



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

Corinna Goron, President
Healthcare Reimbursement Services, Inc.
3900 American Drive, Suite 202
Plano, TX 75075

RE: ***Board Determination on Reconsideration of Dismissal and Reinstatement of***
Prime Healthcare CY 2020 Texas 1115 Waiver Days CIRP Group
Case Number: 24-2269GC

Dear Ms. Goron:

The Provider Reimbursement Review Board (the “Board”) has reviewed the above-captioned common issue related party (“CIRP”) group appeal in response to correspondence received from Healthcare Reimbursement Services, Inc. (“HRS”/ “Representative”) on July 9, 2026. In that correspondence, the Representative requests that the Board reconsider its July 7, 2026 Notice of Dismissal and grant a reinstatement of the subject appeal. The pertinent facts and the Board’s determination are set forth below.

Pertinent Facts:

On **August 13, 2024**, Healthcare Reimbursement Services, Inc. (“HRS”) filed “Prime Healthcare CY 2020 Texas 1115 Waiver Days CIRP Group” - Case No. 24-2269GC.

On **August 14, 2024**, Board issued an Acknowledgement & Critical Due Dates (“ACDD”). The ACDD clearly stated “[u]pon full formation of the group appeal, the Board will issue a Critical Due Dates Notice to establish deadlines for the submission of jurisdictional comments and the preliminary position papers/proposed joint scheduling order.”¹

On **July 31, 2025**, HRS timely responded to Full Formation Comments indicating that the CIRP group was not yet complete, as it was awaiting the addition of one more Provider.

On **April 23, 2026**, HRS added the last participant to the group and simultaneously designated the group to be fully formed.

On **May 5, 2026**, the Board issued the “Group Completion Notice” which set the deadlines for the Rule 20 Certification/Schedule of Providers (“Rule 20/SoP”), as well as the Parties’ Preliminary position papers. Specifically, the Rule 20/SoP deadline was set for **June 22, 2026**.

¹ Acknowledgement and Critical Due Dates Notice at 2 (Aug. 14, 2024).

On **July 7, 2026**, the Board dismissed Case No. 24-2269GC because the Representative failed to meet the Rule 20/SoP deadline.

On **July 9, 2026**, HRS filed a “Request for Reconsideration” in which it requested the Board reinstate the appeal and included a Rule 20 Certification. HRS indicates that it was “awaiting the Board’s Critical Due Date (CDD)” email so that the document could be uploaded through the Case Action tab, rather than utilizing the “Other” filing function.”² While waiting for the Board’s CDD notice, HRS admits it inadvertently missed the deadline.³ HRS claims that “[t]his is a relatively new procedure that was implemented for new critical due dates issued beginning in December. However, no formal notice, guidance, or instructions regarding this change were provided by the Board.”⁴ HRS indicates it has modified its operational process to prevent further infractions. Consequently, because the missed Rule 20 deadline was inadvertent, non-prejudicial and has since been remedied, HRS requests that the Board reinstate the appeal.⁵

Board Determination:

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

HRS has filed a request for the Board to reconsider its dismissal and reinstate the case. Board Rule 47.1 governs motions for reinstatement of an issue or case:⁶

47.1 Motion for Reinstatement

A provider may request reinstatement of an issue(s) or case within three years from the date of the Board’s decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board’s receipt of the provider’s withdrawal of the issue(s) (*see* 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (*see* Rule 44 governing motions). The Board will **not** reinstate an issue(s)/case if the provider was at fault. If an issue(s)/case was remanded pursuant to a CMS ruling (*e.g.*, CMS

² Request for Reconsideration at 1 (July 9, 2026).

³ *Id.*

⁴ *Id.*

⁵ *Id.*

⁶ Rule 47.1 also references Rule 44 governing motions. With respect to the Motion to Reinstate in this case, contrary to Rule 44, HRS’ motion for reinstatement is deficient because it failed to include a statement confirming it had contacted the Medicare Contractor prior to filing the motion to see if the Medicare Contractor would concur or oppose the motion.

Ruling 1498-R), the provider must address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board reinstates an issue(s) or case, the provider will have the same rights (no greater and no less) that it had in its initial appeal. . . .⁷

47.3 Dismissals for Failure to Comply with Board Procedures

Upon written motion demonstrating good cause, the Board **may reinstate** a case dismissed for failure to comply with Board procedures. **Generally, administrative oversight**, settlement negotiations or a change in representative **will not be considered good cause to reinstate**. If the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, then the motion for reinstatement must, *as a prerequisite*, include the required filing before the Board will consider the motion.⁸

Board Rule 47.1 states that the Board will not reinstate if the provider was at fault and Board Rule 47.3 further clarifies that, when the dismissal is based on the failure to comply with Board Procedures (such a filing a required position paper), the Board may reinstate for good cause which does **not** include administrative oversight. Here, the Board finds that the Provider was at fault since it failed to meet the Rule 20/SoP deadline due to its own admitted administrative error.

The Board has considered the facts in this case, as well as the Representative's arguments in support of reinstatement, and DENIES the requested reinstatement. In denying the request, the Board notes that:

- On May 5, 2026, twelve days after the group was designated to be fully formed, the Board issued the Group Completion Notice/CDD via email (*copy enclosed*);
- This Group Completion Notice/CDD clearly stated the deadline for filing the Rule 20 Certification as June 22, 2026 and advised that "If the Providers' Representative misses any of its due dates, the Board will dismiss the appeal."
- Although the Representative suggests that "We were awaiting the Board's Critical Due Date email" –the email was issued to the Parties on May 5, 2026, which was forty-eight (48) days prior to the deadline;
- Moreover, concurrent with the May 5, 2026 Group Completion Notice/CDD notice, a responsive case action was simultaneously created in OH CDMS for the filing of the Rule 20 letter;
- Notwithstanding, HRS could have timely filed the Rule 20 Certification letter within 60 days of the group's full formation using an "other" case action, as it has done many times in the past;
- Prior to the full formation of the instant group case, the Board notes that there were numerous other group cases that had similar Group Completion Notices/CDDs with due

⁷ (Bold emphasis added.)

