budget neutrality adjustment effectively ***fixed*** the standardized amounts for FFY 1984 as used from that point forward (*i.e.*, as used both for the FFY 1984 IPPS payment rates and for subsequent years).

2. *The FFY 1985 budget neutrality adjustment also reduced the FFY 1985 standardized amounts, reaffirming that the Secretary's determined that the initial standardized amounts for FFY 1984 were set too high.*

For FFY 1985 in the August 31, 1984 IPPS final rule, the Secretary applied a budget neutrality adjustment of 0.954 to the standardized amounts used for the Federal national rates and 0.950 to the standardized amounts used for the regional rates and ***specifically confirmed*** that *"*[t]hese budget neutrality-adjusted rates for FY 1985 are then to be used *as the basis for the determination of rates* ***for later years***."[48] The Secretary described these adjustments as follows:

> In accordance with section 1886(e)(1) of the Act, the prospective payment system should result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for FYs 1984 and 1985, the prospective payment system must be "budget neutral".
>
> During the transition period, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. ***Further, effective October 1,1984***, *the Federal portion will be a blend of national and regional rates*. As a result, we must determine three budget neutrality adjustments— one each for both the national and regional rates, and one for the hospital-specific portions. The methodology we are using to make these adjustments is explained in detail in section V. of this addendum.

---

[47] *Id.* at 255.
[48] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added).

> Based on the data available to date, we have computed the following Federal rate budget neutrality adjustment factors:
>
> Regional—.950
> National—.954[49]
>
> ****

By finalizing an adjustment factor less than 1, the Secretary confirmed that the standardized amounts were too high. Thus, like her budget neutrality adjustments made for FFY 1984, the Secretary again confirmed that the standardized amounts were too high and exercised her discretion to reduce the standardized amounts to be used in the ***final*** FFY 1985 IPPS rates.[50]

3. *The Secretary has applied the FFY 1985 budget neutrality-adjusted rates to FFY 1986 and subsequent years.*

For FFY 1986, the Secretary confirmed that she used the FFY 1985 budget neutrality adjusted federal rates as the basis for determining the FFY 1986 federal rates:

> [T]he FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be ***neither more nor less than*** *we estimated would have been paid under prior legislation for the costs of the same services*. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) ***These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years***.
>
> Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts ***to ensure that accuracy of the FY 1986 standardized amounts***. To this end, we have identified several

[49] 49 Fed. Reg. 34728, 34769 (Aug. 31, 1984).

[50] In the preamble to the FFY 1985 Final Rule, the Secretary "noted that most of the data that the budget neutrality adjustment is based on has already been made available [to the public]. We believe that these data in conjunction with the explanation of the budget neutrality methodology presented in the NPRM (49 FR 27458) should enable individuals to replicate the adjustment factors. . . . In addition, we believe the lengthy and detailed description of the data and the development of rates contained in the **Federal Register**, along with the many examples furnished, afford the reader all the information necessary for an understanding of the prospective payment system. Those individuals, hospitals, or associations desiring additional data and other material, either for verification of rates or for other purposes, may request this date under the Freedom of Information Act." 49 Fed. Reg. at 34771.

> factors, discussed in section III.A.3.c., below, that contributed to the *overstatement* of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and have combined them into a proposed composite ***correction*** factor for FY 1986 that equals —7.5 percent.[51]

Significantly, in the above excerpt, the Secretary further confirmed that "[t]hese budget neutrality-adjusted rates for FY 1985 are then to be used *as the basis for the determination of rates* ***for later years***."[52] While it is true that the implementation of these rates for FFY 1986 were delayed by Congressional action extending the FFY 1985 rates through April 30, 1986 (as discussed further in **Appendix B**), the Secretary confirmed that it used the rates published in the FFY 1986 IPPS Final Rule plus a 1.0 percent modification specified by Congress:

> Section 9101(a) of Pub. L. 99-272 amends section 5(c) of Pub. L. 99-107 to extend the FY 1985 inpatient hospital prospective payment rates through April 30,1986. Therefore, the DRG classification changes and recalibrated DRG weights that were set forth in the September 3,1985 final rule (50 FR 35722) are effective for discharges occurring on or after May 1, 1986.
>
> ****
>
> In accordance with the provisions of section 9101(b) and (e) of Pub. L. 99-272, the adjusted standardized amounts that were published in the September 3,1985 final rule (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986. The revised standardized amounts are set forth in Table 1, below.[53]

Significantly, *a glaring gap in the Providers' response to the Medicare Contractor's jurisdictional challenge* is their failure discuss or even recognize how the Secretary interpreted and applied the FFY 1985 budget neutrality adjustment.

The Board has set forth in **Appendix C** excerpts from the preambles of other final rules to provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates applied to later years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 budget neutrality adjustment*, it is clear that:

---

[51] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added). *See also* 49 Fed. Reg. at 34767 (stating "We believe the explicit language of section 2310 of Pub. L. 98-369 and section 1886(d)(3)(A) of the Act requires a reduction in the standardized amounts used to compute the Federal rates before adjusting for budget neutrality. . . . Thus, while the Federal rates . . . . have been reduced in this final rule to reflect the inflation factor prescribed by section 2310 of Pub. L. 98-369, we point out that the offset for budget neutrality has also been adjusted. The reduction in the regional and national standardized rates . . . attributable to section 2310 of Pub. L. 98-369 is entirely due to the revised budget neutrality adjustments for 1984 and 1985.").

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

[53] 87 Fed. Reg. 16772, 16773 (May 6, 1986).

1. The Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and

2. The FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

Accordingly, the Board finds that the Providers' issue is inextricably tied, at a minimum, to the FFY 1985 budget neutrality adjustments.

* * * * *

In summary, the Providers confirm that they do not seek to challenge the FFY 1984 or 1985 IPPS payments or the associated FFY 1984 and 1985 budget neutrality adjustments, but rather they "contest the computation of the 1983 standardized amount used to determine the IPPS payments for the Providers' FYs . . ."[54] They also claim that the Budget Neutrality Preclusion Provisions are not applicable here because they only bar administrative and judicial review of *a **narrow** category of challenges* to the Secretary's determination of the requirement, or the proportional amount, of any budget neutrality adjustment effected pursuant to 42 U.S.C. § 1395ww(e)(1) in FFYs 1984 and 1985.[55]

The Board disagrees and finds that it lacks substantive jurisdiction over the issue raised in these appeals because the ***prospectively-set*** standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY and the 1984 and 1985 budget neutrality adjustments are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[56] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably intertwined* with those applicable budget neutrality adjustments.[57] Indeed, the

---

[54] *E.g.,* Case No. 19-0456GC *et al.*, Providers' Motion to Dismiss MAC's Jurisdictional Challenge at 7 (Nov. 30, 2023).

[55] *Id*. at 11.

[56] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[57] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably intertwined, section 1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and so the shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the "data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is ... a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is

Secretary applied a budget neutrality adjustment to those years to reduce the standardized amounts by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985 and, thus, these budget neutrality adjustments appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on *1981 data*).[58] Because the FFY 1985 budget neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs and because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments and the resulting *final* standardized amounts for FFY 1985 was carried/flowed forward to FFY 1986 and succeeding FFYs, the Board may not review the standardized amount used for the FFYs being appealed as it relates to the common issue in these appeals. In this regard, the Board again notes that the rates for FFY 1986 and subsequent years are based on the budget neutrality adjusted FFY 1985 rates and Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985, *for purpose of future FFYs*, because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.

Accordingly, the Board finds that: (1) the appealed issue is *inextricably* intertwined with the FFY 1984 and 1985 budget neutrality adjustments to the standardized amounts *for purposes of future FFYs* under the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), and both 1395ww(d)(2)(F) and 1395ww(d)(3)(C) which reference 1395ww(e)(1)(B), as demonstrated by the fact that the FFY 1985 budget-neutrality adjusted rates were used for the basis for the determination of rates for FFY 1986 and later years; and (2) 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations[59]) prohibit administrative and judicial review of those budget neutrality adjustments. Based on these findings, the Board concludes that it does not have substantive jurisdiction over the issue in the five (5) CIRP group cases listed in **Appendix A**. Accordingly, the Board hereby closes these five (5) group cases and removes

---

the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board notes that the Board erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget neutrality***. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the Board's discussion herein) demonstrates that any adjustment to the FFY 1984 standardized amounts would be *inextricably* tied to the ensuing budget neutrality adjustments made for FFYs 1984 and 1985.

[58] *See supra* note 40 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

[59] *See, e.g.*, 42 C.F.R. §§ 405.1804, 405.1840(b)(2).

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:

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

For the Board:

2/29/2024

X Clayton J. Nix

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

cc: Michael Redmond, Novitas Solutions, Inc. (J-L)
Wilson Leong, FSS
Jacqueline Vaughn, CMS OAA

APPENDIX A
Jurisdictional Challenges and Responses; Cases at Issue

On October 31, 2023, the Medicare Contractor filed a challenge to the following five (5) cases which all share a common lead Medicare Contractor, Novitas Solutions, LLC (J-L):

19-0456GC	MedStar Health CY 2016 Calculation of Standardized Amount CIRP Group
21-0265GC	MedStar Health CY 2017 Calculation of Standardized Amount CIRP Group
22-1038GC	MedStar Health CY 2019 Standardized Amount Calculation CIRP Group
22-1100GC	MedStar Health CY 2018 Calculation of Standardized Amount CIRP Group
23-0969GC	MedStar Health CY 2020 Calculation of Standardized Amount CIRP Group

APPENDIX B

The following are examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments and the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i):

a. "Restandardization of base year costs per case used in [the] calculation of Federal rates" for both the labor and non-labor portions to reflect the survey-based wage index as discussed in the FY 1986 IPP Final Rule. 50 Fed. Reg. 35646, 35692 (Sept. 3, 1985).

b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.[60] An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.[61]

c. Budget neutrality adjustments made to the standardized amount designated for urban hospitals and the one designated for rural hospitals when certain urban hospitals were

---

[60] The Secretary confirmed that, beginning in 1991, these adjustments are to be made in a budget neutral manner:

> Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

59 Fed. Reg. 45330, 45348 (Sept. 1, 1994).

[61] 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

> *Comment:* A commenter was concerned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.
>
> *Response:* This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs, inclusion of transfer cases tends to ***increase*** the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.
>
> Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

Id. at 35655-56.

deemed to be urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).[62]

d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)[63] and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).[64]

e. Budget neutrality provision at 42 U.S.C. § 1395ww(d)(3)(A)(vi) that allows Secretary to adjust standardized amount to eliminate the effect of "changes in coding or classification of discharges that do not reflect real changes in case mix."[65]

f. The discretion of the Secretary in 42 U.S.C. § 1395ww(d)(3)(I)(i) to "provide by regulation for such other exceptions and adjustments to such payments amounts under this subsection as the Secretary deems appropriate."

---

[62] *See also* 56 Fed. Reg. 43358, 43373 (Aug. 30, 1991) (stating "Consistent with the prospective payment system for operating costs, the September 1, 1987 capital final rule provided for separate standardized amounts for hospitals located in urban and rural areas. Subsequently, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) provided for a higher update factor for hospitals located in large urban areas than in other urban areas and thereby established three standardized amounts under the prospective payment system for operating costs. Large urban areas are defined as those metropolitan statistical areas (MSAs) with a population of more than 1 million (or New England County metropolitan statistical areas (NECMAs) with a population of more than 970,000). Beginning with discharges on or after April 1,1988 and continuing to FY 1995, the Congress has also established higher update factors for rural hospitals than for urban hospitals. The differential updates have had the effect of substantially reducing the differential between the rural and other urban standardized amounts. Section 4002(c) of Public Law 101-508 provides for the elimination of the separate standardized amounts for rural and other urban hospitals in FY 1995 by equating the rural standardized amount to the other urban standardized amount. The separate standardized amount for large urban hospitals would continue. Currently, the large urban standardized amount under the prospective payment system for operating costs is 1.6 percent higher than the standardized amount for hospitals located in other urban areas.").

[63] *See* 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A); *supra* note 20.

[64] Omnibus Reconciliation Act of 1990, Pub. L. 101-508, § 4002(c), 104 Stat. 1388, 1388-33 – 1388-35 (1990).

[65] For example, the Secretary included the following discussion in the preamble to the FFY 1986 IPPS Final Rule:

> As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year). However, we now have data that indicate that case mix has increased an additional 2.6 percent. Hospitals have been realizing the benefit of that increase through increased payments. Our update factor will be adjusted so as to not pass through in the FY 1987 rates 2.0 percentage points of the increase in case mix. However, the 0.6 percentage points that we estimate to reflect a real increase in case mix will be added to the update factor for FY 1987.

51 Fed. Reg. 31505-06.

g. The subsequent amendments that Congress made in 1994[66] and 1997[67] to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. The Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS.[68]

To illustrate the complex nature of these issues, the Board points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,[69] the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).[70] The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

> Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that developed since they were published. *We believe that it is necessary, **each year**, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries*. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.

---

[66] Social Security Act Amendments of 1994, § 109, Pub. L. 103-432, 108 Stat. 4398, 4408 (1994) placed the then-existing language of 42 U.S.C. § 1395ww(d)(5)(I) into clause (i) and added the following clause (ii): "(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater than or lesser than those that would have otherwise been made in such fiscal year."

[67] Balanced Budget Act of 1997, Pub. L. 105-33, § 4407, 111 Stat. 251, 401 (1997), further revised 42 U.S.C. § 1395ww(d)(5)(I) and added § 1395ww(d)(5)(J).

[68] *See* 60 Fed. Reg. 45778, 45854 (Sept. 1, 1995) ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional payments for transfer cases of $159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.").

[69] 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).

[70] U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

In addition to this general consideration, *the FY 1985 adjusted average standardized amounts* (***Federal rates***) *were required by law* ***to be adjusted to achieve budget neutrality***; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more* ***nor*** *less than* we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years*.

Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were ***higher*** *than necessary to achieve budget neutrality*. Therefore, *we have updated the FY 1985 standardized amounts using a factor that takes into account the* ***overstatement*** *of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts*. To this end, we have identified several factors, ***discussed in section II.A.3.c.***, below, that contributed to the overstatement of the FY 1985 standardized amounts. *We have determined an appropriate percent value for each of them, and have combined them into* ***a proposed composite correction factor*** *for FY 1986 that equals –7.5 percent*.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. **We have combined these values into a composite policy target adjustment factor**, **as discussed in section III.3.e., below**. For FY 1986, this factor equals —1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." *Establishing FY 1986 prospective payment rates based on FY 1985 rates* ***that have been demonstrated to be overstated****, clearly would not comport with the statutory requirement that the rates represent payment for efficiently delivered care*.

Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes is +.31 percent, it is clear that there is a potential justification of a –4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:

	Percent
Forecasted market basket increase..	+4.27
Part B costs and FICA taxes.....	+.31
Composite correction factor.....	–7.5
Composite policy target adjustment factor.....	–1.5

However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.[71]

****

(3) *Additional causes for the overstatement of FY 1985 Federal rates.* In addition to the factors above, which we believe we must correct, **other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts**.

When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for 1985. After application of the revised market basket, discussed previously, use of these actuarial estimates would reduce the standardized amounts by an additional 1.2 percent.

[71] 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates. The hospital specific rates were set using later (1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. **Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount**. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals" total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.

We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided <u>at this time not</u> to correct the standardized amounts for these factors.**

We received no comments on this issue.

> (4) ***Composite Correction Factor.*** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:
>
> | | *Percent* |
> |---|---|
> | Case mix..... ..... | –6.3 |
> | Market basket..... | –1.2 |
> | Composite correction factor..... | –7.5[72] |

Congress did immediately act on the Secretary's September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 ("EEA-85") to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates (*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).[73] Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

> - Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
>
> - Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
>
> - Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
>
> - Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.[74]

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.[75] As previously discussed above in the decision at Section B.3, in the final rule published on May 6, 1986, the Secretary confirmed that "*the adjusted standardized amounts that were published in the September 3,1985 final rule* (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986"[76] and these FFY 1986 adjusted standardized rates are based on the FFY 1985 budget neutrality-adjusted rates.

---

[72] *Id.* at 35703-04 (bold and underline emphasis added).
[73] Pub. L. 99-107, § 5(a), 99 Stat. 479, 479 (1985). In July 1984, Congress had *already* reduced the 1 percent update factor planned for FFY 1986 to ¼ of a percentage point. Deficit Reduction Act of 1984, Pub. L. 98-369, § 2310(a), 98 Stat. 494, 1075 (1984). As part of the Emergency Extension Act of 1985, Congress further reduced the update factor for FFY 1986, presumably in response to the Secretary's recommendation.
[74] 51 Fed. Reg. 16772, 16772 (May 6, 1986).
[75] *See id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).
[76] 51 Fed. Reg. at 16773.

The examples highlight concerns about how certain future actions and decisions by the Secretary and Congress build upon prior decisions. Here, the Secretary's recommendation to Congress regard the FFY 1986 update factor were based on its analysis of the FFY 1984 and 1985 standardized amounts that had already been adjusted for budget neutrality. To the extent the 1984 standardized amounts had been *further* adjusted (*as **now** proposed by the Providers*), it could have potentially impacted the Secretary's recommendation to Congress for the FFY 1986 update factor as well as Congress' subsequent revisions to the updated factor. Accordingly, this highlights how revisiting and otherwise adjusting the FY 1984 standardized amounts can have ripple effects with the update factor and other adjustments that were made for subsequent years *based on analysis of the prior year(s) and other information*.

APPENDIX C

In its decision, the Board has noted that the Secretary confirmed in the preamble of the FFY 1986 IPPS Final Rule that the FFY budget neutrality-adjusted rates were used in determining the rates for FFY 1986 and would similarly be part of subsequent FFYs rates. The following excerpts from the preambles to IPPS final rules provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates were part of the rate for later FFYs and illustrate how embedded the FFY 1985 budget neutrality-adjusted rates are in the rates used for FFY 1986 and subsequent years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 budget neutrality adjustment*, it is clear that the Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and that the FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

1. In the preamble to the FFY 1986 IPPS Final Rule, the Secretary recognizes that the FFY 1985 budget neutrality adjustment accounted for the removal of nonphysician anesthetist costs from the base rates and no further adjustments were needed relative to those costs since the FFY 1985 budget neutrality-adjusted rates were used in determining the FY 1986 rates and would similarly be used for the 1987 rates:

> c. *Nonphysician anesthetist costs*. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987. We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, **because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts.** (See 49 FR 34794; August 31, 1984). **Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment**. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.[77]

[77] 50 Fed. Reg. at 35708 (Italics emphasis in original and bold and underline emphasis added). In this regard, the Board notes that the FFY 1985 IPPS Final Rule explained how the FFY 1985 budget neutrality adjustment accounted for Anesthetists services:

> *Anesthetists' Services*. Under section 2312 of Pub. L. 98-369, the costs to the hospital of the services of nonphysician anesthetists will be reimbursed in full by Medicare on a reasonable cost basis. In order to ensure that these services will be paid for only once, we must remove their costs from the prospective payment rates.

2. In the preamble to the FFY 1987 IPPS Final Rule, the Secretary explains how her budget neutrality adjustments for FFYs 1984 and 1985 had "already built case-mix increases into the cost-per case assumptions used in deriving the budget neutral prospective rates for FY 1984 and FY 1985" and confirms that "FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year)":

> *Comment*: Several commenters stated that we did not consider real case mix increases in the 1983 to 1984 period, and that we finally are considering real case mix increases for the first time.
>
> *Response*: FY 1984 and FY 1985 were years subject to the requirements for budget neutrality. As required under section 1886(e)(1) of the Act, payments under the prospective payment system were to be equal to what would have been paid under rate-of-increase and peer group limits on reasonable costs under prior law (section 1886(b) of the Act) as if the prospective payment system had never been implemented. Under the rate-of-increase limits and peer group limits, as long as a hospital's cost was lower than that hospital's limits, we paid that cost, regardless of whether real case mix increased or decreased, and regardless of the effect of actual case mix on the cost level for that hospital. . . . Increases in real case mix were built into the cost per case increase assumptions we used to model the rate-of-increase limits. These assumptions took into account estimates of the impact of the rate-of-increase limits and the peer group limits. **Consequently, we considered increases in real case mix in FYs 1984 and 1985.** Moreover, even these assumed increases in cost per case proved to be overstated as we received more recent data against which to evaluate our estimates. To have passed through updated prospective payment case-mix increases for FY 1984 and FY 1985 would have been improper because they would increase program payments over the level that would have been paid under the section 1886(b) limits. **As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.**

For cost reporting periods beginning in FY 1985, we have reduced the adjusted standardized amounts to reflect the removal of these costs **by means of the budget neutrality adjustment methodology**. Our method for doing this is explained in section V.D. of this Addendum. We estimate that FY 1985 payments for anesthetists' services will be about $160 million, or 0.5 percent of Medicare operating costs for hospital accounting years beginning in FY 1985.

> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. **Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year).**

3. In the preamble to the FFY 1988 IPPS Final Rule, the Secretary again recognizes the prior FFY 1985 budget neutrality adjustments to the standardized amounts had already taken into account the removal of nonphysician anesthetist costs and the *FFY 1985 budget neutrality-adjusted rates* ***were reflected in the FFY 1986, 1987, and 1988 rates.***

> c. *Nonphysician Anesthetist Costs*. Section 1886(d)(5)(E) of the Act provides that hospital costs for the services of nonphysician anesthetists are paid in full as a reasonable cost pass-through. Under section 2312(c) of Pub. L. 98-369, this pass-through was made effective for cost reporting periods beginning on or after October 1,1984, and before October 1,1987. Section 9320(a) of Pub. L. 99-509 extended the period of applicability of this pass-through so that services will continue to be paid under reasonable cost for any cost reporting periods (or parts of cost reporting periods) ending before January 1,1989 and struck subsection (E) effective on that date.
>
> In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, it was incorporated in the overall **budget neutrality** adjustment (50 FR 35708). Therefore, **because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived**, we did not propose to make further adjustments to the average standardized amounts for FY 1988.[78]

[78] 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Blvd., Ste. 700
Los Angeles, CA 90064-1582

RE: ***Notice of Dismissal***
Blumberg Ribner Treatment of Part C Days Final Rule Appeals
Case Nos. 24-0341 *et al.* (*see* Appendix A listing 11 cases)

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the eleven (11) above-referenced individual provider and group appeals represented by Blumberg, Ribner, Inc. ("Blumberg Ribner"). Set forth below is the decision of the Board to dismiss these appeals challenging the Treatment of Part C Days from the Final Rule published on June 9, 2023.

Background

Blumberg Ribner represents a number of Providers which are challenging the Treatment of Part C Days as appealed from the final rule that the Secretary of Health and Human Services ("Secretary") published in the June 9, 2023 Federal Register ("June 2023 Final Rule"). On December 4, 2023, Blumberg Ribner filed eleven (11) appeal requests on behalf of the Providers concerning June 2023 Final Rule as it relates to the Providers' FY 2004-2013 Medicare disproportionate share hospital ("DSH") reimbursement.[1] *Significantly, the Providers' attached to their respective appeal request a copy of the June 2023 Final Rule and identified that document as the "Final Determination Document" being appealed.*

The Providers in the individual and group appeals all involve fiscal years ranging from 2004 to 2013. The ***sole*** issue in each of these appeals is "whether the Retroactive Rule, which pertains to the calculation of Disproportionate Share payments from Medicare to hospitals who serve a disproportionate number of low-income patients, is invalid and void because it impermissibly provides for 'retroactive' change in CMS's policy to include Medicare Part C patient days, (also known as 'Medicare Advantage') in the Medicare/SSI Fraction Denominator for fiscal years prior to 2014."[2]

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] Issue Statement at 1 in Case No. 24-0341. Each of the Issue Statements in the 11 Blumberg Ribner appeals referenced in this decision are materially identical.

In the June 2023 Final Rule, the Secretary adopted and finalized its policy to include Part C days in the SSI fraction as used in the DSH calculation for Part C discharges occurring prior to October 1, 2013. The Blumberg Ribner-represented Providers challenge this policy, as well as the procedural and substantive validity of the rule.[3]

Issue in Dispute

Blumberg Ribner represents the Providers in the eleven (11) cases filed on December 4, 2023. Each case has the same issue statement, which reads in part:

> **This is an appeal to challenge and invalidate the Final Rule** that the Secretary of Health and Human Services ("Secretary") **published June 9, 2023**, 88 Fed. Reg. 37772 (June 9, 2023) ("Retroactive Rule"), **and to challenge and invalidate the SSI Ratio published on or about October 16, 2023** ("CMS 1739F SSI Ratio").
>
> **The main issue is whether the Retroactive Rule**, which pertains to the calculation of Disproportionate Share payments from Medicare to hospitals who serve a disproportionate number of low-income patients, **is invalid and void** because it impermissibly provides for "retroactive" change in CMS's policy to include Medicare Part C patient days, (also known as "Medicare Advantage") in the Medicare/SSI Fraction Denominator for fiscal years prior to 2014. **Because the Retroactive Rule is the basis of the calculations underlying the CMS 1739F SSI Ratio, the CMS 1739F SSI Ratio must also fail for all of the following reasons**.
>
> The Secretary has long had a policy of NOT including Medicare Part C Days in the denominator of the Medicare/SSI Fraction, which has been held in legal cases to be a policy that could not be changed until after official rulemaking and a final rule. Change prior to the effective date of a new rule is not legally permissible, especially under legal case precedent and for other reasons including those referenced below. The Secretary's policy in this regard was articulated, as late as 2004, when the Secretary admitted:
>
> > 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

[3] 88 Fed. Reg. 37772 (June 9, 2023).

> 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. (68 Fed. Reg. 27154, 27208 (May 19, 2023).

The new retroactive rule is improper under the law and violates the rulings in all the court cases that have been decided up to this point on this issue. Inclusion of Medicare Part C patient days in the Medicare Fraction Denominator was held to be impermissible for fiscal years prior to 2014 in Allina I, Northeast Hospital, and Allina II, all of which held that the prior policy and practice of the Secretary – which was NOT to include Medicare Part C days in the denominator of the Medicare/SSI Fraction – could not be changed before proper rulemaking and the effective date of a Final Rule. The Retroactive Rule is contrary to the principals and practices of the Medicare agency for many years and cannot be changed by making a new rule "retroactive" for years when there was a different established practice in place.

****

Retroactivity of the new rule exceeds the agency's rulemaking authority under the Medicare statute. The span of many years of retroactivity encompassed in the Retroactive Rule is per se unreasonable, arbitrary, capricious, and contrary to the spirit and policy of the rulemaking authority under the Administrative Procedure Act which governs Medicare.

****

Administration of these claims, as required by Allina I, Northeast Hospital, and Allina II, has been long and unreasonably delayed since 2010. . . .

If it continues to be the Secretary's position that, unless and until CMS issues new or revised Notice of Program Reimbursement ("RNPR's") for all the claims that have been previously remanded to await this new rule, appellants have no right to object or seek remedy from the courts. Under this argument, the Secretary controls when or even if these particular claimants can pursue administrative remedies. This is violative of the APA, and sound legal principles including due process rights.