⁸ (Italics and underline emphasis in original, bold emphasis added.)

dates for which HRS **did** file timely responses in early 2026 (*see, e.g.*, Case Nos. 25-2617GC, 25-3626GC, 26-1181GC, 26-1218GC, 26-1358GC, 26-1579GC);

- The Board is aware that it has specifically issued correspondence to HRS in the past in which it clarified the Rule 20 requirements (*e.g.*, as far back as 2023 in Case No. 17-1092GC). Consequently, the Board finds that HRS is fully aware of the need to TIMELY file a Rule 20 Certification;
- Finally, the Rule 20 requirement has been consistent with a 60-day deadline after full formation since November 1, 2021, when the Board issued updated rules after the implementation of its electronic system, OH CDMS. The recent revision (which HRS referred to as a new procedure) is not a change, rather it makes the deadline explicitly known in the CDD and provides a responsive case action in OH CDMS; it makes NO change to the due date or the required response.

The Group Completion Notice/CDD clearly stated that Representative had to file the Rule 20 Certification (or a traditional Schedule of Providers) and that failure to do so would result in dismissal. Specifically, it stated that “[t]he parties must meet the . . . due dates regardless of any outstanding jurisdictional challenges, motions, or subpoena requests . . . [i]f the Providers’ Representative misses any of its due dates, the Board will dismiss the appeal.”⁹

The Board requirements are consistent with 42 C.F.R. § 405.1853(b). Here, the Representative (which is not new to Board procedures) failed to follow the process set forth in the Group Completion Notice/CDD and Board Rules. A representative is charged with being familiar with Board Rules and deadlines and failure of the representative to carry out his/her responsibilities as a representative is not considered good cause for failing to meet filing deadlines:

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/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-rules-and-board-orders> (*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*

⁹ CIRP Group Fully Formed and Critical Due Dates Notice at 1 (May 5, 2026).

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.¹⁰

In summary, pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b), the Board *DENIES* HRS' request for reinstatement of Case No. 24-2269GC. The Board finds that the Representative was at fault and failed to establish good cause under Board Rules 47.1 and 47.3 as it admitted fault. Therefore, the Board declines to exercise its discretion to reinstate Case No. 24-2269GC and it thereby remains closed. The Board denial is consistent with numerous cases in which federal courts have upheld the Board's authority to dismiss cases for failure of the provider to timely file position papers or other Board filings.¹¹

Board Members Participating:

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

For the Board:

8/3/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A

Enclosure: May 5, 2026 Group Completion CDD Notice

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

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

¹¹ *Kaiser Found. Hosps. v. Sebelius*, 649 F.3d 1153 (9th Cir. 2011) (upholding dismissal for failure to file preliminary position paper); *Baptist Mem'l Hosp.-Golden Triangle v. Sebelius*, 566 F.3d 226 (2009) (upholding dismissal for failure to file preliminary position paper); *High Country Home Health Inc. v. Thompson*, 359 F.3d 1307 (10th Cir. 2004); *Inova Alexandria Hosp. v. Shalala*, 244 F.3d 342, 351 (4th Cir. 2001) (upholding dismissal for failure to file preliminary or final position papers and stating "The Hospital argues that the Board irrationally concluded that administrative oversight is not a valid excuse. We disagree. Because the Hospital's failure to file timely position papers was due to circumstances entirely within its own control, the Board had a rational basis for its decision."); *UHI, Inc. v. Thompson*, 250 F.3d 993 (6th Cir. 2001); *Lutheran Med. Ctr. v. Burwell*, No. 14-CV-731, 2016 WL 3882896 (E.D. N.Y. July 13, 2016); *Rapid City Reg. Hosp. v. Sebelius*, 681 F. Supp. 2d 56 (D.D.C. 2010) (upholding dismissal for failure to file preliminary position paper and citing to "the general proposition that legitimate procedural rules can be relied upon to control the Board's docket by dismissing appeals that are not timely filed" (citations omitted) and upholding Board denial; *S.C. San Antonio Inc. v. Leavitt*, No. SA-07-CA-527-OG, 2008 WL 4816611 (W.D. Tex. Sept. 30, 2008); *Lutheran Med. Ctr. v. Thompson*, No. 02-CV-6144, 2006 WL 2853870 (E.D.N.Y. Oct. 2, 2006); *Novacare, Inc. v. Thompson*, 357 F. Supp. 2d 268, 272-273 (D.D.C. 2005) (upholding denial of reinstatement where the Board explained that "failure to communicate clearly with its counsel was an insufficient basis to justify reinstatement"); *Saint Joseph Hosp. v. Shalala*, No. 99-C7775, 2000 WL 1847976 (N.D. Ill. Dec. 15, 2000).



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May 5, 2026

Corinna Goron
President
Healthcare Reimbursement Services, Inc.
3900 American Drive, Suite 202
Plano, TX 75075

Paul Zarling
Appeals Lead, J-H & J-L Provider Audit and
Reimbursement
Novitas Solutions, Inc. c/o GuideWell Source (J-H)
2020 Technology Drive, Suite 100
Mechanicsburg, PA 17050

RE: CIRP Group Fully Formed and Critical Due Dates Notice
Prime Healthcare CY 2020 Texas 1115 Waiver Days CIRP Group
PRRB Case Number: 24-2269GC

Dear Ms. Goron and Mr. Zarling:

On April 23, 2026, the Provider Reimbursement Review Board ("Board") received the notice that the above-captioned Common Issue Related Party ("CIRP") group appeal is fully formed. The Providers' Representative must advise the Board within 15 days of the date of this notice if it proposes a change to the lead Medicare Contractor. See **Board Rule 19.3**.

The parties are responsible for pursuing the appeal in accordance with the **Board's Rules**.¹ The parties must meet the following due dates regardless of any outstanding jurisdictional challenges, motions, subpoena requests, or the expectation of an administrative resolution. If the Providers' Representative misses any of its due dates, the Board will dismiss the appeal. If the Medicare Contractor fails to meet its deadlines, the Board will take appropriate action as described under 42 C.F.R. § 405.1868.

Due Dates and Required Documents

CIRP Group Fully Formed and Critical Due Dates Notice
Prime Healthcare CY 2020 Texas 1115 Waiver Days CIRP Group
Case Number: 24-2269GC
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June 22, 2026

Final Schedule of Providers – The Providers' representative must address the group case participants by electronically filing one of the following options.

1. **Board Rule 20 Certification** – For groups where **all** of the participants in that group are listed under the Participants tab in the Office of Hearings Case and Document Management System ("OH CDMS"), the Providers' Representative must: (a) review the record in OH CDMS to determine if the supporting jurisdictional documentation is complete for **each** of the participants; (b) supplement the record with any identified missing jurisdictional documentation; and (c) file a statement certifying that participants in the group are fully populated behind the Participants tab in OH CDMS with the relevant supporting jurisdictional documentation. See **Board Rule 20**.

NOTE—When Rule 20 applies, do not file the traditional Schedule of Providers unless specifically requested by the Board.

2. **Traditional Schedule of Providers** – For cases where one or more participants are **not** listed under the Participants tab in OH CDMS, the Providers' Representative must prepare and electronically file a traditional schedule of providers with the supporting jurisdictional documentation for **all** participants. See **Board Rule 20.1**.

NOTE—You must make an additional **hard copy** filing of the traditional Schedule of Providers if you file a request for expedited judicial review as explained in **Board Rule 20.1.2**.

August 21, 2026

Medicare Contractor's Review of Schedule of Providers – Upon receipt of the above-applicable filing, the Medicare Contractor must (1) review the Schedule of Providers and supporting jurisdictional documentation; and (2) submit any filings addressing whether the fully formed group satisfies the requirements for a Board hearing as specified in 42 C.F.R. § 405.1837(c) and whether any jurisdictional or other impediments exist for participating providers. See **Board Rule 22**.

NOTE—If the Providers' Representative, either concurrently or within 60 days, files a request for expedited judicial review, then the 60-day period the Medicare Contractor has to respond to this requirement is truncated as explained in **Board Rule 44.6** and may be further modified by a Board Scheduling Order.

CIRP Group Fully Formed and Critical Due Dates Notice
Prime Healthcare CY 2020 Texas 1115 Waiver Days CIRP Group
Case Number: 24-2269GC
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August 21, 2026

Group's Preliminary Position Paper – For the claim appealed by the Providers, the position paper must: (1) address the Board's jurisdiction over the claim; (2) state the material facts that support that claim; (3) identify the controlling authority (*e.g.*, statutes, regulations, policy, or case law); and (4) present arguments applying the material facts to the controlling authorities. See 42 C.F.R. § 405.1853(b)(2)-(3) and **Board Rule 25**. This filing must include any exhibits the Group will use to support its position (unless omitted pursuant to the process in **Board Rule 25.2.2**, see generally 42 C.F.R. § 405.1853(a)(3), (b)(3) and **Board Rule 25.2**) and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853(a)-(b)(1) and **Board Rule 25.3**.

***NOTE**—There can only be one issue or claim in a group appeal and, as such, the position paper should pertain to one claim/issue. See 42 C.F.R. § 405.1837(a)(2) and **Board Rules 8, 12.2, 13**. To the extent the group appeal was filed in error with more than one issue, the Providers' Representative should file a request for bifurcation of any additional issues as soon as possible but no later than the filing of the preliminary position paper.*

OR

Proposed Joint Scheduling Order ("PJSO") – This document must memorialize the written agreements between the parties and propose a scheduling plan covering all pre-hearing and hearing dates. It must be signed by both parties and request a hearing month and year. See **Board Rule 24**.

December 19, 2026

Medicare Contractor's Preliminary Position Paper – For each claim appealed by the Provider, the position paper must: (1) address the Board's jurisdiction over the claim; (2) state the material facts that support the Medicare Contractor's adjustments; (3) identify the controlling authority (*e.g.*, statutes, regulations, policy, or case law); and (4) present arguments applying the material facts to the controlling authorities. See 42 C.F.R. § 405.1853(b)(2)-(3) and **Board Rule 25**. This filing must include any exhibits the Medicare Contractor will use to support its position (unless omitted pursuant to the process in **Board Rule 25.2.2**, see generally 42 C.F.R. § 405.1853(a)(3), (b)(3) and **Board Rule 25.2**) and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853(a)-(b)(1).

Hearing Date and Final Position Papers

Prior to the hearing date, the Board will send a Notice of Hearing to notify the parties of the specific time, date, and location of the hearing. The Notice of Hearing will also establish due dates for the final position papers.

CIRP Group Fully Formed and Critical Due Dates Notice

Prime Healthcare CY 2020 Texas 1115 Waiver Days CIRP Group

Case Number: 24-2269GC

Page 4 of 4

Sincerely,

A handwritten signature in black ink, reading "Lisa Ogilvie-Barr". The signature is written in a cursive, flowing style.

Lisa Ogilvie-Barr

Director

Division of PRRB Services

Office of Hearings

cc: Wilson C. Leong, Federal Specialized Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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

RE: ***Notice of Dismissal***

Baylor Scott & White Medical Center Centennial, Prov. No. 45-0885, FYE 02/28/2018
Case No. 23-0119

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0119. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days.

Background

A. Procedural History for Case No. 23-0119

On **May 20, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end February 28, 2018.