> **Also the RNPRs are being unreasonably delayed**. While the Retroactive Rule indicates that instructions will be provided to the Medicare Administrative Contractors ("MAC") for publishing such RNPRs, none have been forthcoming even though the Retroactive Rule was published June 9, 2023. **CMS has given no explanation for the delay in publishing the instructions to the MAC for publishing of such RNPRs**.
>
> The Retroactive Rule is an appealable final determination under 42 USC Section 1395oo(a)(1)(A)(ii), bc [*sic* because] there are NO other variables in calculating the DSH payment missing from the Final Rule. Especially because the Final Rule expressly states that the Part C Days have been correctly shown in the Medicare Fraction Denominator for the determination of DSH payments to the providers for fiscal years 2005-2013, there are no other determinations or variables on which the Provider's ultimate DSH payment depends if the Final Rule is implemented. The Final Rule IS an appealable final determination "as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title" (as set forth in 42 U.S.C. § 1395oo(a)(1)(A)(ii)) or as to "the total amount of reimbursement due the provider" (as set forth in 42 C.F.R. § 405.1835(a)). "The D.C. Circuit has held that any administrative action that provides a "hospital] [with] advance knowledge of the amount of payment it will receive" is a "final determination." *See Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 141 (D.C. Cir. 1986); *Cape Cod Hospital v. Sebelius*, 630 F.3d 203 (2011) (holding that an agency may appeal to the PRRB from issuance of the Final Inpatient Prospective Payment System Rule). In other words, section 1395oo permits providers to prospectively appeal what they will, in the future, receive as a result of services provided to eligible patients. *Bowen*, 795 F.2d at 145. Subsection 1395oo(a)(1)(A)(ii) also "eliminates the requirement that [a provider] file a cost report prior to appeal." *Id*. [Cited in *Battle Creek Health System v Becerra*, U.S.D.C. District of Columbia, Civil Action No. 17-0545 (CKK) Memorandum Opinion dated October 31, 2023.] [4]

Based on the following rationale, the Providers contend that the Board has jurisdiction over these appeals:

> For each specific matter and question included in the request, the Board has jurisdiction under 42 CFR §405.1840 over each matter at issue, all as stated in the accompanying appeal. The Retroactive Rule

[4] Issue Statement at 1 in Case No. 24-0341 (emphasis in original except bold & underline emphasis added; footnotes omitted). Each of the Issue Statements in the 11 Blumberg Ribner appeals referenced in this decision are identical.

> is an appealable final determination under 42 USC Section 1395oo(a)(1)(A)(ii), bc there are NO other variables in calculating the DSH payment missing from the Final Rule. Especially because the Final Rule expressly states that the Part C Days have been correctly shown in the Medicare Fraction Denominator for the determination of DSH payments to the providers, there are no other determinations or variables on which the Provider's ultimate DSH payment depends if the Final Rule is implemented. The Final Rule IS an appealable final determination "as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title" (as set forth in 42 U.S.C. § 1395oo(a)(1)(A)(ii)) or as to "the total amount of reimbursement due the provider" (as set forth in 42 C.F.R. § 405.1835(a)).
>
> For each of the hospital years represented in the appeal,
>
> 1. *the cost report remains open* and not yet finally settled ***due to an appeal previously filed (<u>and remanded</u>)***, which included the Part C Days issue, or a Notice of Reopening.
>
> 2. that reimbursement on each such open cost report would not change based on the Part C Days issue if the Retroactive Rule were implemented but WOULD change by more than $10,000 if the Retroactive Rule were invalidated and reimbursement re-calculated in accordance with Allina I and Allina II, as asserted in the previously remanded appeals[5]

<u>Statutory and Regulatory Background</u>

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[6] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[7]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[8] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[9]

---

[5] *Id.* (emphasis added).
[6] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[7] *Id.*
[8] *See* 42 U.S.C. § 1395ww(d)(5).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[10] 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.[11] The DPP is defined as the sum of two fractions expressed as percentages.[12] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State 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 . . . .[13]

The Medicare/SSI fraction is computed annually by the Centers for Medicare and Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[14]

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.[15]

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.[16]

---

[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[12] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(2)-(3).
[15] (Emphasis added.)
[16] 42 C.F.R. § 412.106(b)(4).

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

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

In the September 4, 1990, Federal Register, the Secretary[17] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[18]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[19]

With the creation of Medicare Part C in 1997,[20] 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

---

[17] of Health and Human Services.
[18] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[19] *Id.*
[20] 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.

days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal years 2001-2004.[21]

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 . . . .*[22]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[23] 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.*[24]

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

---

[21] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).
[22] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[23] 69 Fed. Reg. at 49099.
[24] *Id.* (emphasis added).

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.[25] 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).[26] 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."[27]

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.[28]
In 2014, the U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[29] 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.[30] 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.[31] 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.[32] 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

---

[25] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[26] *Id*. at 47411.
[27] 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).
[28] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[29] 746 F. 3d 1102 (D.C. Cir. 2014).
[30] *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.").
[31] *Id.* at 2011.
[32] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).

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

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

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[39]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[40] 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

[33] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[34] 139 S.Ct. 1804 (2019).
[35] *Id.* at 1817.
[36] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[37] 139 S.Ct at 1814.
[38] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[39] CMS Ruling 1739-R at 1-2.
[40] 88 Fed. Reg. 37772 (June 9, 2023).

> DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals whose DSH payments ***for those periods are still open or have not yet been finally settled***, encompassing thousands of cost reports.[41]

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

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

Decision of the Board

As set forth below, the Board hereby ***dismisses*** the Providers' appeals because they failed to appeal from a final determination and their appeals are premature to the extent their ***unsupported*** *contention*[43] in the issue statement that "the cost report remains open and not yet finally settled due to an appeal previously filed (and remanded), which included the Part C Days issue, or a Notice of Reopening" is, in fact, true. Further, their appeal requests failed to meet the content requirements for a request for hearing as an individual or group appeal.

A. The Part C Policy finalized in the June 2023 Final Rule Is Not an Appealable "Final Determination" under 42 U.S.C. § 1395oo(a)(1)(A)(ii).

In their appeal requests, the Providers allege (without providing any proof[44]) that "the[ir respective] cost report remains open and not yet finally settled due to an appeal previously filed

---

[41] *Id.* at 37775 (emphasis added).
[42] 88 Fed. Reg. at 37788 (emphasis in original).
[43] *See infra* note 44.
[44] As discussed *infra*, it is a provider's responsibility to include all relevant documentation with its appeal request consistent with: (a) 42 C.F.R. § 405.1835(b)(3) for individual provider appeals which specifies that the appeal request must include "any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section"; and (b) 42 C.F.R. § 405.1837(c)(3) for group appeals which similarly states that the appeal request must include ".any other documentary evidence the providers consider

(and remanded), which included the Part C Days issue, or a Notice of Reopening." The Providers essentially state that they have grown impatient waiting on the issuance of an RNPR upon remand. Notwithstanding the fact that these *other* alleged appeals are still *pending* and involve the *same* issue and fiscal years, the Providers filed appeal requests to establish the instant 11 appeals set forth in **Appendix A** based on their appeal of the finalization of the policy at issue in the June 2023 Final Rule. In filing these group appeals, the Providers identified the June 2023 Final Rule as the "final determination" being appealed and, to that end, attached a copy of that final rule as the "Final Determination Document." As this is a final rule (as opposed an NPR or revised NPR), they appear to be asserting that their right to appeal is based on 42 U.S.C. § 1395oo(a)(1)(A)(ii). In this regard, § 1395oo(a) the following in pertinent part:

> **(a) Establishment**
>
> . . . *[A]ny hospital* which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title *and which has submitted such [cost] reports within such time as the Secretary may require in order to make payment under such section* may obtain a hearing with respect to such payment by the Board, if—
>
> (1) such provider—
>
> (A) . . .
>
> (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, ...[45]

However, the Board finds that the adoption/finalization of this policy in the June 2023 Final Rule is not a "final determination" directly appealable to the Board *for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii)*. Rather, the providers' appeals are premature as described below.