On **October 26, 2022**, Quality Reimbursement Services, Inc. ("QRS") filed an appeal on behalf of the Provider which included six (6) issues¹:

1. SSI Provider Specific²
2. SSI Unduly Narrow Definition of SSI Entitlement³
3. Medicaid Eligible Days
4. SSI MCD PT C⁴
5. SSI MCD Dual⁵
6. Standardized Payment Amount⁶

¹ On June 28, 2023, the Board agreed to bifurcate Issue #5 (SSI MCD Dual) into two issues. The SSI Fraction Dual Eligible ("DE") Days issue remained as Issue #5 and a new issue was created for the Medicaid Fraction DE Days issue at #7.

² On May 27, 2026, this issue was withdrawn.

³ On June 2, 2023, the Provider transferred this issue to an SSI Percentage CIRP Group, PRRB Case No. 20-1747GC. The Parties will receive correspondence regarding the transfer of the Unduly Narrow issue to the SSI Percentage group under separate cover.

⁴ On June 15, 2022, the Provider transferred this issue to PRRB Case No. 20-1748GC.

⁵ On June 19, 2022, the Provider transferred this issue to PRRB Case No. 20-1749GC.

⁶ On June 15, 2022, the Provider transferred this issue to PRRB Case No. 20-1752GC.

7. Medicaid Fraction Dual Eligible Days⁷

On **October 27, 2022**, the Board issued an Acknowledgement & Critical Due Dates letter providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

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 **June 20, 2023**, the Provider filed its PPP, and the MAC filed its PPP on **October 20, 2023**.

On **February 25, 2026**, the Board issued a Notice of Hearing scheduling the case for a hearing on **September 4, 2026**.

On **June 2, 2026**, the Provider filed its final PP, and on **July 2, 2026**, the MAC filed its final PP.

On **June 22, 2026**, the MAC filed a Jurisdictional Challenge over the last issue, ME Days.

Description of Issue 3 in the Appeal Request

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

Statement of Issue

Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.

Statement of the Legal Basis

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

The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days,

⁷ On June 19, 2022, the Provider transferred this issue to PRRB Case No. 20-1751GC.

⁸ (Emphasis added).

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.⁹

The Provider filed its PPP in which it indicated that it would be sending the eligibility listing under separate cover.¹⁰ The position paper did not identify how many Medicaid eligible days remained in dispute in this case. The following is the Provider's **complete** position on Issue 3 set forth therein:

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

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

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

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

Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all

⁹ Appeal Request at Issue 3.

¹⁰ Provider's PPP at 8.

Medicaid eligible days (including section 1115 waiver days).

Based on the Listing of Medicaid Eligible days being sent under separate cover, including Section 1115 waiver days, the Provider contends that the total number of days reflected in its 2018 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

With respect to section 1115 waiver days, the courts have firmly rejected CMS's interpretation of its regulations, holding instead that the plain language of the statute and the regulations require inclusion in the Medicaid Fraction of the days belonging to individuals who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool. See *Forrest General Hospital*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. 2018); *Bethesda Health Inc., v. Azar*, 389 F. Supp. 3d 32, (D.D.C. 2019), *aff'd*, 980 F.3d 121 (D.C. Cir. 2020). CMS has acquiesced in Bethesda and is now following the statute and the plain meaning of its own regulations (which regulations represent the official policy of CMS all along). See CMS Manual Instructions System, Change Request 12669, Transmittal No. 11912 (March 163, 2023) ("Transmittal 11912"), attached as Exhibit P-4.¹¹

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

The MAC contends that the Provider failed to properly develop its arguments within its PPP and final PP in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rules 25 and 27. The MAC argues the Provider has not submitted an auditable list of Medicaid Eligible days, nor did it explain why it could not produce the documents. Therefore the MAC considers the issue to have been abandoned and requests the Board dismiss the issue.

Additionally, the MAC contends the Provider is attempting to improperly and untimely add the Section 1115 Waiver days issue. The Section 1115 Waiver days were not part of the initial appeal and were not mentioned until the PPP.

Provider's Jurisdictional Response

Pursuant to Board Rule 44.4.3, a Provider must respond to a MAC's jurisdictional challenge within 30 days of the 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.

QRS failed to file a timely response to the MACs challenge by the 30 day deadline which elapsed on July 22, 2026 (*30 days after the challenge was filed on June 22, 2026*).

¹¹ Provider's PPP at 9-10.

Decision of the Board

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

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

A. DSH Payment – Medicaid Eligible Days

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

With regard to the filing of an individual appeal, Board Rule 7 - Support for Appealed Final Determination, Availability of Issue-Related Information and Basis for Dissatisfaction (Dec. 2023) 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.**¹²

¹² (Bold emphasis added.)

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

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

Rule 25 - Preliminary Position Papers¹³

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

¹³ (Underline emphasis added to these excerpts and all other emphasis in original.)

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

COMMENTARY: Note that this is a change in previous Board practice. Failure to file a <u>complete</u> 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. (<i>See</i> Rule 23.4.)
--

The October 27, 2022 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish *each Medicaid eligible day* being

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

The hospital has the burden of furnishing data adequate to prove eligibility for *each* Medicaid patient *day claimed* under this paragraph, *and* of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.¹⁴

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 June 20, 2023, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.¹⁵ Significantly, the PPP 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 \$20,379 based on an estimated 50 days). Excerpts from the Provider's PPP briefing the Medicaid Eligible days issue are stated *supra*.

In its June 22, 2026 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid Eligible days issue because the Provider failed to file complete position papers pursuant to Board

¹⁴ (Emphasis added.)

¹⁵ Provider's PPP at 10.

Rules 25 and 27 and 42 C.F.R. § 405.1853. In addition, the Provider neglected to include all supporting documentation or alternatively, state the efforts made to obtain missing or unavailable documents in accordance with Board Rule 25.2.2. Thus, the MAC asserts that the Provider has essentially abandoned the issue.¹⁶

The Board concurs with the MAC- 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)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid Eligible days issue because the provider failed to identify any specific Medicaid Eligible days at issue (much less any supporting documentation for those days) in either its appeal request or its PPP. Finally, as the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the PPP filing (much less provide the supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is \$0.

B. Section 1115 Waiver Days

The Board also concurs with the MAC that the Section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. While the Provider appealed Medicaid Eligible days, this issue is separate and distinct from the Section 1115 Waiver days.

The appeal was filed with the Board in October 2022 and the regulations required the following:

(b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing...must be submitted in writing to the Board, and the request must include...

(2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final...determination under appeal, including an account of...

(i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]

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.

(ii) How and why the provider believes Medicare payment must be determined differently for each disputed item...¹⁷

Board Rule 7.2.1 (2021) elaborated on this regulatory requirement, instructing providers:

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

- An issue title and a concise issue statement describing:
 - the adjustment, including the adjustment number,
 - the controlling authority,
 - why the adjustment is incorrect,
 - how the payment should be determined differently,
 - the reimbursement effect, and
 - the basis for jurisdiction before the [Board].

Board Rule 8 (Nov.2021) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "...each contested component must be appealed as a separate issue and described as narrowly as possible...". The Rule goes on:

Several examples are identified below, but these are not exhaustive lists of categories or issues.

A. Disproportionate Share Hospital Payments

Common examples include: . . . ***Section 1115 waiver days (program/waiver specific)***. . .¹⁸

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.¹⁹

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

(e) Adding issues to the hearing request. After filing a hearing request... a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
...

¹⁷ 42 C.F.R. § 405.1835(b).

¹⁸ (Bold and italic emphasis added).

¹⁹ See 73 Fed. Reg. 30190 (May 23, 2008).

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

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

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid Eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.²⁰ Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying Section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a Section 1115 Waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2019) states in pertinent part:

(4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

(ii) **Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**

²⁰ 65 FR 47054, 47087 (Aug. 1, 2000).

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

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

Regardless, even if the Provider had included in its appeal request (*which it did not*), the Provider failed to properly develop the issue in its PPP filing as it does not identify the specific 1115 Waiver day program(s) at issue). In addition, the PPP does not discuss whether or not the Section 1115 Waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as “days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act” and the patients underlying those days are “deemed eligible for Medicaid” based on “the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered.” Rather, the PPP is perfunctory in that it only makes cursory conclusions.²¹ Again, the Provider failed to so develop its PPP, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Nov. 2021).

As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider “has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.” Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has 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.” The Provider’s briefing fails to establish the merits of its position on the *alleged* Section 1115 Waiver days sub-issue.

The Board’s finding that neither the appeal request nor the PPP 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, et al. v. Becerra*.²² In that case, the provider’s issue was tied to improper calculation to DSH payment and read in part, “[t]he intermediary

²¹ For example, QRS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that “the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool.” However, QRS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is QRS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? QRS fails to brief the merits of its claims and fails to establish the Board’s jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the PPP references “uncompensated care pool.”

²² No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

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 . . .”²³ The Court found that “[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently.”²⁴ The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.²⁵ Here, the Board makes the same finding based on similar *overly generalized language*.

* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible days (Issue #3) including Section 1115 Waiver days. As no issues remain, the Board hereby closes Case No. 23-0119 and removes it from the Board’s docket.

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

Board Members Participating:

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

For the Board:

8/3/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

²³ *Id.* at *11.

²⁴ *Id.*

²⁵ *Id.*



Provider Reimbursement Review Board
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Via Electronic Delivery

Lisa Ellis
Toyon Associates, Inc.
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Concord, CA 94520

RE: *Expedited Judicial Review Determination*

Case Number: 22-1041GC - BS&W Health FFY 2022 OPPTS Section 401 Hospitals
Rural Floor CIRP Group
Case Number: 22-1042GC - Providence St. Joseph FFY 2022 OPPTS Section 401
Hospitals Rural Floor CIRP Group
Case Number: 22-1043G - Toyon Associates FFY 2022 OPPTS Section 401 Hospitals
Rural Floor Group

Dear Ms. Ellis:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Consolidated Petition for Expedited Judicial Review ("EJR") filed on **June 9, 2026** concerning the above referenced common issue related party ("CIRP") and optional group appeals. The Board's decision on jurisdiction and EJR for these cases is set forth below.

Issue:

The Board received requests to establish two (2) Common Issue Related Party ("CIRP") groups and one Optional group from Toyon Associates, Inc. on **May 12, 2022**. The participants in each group are appealing from the Outpatient Prospective Payment System ("OPPS") Final Rule published in the Federal Register on November 16, 2021, with regard to the calculation of the rural floor for federal fiscal year ("FFY") 2022. On **June 9, 2026**, the Providers filed a Consolidated Petition for Expedited Judicial Review over this issue.

Statutory and Regulatory Background:

1. Wage Index; Rural and Urban Classification

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates¹ known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital

¹ 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).

discharge. Discharges are classified according to a list of diagnosis-related groups (“DRGs”). The base payment rate is comprised of a standardized amount² for all subsection (d) hospitals located in an “urban” or “rural” area.³

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary⁴ adjust the standardized amounts “for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.” This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas (“CBSAs”) established by the Office of Management and Budget. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).⁵

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives “an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts.”⁶

In 1999, Congress recognized that in some cases, a hospital in one geographical area may compete for the same labor pool as hospitals in a nearby, larger urban area but receive lower reimbursement because they are geographically located in a lower wage index area. This resulted in some hospitals being underpaid for their labor costs. As a result, “Congress amended the Medicare Act in order to allow a hospital to seek reclassification from its geographically-based wage area to a nearby wage area for payment purposes if it met certain criteria”⁷ and

² The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. § 1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27708, 27765-27766 (May 27, 1994). Section 1395ww(d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).