Unlike DRG rates and other adjustments such as the wage index, 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*.[46] To this end, DSH eligibility ***and*** payment, if any, is determined, calculated,

---

to satisfy the hearing request requirements of paragraphs (c)(1) and (c)(2) of this section" To the end, Board Rule 35.3 states: "The Board will ***not*** be responsible for supplementing any record with evidence from a previous hearing. *All evidence submitted into the record,* ***must be done by the parties***." (Emphasis added.)

[45] (Bold emphasis in original and italics and underline emphasis added.)

[46] 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

and finalized *annually* through the cost report audit/settlement process as made clear in 42 C.F.R. § 412.106(i) which sets forth the following instructions regarding the determination of a hospital's eligibility for a DSH payment for each fiscal year and, if so, how much:

> (i) *Manner and timing of [DSH] payments*. (1) **Interim** [DSH] **payments** are made **during the payment year to each hospital that is estimated to be eligible** for payments under this section at the time of the annual final rule for the hospital inpatient prospective payment system, **subject to the final determination of eligibility at the time of cost report settlement for each hospital**.
>
> (2) **Final payment determinations are made at the time of cost report settlement**, based on the **final** determination of each hospital's eligibility for payment under this section.[47]

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***."[48] Examples of other adjustments to IPPS payment rates that are based, in whole

---

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.

[47] (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)).

[48] 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.
>
> *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.
>
> ****
>
> **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**

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,[49] direct graduate medical education ("GME"),[50] and indirect GME.[51]

Here, none of the Providers' appeal requests included a copy of the NPR or revised NPR (with associated audit adjustment pages) for the year at issue that would underlie the alleged pending remand to the MACs. As a result, it is unclear whether that those NPRs/revised NPRs addressed consistent with 42 C.F.R. § 412.106(i) both: (1) whether each of these Providers is eligible for a DSH payment *for the relevant year at issue*; and (2) if so, how much.[52] Further, as discussed *infra*, each of these Providers have alleged that it has pending before the MAC another appeal of the same Part C days issue; however, it is unclear why the Providers were remanded as alleged (*e.g.*, remanded pursuant to a Court Order vs. remanded pursuant to CMS Ruling 1498-R) and what the parameters of those remands is.

Regardless, the four corners of the June 2023 Final Rule confirms that the Providers appeals are premature because the June 2023 Final Rule confirms both that: (1) it is ***not*** a final determination

---

> **settlement.** As we discuss in greater detail in section V.E.3.f. of the preamble to this final rule, we will make interim eligibility determinations based on data from the most recently available SSI ratios and Medicaid fractions prior to the beginning of the payment year. We will then make final determinations of eligibility at the time of settlement of each hospital's cost report. Therefore, we proposed that, at cost report settlement, the fiscal intermediary/MAC will issue a notice of program reimbursement that includes a determination concerning whether each hospital is eligible for empirically justified Medicare DSH payments and, therefore, eligible for uncompensated care payments in FY 2014 and each subsequent year. In the case where a hospital received interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year on the basis of estimates prior to the payment year, but is determined to be ineligible for the empirically justified Medicare DSH payment at cost report settlement, the hospital would no longer be eligible for either payment and CMS would recoup those monies. For a hospital that did not receive interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year, but at cost report settlement is determined to be eligible for DSH payments, the uncompensated care payment for such a hospital is calculated based on the Factor 3 value determined prospectively for that fiscal year.

Id. at 50626-27 (emphasis added).

[49] 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.).

[50] 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.").

[51] 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)).

[52] In this regard, a provider that did not qualify in its NPR for a DSH payment adjustment for a particular fiscal year may appeal that finding by challenging multiple components of the DSH adjustment calculation which, if successful, could result in the provider qualifying for a DSH adjustment for that year. Further, the fact that a hospital has received a DSH payment in a ***prior*** fiscal year, does not mean or guarantee that the hospital will (or continue to) be eligible for and receive a DSH payment in a subsequent fiscal year. For each fiscal year, the Medicare contractor determines whether a hospital is eligible for a DSH payment and, if so, how much based on multiple variables associated with that fiscal year (*e.g.*, the number of Medicaid eligible days in the relevant fiscal year).

appealable to the Board; *and* (2) the Secretary did ***not*** otherwise intend for it to be a final determination appealable to the Board. The June 2023 Final Rule simply finalizes the adoption of the Part C days policy at issue for open and prospective cost reporting periods relating to discharges occurring prior to October 1, 2013. It does not make any determination on *any* hospital's DSH eligibility (much less these Providers') and, if so, how much. Moreover, it does not publish *any* hospital's SSI percentage (much less these Providers for the relevant years at issue) that would be used in DSH calculations for those hospitals whose eligibility would later be determined as part of their cost report settlement process for the relevant fiscal years. Further, the following excerpts from the June 2023 Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule to be an appealable "final determination":

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports***. *In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[53]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[54]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new

[53] 88 Fed. Reg. at 37774-75 (emphasis added).
[54] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).

final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised **NPRs** will provide hospitals with a **vehicle to appeal** the new final action* even if the Medicare fraction or DSH payment does not change numerically."[55]

4. "*When the Secretary's treatment of Part C days in this final action is reflected **in NPRs and revised NPRs**, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation **by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[56]

The above discussion in the preamble to the June 2023 Final Rule makes clear that hospitals would be *not* able to ***directly*** appeal from Final Rule since the finalized policy is not applied in the Final Rule to any specific hospitals and the preamble's discussion of a hospital's right to challenge that finalized policy is only in the context of the yet-to-be issued NPRs (original or revised) that: (1) would be issued *following publication of the new SSI percentages*; and (20 would both apply the finalized policy and would be sued to determine DSH eligibility for a hospital's prior pre-October 1, 2013 cost reporting period that is still open for resolution (whether through issuance of an original or revised NPR[57]) and, if so, the amount of the DSH payment. Here, if the June 2023 Final Rule will be applied to them for the fiscal years at issue, then it is clear that Providers' appeals are premature as they will have an opportunity to later file an appeal to challenge the policy at issue once their respective fiscal year NPRs/revised NPRs are issued *consistent with the above excerpts from the preamble to the June 2023 Final Rule and 42 C.F.R. § 412.106(i)*.

The Board recognizes that the Part C issue has a long litigation history and the most recent is referred to as the *Allina II* litigation.[58] However, the *Allina II* litigation has no relevance to the ***jurisdictional*** issue that the Board is addressing in the instant case because that litigation did *not* address the Board's *jurisdiction* over the underlying appeals of the nine (9) Plaintiff hospitals in *Allina II* (*i.e.*, it does not address whether the publication of the SSI ratios was a "final determination" *for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii)*).[59]

---

[55] *Id.* at 37788 (emphasis added).
[56] *Id.* (emphasis added).
[57] Just because a hospital was eligible for a DSH payment in the original NPR, does not mean that the hospital would *continue* to be eligible for a DSH payment following the issuance of a revised NPR pursuant to the June 9, 2023 Final Rule. Similarly, the converse may be true. As such, a hospital eligibility status may change following the issuance of a revised NPR pursuant to the June 9, 2023 Final Rule. Moreover, there could be other DSH variables at play in the NPR/revised NPR such as consideration of Medicaid eligible days (removal or addition of such days) depending on what other issues may remain open in the relevant fiscal year.
[58] *Allina II* began as *Allina Health Servs. v. Burwell*, No. 14-01415, (D.D.C. Aug. 19, 2014) resulting in *Allina Health Servs. v. Burwell*, 201 F. Supp. 3d 94 (D.D.C. 2016), *reversed Allina Health Servs. v. Price*, 863 F.3d 937 (D.C. Cir. 2017), *aff'd sub nom. Azar v. Allina Health Servs.*, 139 S. Ct. 1804 (2019) ("*Allina II*").
[59] Rather, *Allina II* addresses the Board's "no-authority determination" when it granted EJR for the *Alliana II* providers. This is not a *jurisdictional* issue under 42 U.S.C. § 1395oo(a)(1), but rather an issue relating to whether the Board appropriately granted EJR pursuant to 42 U.S.C. § 1395oo(f)(1). Further, the Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their

Similarly, the Board declines to follow D.C. District Court's decision in *Battle Creek*[60] and instead continues to find the D.C. District Court's 2022 decision in *Memorial Hospital* to be instructive. *Memorial Hospital* concerns another variable used in the DSH adjustment calculation. Specifically, the providers in that case appealed ***the publication of their DSH SSI ratios*** (which is one step *after* the cases at hand where Providers are appealing the final rule adopting/finalizing a policy ***prior to*** the publication of the DSH SSI ratios reflecting that Final Rule[61]). 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 this case because "the secretarial determination at issue was either the only determination on which payment depended or clearly promulgated as a final rule."[62] 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,"* it 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*."[63] The D.C. District Court concluded:

---

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)).

[60] 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 cases at hand. *Battle Creek* addressed whether the publication of SSI fractions is a final determination. In contrast, the Providers did not ***expressly*** appeal the publication of SSI fractions (no copy of that publication was included with the appeal request, *see infra* notes 61 and 76), but rather a final rule adopting and finalizing the policy at issue ***prior to*** the issuance of new SSI fractions to be used in the yet-to-be issued NPRs/revised NPRs for the hospital covered by the terms of that final rule. To this end, in finalizing that policy adoption in the June 2023 Final Rule, the Secretary announced that "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*** . . . ." 88 Fed. Reg. at 37774 (emphasis added).

[61] The Providers' appeal requests are clear that they were filed to appeal from the June 2023 Final Rule, as opposed to appeal from any publication of SSI fractions. Indeed, it is not clear from the record before the Board whether any new SSI percentages for these Providers *for the specific fiscal years appealed* have been in fact issued *pursuant to the implementation of the June 2023 Final Rule as set forth therein* (no copy of the alleged publication has been included). To this end, the Board notes that 42 C.F.R. § 405.1837(c)(3) requires an appeal request to include a copy of the final determination being appealed, but none of the appeal request include a copy of the publication of any SSI fractions. *See infra* note 60 and *supra* note 76.

[62] 2022 WL 888190 at *8.

[63] *Id.* at *9 (emphasis added).

> 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).").[64]

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.[65]

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 . . . .";[66] and (b) "The amount is the per-patient amount calculated under § 1395ww(d) and is final once the Secretary has published the DRG amounts (as 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."[67]

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 June 2023 Final Rule, it is ***not*** a "final determination" as to the amount of payment received by Providers for their various fiscal years at issue. Rather, the June 2023 Final Rule 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"[68] 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)*.[69] In this regard, the Board again notes that the June 2023 Final Rule did not make a determination on any specific hospital's DSH eligibility

---

[64] *Id.* at *8.
[65] *Id.* at *9.
[66] 795 F.2d at 143 (emphasis added).
[67] *Id.* at 147 (footnote omitted).
[68] 42 C.F.R. § 412.106(i)(2) (emphasis added).
[69] 2022 WL 888190 at *9 (emphasis added).

and, if so, the amount of DSH payment. Rather, as it relates to this appeal, the Final Rule adopts a policy that is to be applied *retroactively* but only to certain hospitals and makes clear that, *following the publication of new SSI percentages*, those affected hospitals who had open cost reporting periods for this issue would be issued an NPR (original or revised) that both would apply the finalized policy and would determine: (a) DSH eligibility for a hospital's prior period that is still open for resolution (whether through issuance of an original or revised NPR); and (b) if so, the amount of the DSH payment.[70]

In summary, the Board finds that the June 2023 Final Rule appealed in the instant case is not an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835(a) and the appeal (as alleged) appears premature.[71] Accordingly, the Board finds it is appropriate dismiss the instant appeal and remove it from the Board's docket, since satisfying the criteria set out in 42 C.F.R. § 405.1835(a) is required (as explained in 42 C.F.R. §§ 405.1837(a)(1) and 405.1837(c)(1)) before the Board can exercise jurisdiction over an appeal,[72] and since the Providers have failed to demonstrate in its hearing request that those criteria have been met for the fiscal years under appeal.[73]

B. Even if the June 9, 2023 Final Rule Could Be Appealed as a "Final Determination" Under 42 U.S.C. § 1395oo(a)(1)(A)(ii), the Providers' Appeal Requests Failed to Meet the Minimum Content Requirements For an Appeal Request to Demonstrate that the Final Rule Was Applicable to Them For the Fiscal Years at Issue.

For group appeals, 42 C.F.R. § 405.1837(c) specifies the content requirements for a request for a Board hearing as a group appeal. Similar requirements are located at 42 C.F.R. § 405.1835(b) for individual provider appeals. The Providers allege that the issue in these appeals "is pending in an appeal that was remanded to the MAC." Notwithstanding, they have not provided any explanation in their appeal requests of why the Board has jurisdiction over their appeal and *none has included* ***any*** *information on the other "pending . . . appeal that was remanded to the MAC"* ***they allege*** *in their group appeal requests*. In this regard, the Board notes that it is the Providers' responsibility under 42 C.F.R. §§ 405.1837(c)(3) and 405.1835(b)(3) and Board Rules to include the necessary documentation in the appeal request to demonstrate the Board's jurisdiction over the appeals.

42 C.F.R. § 405.1837(a)(1) makes clear that a provider's right to a Board hearing as part of group appeal is dependent on "[t]he provider satisfy[ng] individually the requirements for a Board hearing under § 405.1835(a) or § 405.1835(c), except for the $10,000 amount in controversy

---

[70] *See supra* notes 60 and 61 (confirming that none of the Providers appealed from the publication of SSI fractions nor did they have a basis to do so); supra note 61 and *infra* note 76 (confirming that, even if they had and could do so, the appeal requests would still be dismissed as fatally flawed).