³ 42 U.S.C. § 1395ww(d)(2)(A)-(D).

⁴ of the Department of Health and Human Services.

⁵ <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index> (last visited August 4, 2026).

⁶ *Id.*

⁷ *Robert Wood Johnson University Hosp. v. Thompson*, 297 F. 3d. 273, 276 (3d Cir. 2002).

established the Medicare Geographic Review Board (MGCRB) to administer the reclassification process.^{8,9}

Ten years after the MGCRB was established, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106-113).¹⁰ This legislation instructed the Secretary that urban hospitals that applied to the MGCRB for redesignation as rural were to be treated as such. Hospitals that receive these redesignations are sometimes known as “Section 401” hospitals. Codified at 42 U.S.C. § 1395ww(d)(8)(E), the statute states that:

- (E)(i) For purposes of this subsection, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital described in clause (ii), the Secretary ***shall treat the hospital as being located in the rural area*** (as defined in paragraph (2)(D)) of the State in which the hospital is located.
- (ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban area (as defined in paragraph (2)(D)) and satisfies any of the following criteria:
 - (I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).
 - (II) The hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).
 - (III) The hospital would qualify as a rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.
 - (IV) The hospital meets such other criteria as the Secretary may specify.¹¹

In the Conference Report accompanying Section 401, Congress noted that:

Hospitals qualifying under this section shall be eligible to qualify for all categories and designations available to rural hospitals, including sole community, Medicare dependent, critical access, and referral centers. Additionally, qualifying hospitals shall be eligible to apply to the [MGCRB] for geographic reclassification to another area. The [MGCRB] shall regard such hospitals as rural and as entitled to the exceptions extended to referral centers and sole community hospitals, if such hospitals are so designated.¹²

⁸ *Id.*

⁹ 42 U.S.C. § 1395ww(d)(10)(D)(v).

¹⁰ See Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Public L. 106-113, app. F. § 401, 113, Stat. 1501, 1501A-321 (Nov. 29, 1999). Codified as 42 U.S.C. § 1395ww(d)(8).

¹¹ *Id.* (emphasis added).

¹² H.R. Conf. Rep. No. 106-479, 512 (1999).

2. Rural Floor Adjustment

In 1997, Congress observed that the calculation of the wage index for all regions of a state can sometimes result in “some urban hospitals being paid less than the average rural hospital in their state.”¹³ To correct this problem, in the Balanced Budget Act of 1997, Congress provided that the wage index assigned to a hospital in an urban area must be at least as great as the wage index assigned to rural hospitals within the same state. The statute provides that:

For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) may not be less than the area wage index applicable under such section to hospitals located in rural areas in the State in which the hospital is located.¹⁴

This provision is commonly referred to as the “rural floor.”

3. Changes to the Wage Index Calculation

In the FFY 2019 IPPS proposed rule,¹⁵ the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information (“RFI”) as part of the FFY 2020 IPPS proposed rule.¹⁶ Therein, the Secretary noted that many respondents expressed: (1) “a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals”; and (2) “concern that the calculation of the rural floor has allowed a limited number of states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities.”¹⁷ In the FFY 2020 IPPS Final Rule, the Secretary proposed several policies to address wage index disparities.¹⁸ Relevant to the issue under appeal here are the Secretary’s proposals to prevent allegedly inappropriate payment increases due to rural reclassifications made under the

¹³ H.R. Rep. No. 105-149, at 1305 (1997).

¹⁴ 42 U.S.C. § 1395ww note (Floor on Area Wage Index).

¹⁵ 83 Fed. Reg. 20164 (May 7, 2018).

¹⁶ 84 Fed. Reg. 19158, 19393-94 (May 3, 2019).

¹⁷ *Id.*

¹⁸ *See generally* 84 Fed. Reg. 42044, 42336-42339 (Aug. 16, 2019).

provisions of 42 C.F.R. § 412.103.^{19,20} The Secretary finalized without modification the proposals

- to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . . [42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103); and
- for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . . (as implemented at § 412.103) from the calculation of “the wage index for rural areas in the State in which the county is located” referred to in section [1395ww](d)(8)(C)(iii). . . .²¹

The Secretary contends that this policy “is necessary and appropriate to address the unanticipated effects of rural reclassifications on the rural floor and resulting wage index disparities, including the effects of the manipulation of the rural floor by certain hospitals.”²² The Secretary concludes that “the inclusion of reclassified hospitals in the rural floor calculation has had the unforeseen effect of exacerbating the wage index disparities between low and high wage index hospitals.”²³

Under the 2020 IPPI Final Rule, the Secretary “would continue to calculate the rural floor based on the physical non-MSA area of the state, which is the same rural area to which a hospital is reclassified under section [1395ww](d)(8)(E). However, for purposes of calculating the rural floor wage index for a state, [the Secretary] would not include in the rural area the data of hospitals that have reclassified as rural under section [1395ww](d)(8)(E).”²⁴ The Secretary pointed out that the “legislative intent of the rural floor was to correct the ‘anomaly’ of ‘some

¹⁹ 42 C.F.R. § 412.103 states in relevant part that:

(a) General criteria. A prospective payment hospital that is located in an urban area (as defined in subpart D of this part) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:

(1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification, the Rural–Urban Commuting Area codes, ...

(2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.

(3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.

(7) For a hospital with a main campus and one or more remote locations under a single provider agreement where services are provided and billed under the inpatient hospital prospective payment system and that meets the provider-based criteria at § 413.65 of this chapter as a main campus and a remote location of a hospital, the hospital is required to demonstrate that the main campus and its remote location(s) each independently satisfy the location conditions specified in paragraphs (a)(1) and (2) of this section.

²⁰ *Id.* 84 Fed. Reg. at 42332.

²¹ *Id.* at 42336.

²² *Id.* at 42333.

²³ *Id.*

²⁴ *Id.* at 42334.

urban hospitals being paid less than the average rural hospital in their States.”²⁵

The Secretary found that under the current rural floor wage index calculation, rather than raising the payment of some urban hospitals to the level of the average rural hospital in their State, urban hospitals may have their payments raised to the relatively high level of one or more geographically urban hospitals reclassified as rural. The Secretary explained that while urban hospitals in mostly rural states may benefit from an increase in the rural floor due to urban to rural reclassification, other states with high wage urban hospitals using 42 C.F.R.

§ 412.103 reclassification to raise the rural floor can mitigate those gains for mostly rural states, due to budget neutrality. The Secretary believes that excluding the data of hospitals that reclassify as rural under section 1395ww(d)(8)(E) from the rural floor wage index is necessary and appropriate to address the unanticipated effects of the rural floor reclassifications on the rural floor and the resulting wage index disparities.²⁶

The Secretary contends that his reimbursement calculation is permissible under 42 U.S.C. § 1395ww(d)(8)(E) (as implemented by 42 C.F.R. § 412.103) and the rural floor statute (42 U.S.C. § 1395ww(d) note). The statute does not specify where the wage data of reclassified hospitals must be included. Therefore, the Secretary believes that he has the discretion to exclude the wage index data of such hospitals from the calculation of the rural floor. In addition, the Secretary points out, the rural floor statute does not specify how the rural floor wage index is to be calculated or what data are to be included in the calculation. Consequently, the Secretary believes that he has the discretion under the rural floor statute to exclude the wage data of hospitals reclassified under section 1395ww(d)(8)(E) from the calculation of the rural floor.²⁷ Furthermore, the Secretary explained that the rural floor statute does not specify how the rural floor wage index is to be calculated or what data are to be included in the calculation. Therefore, the Secretary believes that he has the discretion under the rural floor statute to exclude the wage data of hospitals reclassified under section 1395ww(d)(8)(E) from the calculation of the rural floor.²⁸

CMS has adopted the FY 2020 IPPS Final Rule’s policy in its FY 2022 OPBS Final Rule, meaning for FFY 2022 it will calculate the rural floor in a state without reference to the wage index that applies for any hospitals in that state which were reclassified as rural pursuant to Section 401.²⁹

²⁵ *Id.* at 42334.

²⁶ *Id.*

²⁷ *Id.*

²⁸ *Id.* at 42333.

²⁹ 86 Fed. Reg. 63458, 63511 (Nov. 16, 2021) (stating “We are continuing to apply for the CY 2022 OPBS wage index any adjustments for the FY 2022 IPPS post-reclassified wage index, including, but not limited to, the rural floor adjustment . . .”).

Positions of the Parties:

1. Providers' Appeal Requests

The Providers in each case have materially identical Issue Statements which describe the appealed issue as follows:

The Providers in this group appeal challenge the Secretary's calculation of the rural floor in the outpatient prospective payment system (OPPS) final rule for calendar year (CY) 2022.

For wage index purposes, there are two types of geographic areas: urban and rural.

When a hospital reclassifies as rural, its wage and hour data is included in the calculation of the state rural wage index adjustment in the next federal fiscal year.

The Medicare statute contains a provision requiring that no urban hospital can be assigned a wage index adjustment that is lower than the wage index assigned to rural hospitals in the state.

In the IPPS final rule for FY 2020, the . . . rural wage index will continue to be calculated based on the average hourly wage of all rural hospitals and all urban hospitals that have reclassified as rural. The rural floor, however, will not include the wage and hour data of reclassified rural hospitals; it will be based solely on the wage data of naturally rural hospitals. Since adopting this policy, the Secretary has applied the same rural floor policy to the OPPS final rules for CYs 2020, 2021 and 2022.

[A]s a direct result of this policy, in CY 2022, urban hospitals in some states have been assigned a wage index that is lower than the wage index assigned to rural hospitals in those states. This result violates the rural floor, which expressly prohibits the Secretary from assigning a wage index to urban hospitals that is lower than the wage index of rural hospitals in the same state. *See* 42 U.S.C. § 1395ww note. Even if this result did not violate the rural floor (it does), the Secretary's policy would separately violate 42 U.S.C. § 1395ww(d)(8)(E)(i), which requires the Secretary to treat a hospital that has elected to reclassify as rural as rural for the purposes of the prospective payment system.

For the forging reasons, the Providers in this group appeal request that the Board reverse the Secretary's calculation of the rural floor for CY 2022 and direct the Secretary to recalculate those payments in the manner required by the statute.³⁰

2. Providers' Request for EJR

The Providers filed their Petition for EJR to challenge CMS' new wage index rule as unlawful because it conflicts with the Medicare statute.³¹ They argue that the FY 2020 rulemaking (1) does not treat reclassified "Section 401" hospitals as being located in a rural area as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).³²

The Providers argue:

CMS's election to exclude Section 401 hospitals from its rural floor calculations is contrary to the text of the statute that the secretary purports to interpret. Section 401 specifies that, for purposes of the IPPS statute, CMS "*shall treat*" a qualifying hospital "as being located in the rural area ... of the State in which the hospital is located." 42 U.S.C. § 1395ww(d)(8)(E)(i) (emphasis added). And the rural floor statute specifies that the wage index for hospitals in a state "*may not* be less than the area wage index applicable under such section to hospitals located in rural areas in the State in which the hospital is located." Pub. L. No. 105-33, § 4410(a), 111 Stat. 251, 402 (Aug. 5, 1997) (emphasis added). Contrary to CMS's characterization of these provisions in its rulemaking, neither provision leaves it to CMS's discretion as to whether it will comply with their terms. Instead, these statutes are mandatory. *See, e.g., Lopez v. Davis*, 531 U.S. 230, 231 (2001) ("Congress used 'shall' to impose discretionless obligations").³³

They note that CMS changed this approach in the FY 2023 IPPS Rule, but only on a prospective basis.³⁴

The Providers insist they have met the criteria set forth in 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), namely that the Board has jurisdiction over the appeal but lacks the authority to grant the relief the Provider seeks.³⁵

³⁰ *E.g.*, Case No. 22-1041GC, Statement of the Issue (May 12, 2022).