[71] The Board's dismissal does not mean that the Secretary's policy finalized in the June 2023 Final Rule cannot be appealed. As noted *supra* in the preamble to the June 2023 Final Rule, providers may appeal NPRs or revised NPRs that are subsequently issued and reflect this policy *as it relates to prior periods held open for this issue*. This may encompass the Providers depending on the nature and status of the alleged remand(s) referenced by the Providers and the issuance of revised NPRs as appropriate and consistent with the terms of that remand.

[72] 42 C.F.R. § 405.1840(a), (b).

[73] 42 C.F.R. § 405.1837(c).

requirement." One of the requirements in § 405.1835(a) is that the provider is appealing "a final contractor or Secretary determination." The same requirements are stated for individual provider appeals at 42 C.F.R. §§ 405.1835(a)(1).

The content requirements for a group appeal request are located at 42 C.F.R. § 405.1837(c) and specify that the appeal request must "demonstrate[e] that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section" and that, in addition to the "final contractor or Secretary determination under appeal", must include "any other documentary evidence the providers consider to satisfy the hearing request requirements of paragraphs (c)(1) . . . of this section." The same "content" requirement applies to appeal request for individual appeals at 42 C.F.R. § 405.1835(b).

Here, none of the Providers include as part of their appeal requests any documentation relating to the implied *prior* appeals and related remand, notwithstanding: (1) their responsibilities under 42 C.F.R. §§ 405.1837(c) and 405.1835(b), and (2) the fact that Board Rule 35.3 specifies that evidence must be submitted into the record by a party including evidence from another Board case:

> The Board will ***not*** be responsible for supplementing any record with evidence *from a previous hearing*. All evidence submitted into the record, ***must*** be done by the parties.[74]

Without having the NPR or any additional documentation on the Providers' alleged remand as it relates to the fiscal years at issue, the Board cannot confirm that the June 2023 Final Rule is, in fact, applicable to the Provider's for the fiscal years at issue (*i.e*., that the fiscal years appealed by the Providers remain open and are eligible for resolution of the Part C days issue raised in the this appeal through the operation of the June 2023 Final Rule). Indeed, if the Providers' alleged remand(s) for the fiscal years at issue is still pending before MAC, then the Remand Order itself (whether from a Court, the Administrator, or the Board) is relevant since it might otherwise preclude Board consideration of these appeals.[75] In this regard, the Board is unable determine whether each of the Providers even qualified for a DSH payment during the fiscal years at issue since the record does not include a copy of the relevant NPR/revised NPR with the relevant audit adjustment pages alleged to have been issued to the Providers for the relevant fiscal years. Accordingly, the Board finds that the Providers' group appeal requests are *fatally* flawed because, even if the June 2023 Final Rule were an appealable "final determination" under 42 U.S.C. § 1395oo(a)(1)(A)(ii), it is unclear whether that Final Rule is, in fact, applicable *to the fiscal years appealed by the Provider* given their failure to comply with the content requirements of 42 C.F.R. § 405.1837(c) requiring its appeal request demonstrate that each of the Providers satisfies the requirements for Board hearing and that the "final determination" being appealed, *in fact*, involves

[74] (Emphasis added.)
[75] *See also* CMS Ruling 1739-R; Board Rule 4.6 (entitled "No Duplicate Filings" and specifying in 4.6.2 that "Appeals of the same issue from distinct determinations covering the same time period must be pursued in a single appeal").

a payment determination ***retroactively*** *applicable to them* under the terms of the Final Rule. This finding serves as an alternative and *independent* basis for the Board's dismissal of these appeals.[76]

C. Conclusion

The Board finds that: (1) the Part C policy issued in the June 2023 Final Rule that the Providers appealed for the fiscal years at issue is not an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835(a); and (2) even if the June 2023 Final Rule could be appealable as a "final determination" under 42 U.S.C. § 1395oo(a)(1)(A)(ii), the Providers' appeal request failed to meet the content requirements under the relevant provisions of 42 C.F.R. §§ 405.1837(c) and 405.1835(b) based on its failure to demonstrate that the June 2023 Final Rule was, in fact, a payment determination *retroactively* applicable to them for the fiscal years at issue consistent with the terms of that Final Rule. Based on the foregoing, the Board hereby dismisses the eleven (11) Blumberg Ribner appeals listed in **Appendix A** in their entirety 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 Participating:

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

For the Board:

2/29/2024

X Clayton J. Nix

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

cc: Lorraine Frewert, Noridian Healthcare Solutions, c/o CGS Administrators (J-E)
Michael Redmond, Novitas Solutions, Inc. (J-H)
Danelle Decker, National Government Services, Inc. (J-K)
Byron Lamprecht, WPS Government Health Administrators (J-5)
Jacqueline Vaughn, OAA
Wilson Leong, FSS

[76] The Board recognizes that the Providers issue statement also seeks to "challenge and invalidate *the SSI Ratio* ***published on or about October 16, 2023*** ("CMS 1739F SSI Ratio")." (Emphasis added.) To the extent the Providers are also attempting to appeal from the alleged publications of SSI Ratios published *on or about October 16, 2023*, the Board would similarly dismiss these appeals because, notwithstanding the requirements in 42 C.F.R. §§ 405.1837(c) and 405.1835(b), the Providers did neither identified it as a final determination being appealed nor did they attach a copy of that publication to their appeal request. Indeed, it is not clear that each of these Providers were included in that alleged publication "on or about October 16, 2023" (much less whether each Provider's relevant fiscal year is even open/pending). Thus, in such instance, the appeal requests would be fatally flawed. *See also supra* notes 60 and 61 (discussing why the Providers are not able to appeal from the publication of the SSI fractions).

APPENDIX A

Listing of 11 Blumberg, Ribner Providers' Appeals

24-0341	Scripps Mercy Hospital (05-0077), FFY 2004
24-0342	Scripps Mercy Hospital (05-0077), FFY 2005
24-0343GC	East Texas Reg. HS CY 2012 East Tex. RHS 2012 Challenge to 1739F CIRP Grp.
24-0344G	Blumberg Ribner CY 2006 BRI Indep Hospitals Challenge to CMS1739F Group
24-0345G	Blumberg Ribner CY 2007 BRI Indep Hospitals Challenge to CMS1739F Group
24-0346G	Blumberg Ribner CY 2008 BRI Indep Hospitals Challenge to CMS1739F Group
24-0347G	Blumberg Ribner CY 2009 BRI Indep Hospitals Challenge to CMS1739F Group
24-0348G	Blumberg Ribner CY 2010 BRI Indep Hospitals Challenge to CMS1739F Group
24-0349G	Blumberg Ribner CY 2011 BRI Indep Hospitals Challenge to CMS1739F Group
24-0350G	Blumberg Ribner CY 2012 BRI Indep Hospitals Challenge to CMS1739F Group
24-0351	East Texas Medical Center Athens (45-0389), FFY 2013