³¹ Consolidated Petition for Expedited Judicial Review at 2 (June 9, 2026).

³² *Id.* at 1, 4-6.

³³ *Id.* at 6.

³⁴ *Id.* at 7 (citing 87 Fed. Reg. 48780, 49004 (Aug. 10, 2022)).

³⁵ *Id.* at 7-11.

3. Medicare Contractor's Position

On **June 15, 2026**, the Medicare Contractor's designated representative, Federal Specialized Services ("FSS"), filed a response to the Consolidated Request for Expedited Judicial Review. It took no position on the Request for EJR but noted that "the MAC will file a substantive claim challenge in each of the three above-cited cases."³⁶ FSS filed timely challenges in all three cases, which are addressed, below.

Decision of the Board:

1. Jurisdiction and Request for EJR

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

The participants that comprise these three (3) group appeals have filed appeals involving federal fiscal year 2022. Based on its review of the record, the Board finds that each of the participants in these groups filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835, that the providers each appealed the issue in this appeal, and that the Board is not precluded by regulation or statute from reviewing the issue in this appeal. Finally, the amount in controversy meets the \$50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3). Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying Providers. The estimated amounts in controversy are subject to recalculation by the Medicare contractors for the actual final amounts in each case.

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

In the November 13, 2015 Final Outpatient Prospective Payment Rule,³⁷ the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.³⁸ The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the NPR issued by the Medicare Contractor or in any decision or

³⁶ Response to Provider's Request for Expedited Judicial Review (Consolidated) at 1 (June 15, 2026).

³⁷ 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).

³⁸ *Id.* at 70555.

order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the “claim-specific dissatisfaction requirement”). All of the participants in these cases have fiscal years that began on or after January 1, 2016, so the claim-specific dissatisfaction requirement is not applicable to the Board’s analysis regarding **jurisdiction**. The Board must, however, prepare written specific findings of fact and conclusions of law on the question of whether the provider’s cost report complied with the cost report claim requirements of § 413.24(j).

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

(1) *General Requirement*. In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), **must include an appropriate claim for the specific item**, by either—

(i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or

(ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.

(2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—

(i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and

(ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full

reimbursement in its cost report for the specific item) **and**
describing how the provider calculated the estimated re-
imbursement amount for each specific self-disallowed item.³⁹

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

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

(b) *Summary of Procedures.*

(2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .

(d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*

(2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .

(e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*

³⁹ (Bold and underline emphasis added.)

(1) Board jurisdictional dismissal decision. **If the Board issues a jurisdictional dismissal decision** regarding the specific item under appeal (pursuant to § 405.1840(c)), **the Board's specific findings of fact and conclusions of law** (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must not be included in such jurisdictional dismissal decision.**⁴⁰

These regulations are applicable to the cost reporting periods under appeal for all the participants in the instant cases, which have cost reporting periods ending on or after December 31, 2016. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to

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

Timely Substantive Claim Challenges were filed in Cases 22-1041GC, 22-1042GC, and 22-1043G, and are discussed below. The Providers encompassed in these three (3) challenges will be collectively referred to as "the Challenged Providers."

i. Case 22-1041GC

FSS filed a Substantive Claim Challenge on **June 23, 2026**. The challenge argues that none of the Providers in this group made an appropriate claim on their cost reports for the issue being appealed. It claims that the Providers either claimed \$0 in Part A and B protested amounts on their cost reports, or, if they did claim some amount, the accompanying summary of protested items did not establish a self-disallowed item for the Rural Floor OPPTS issue.⁴¹

ii. Case 22-1042GC

FSS filed a Substantive Claim Challenge on **June 22, 2026**. The challenge argues that there are two (2) providers with four (4) affected cost reports in this appeal. It claims the following three (3) cost reports did not contain an appropriate claim for the issue under appeal:

- Covenant Medical Center (Provider No. 45-0040; FYE: 06/30/2022)

⁴⁰ (Bold and underline emphasis added.)

⁴¹ Case No. 22-1041GC, Medicare Administrative Contractor's Substantive Claim Challenge at 4-9 (June 23, 2026).

- Grace Medical Center (Provider No. 45-0162; FYE 12/31/2021 and 12/31/2022)

The challenge argues these two (2) Providers for these three cost reporting periods in this group failed to make an appropriate claim on their cost reports for the issue being appealed. It claims that the Providers either claimed \$0 in Part A and B protested amounts on their cost reports, or, if they did claim some amount, the accompanying summary of protested items did not establish a self-disallowed item for the Rural Floor OPPTS issue.⁴²

iii. Case 22-1043G

FSS filed a Substantive Claim Challenge on **June 22, 2026**. The challenge argues that none of the seven (7) Providers (with 13 affected cost reports) in this group made an appropriate claim on their cost reports for the issue being appealed. It claims that the Providers either claimed \$0 in protested amounts on their cost reports, or, if they did claim some amount, the accompanying summary of protested items did not establish a self-disallowed item for the Rural Floor OPPTS issue.⁴³

iv. Non-Challenged Participants

For all remaining participants in these cases (collectively “the Non-Challenged Participants”), since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,⁴⁴ the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d) for the Non-Challenged Participants.

v. Providers’ Responses

The Providers filed timely, materially identical responses to all the Substantive Claim Challenges outlined above. The Providers do not dispute that they failed to include an appropriate cost report claim for the issue under appeal. Instead, they argue that the regulations requiring an appropriate cost report claim are unlawful and unenforceable. They cite *Bethesda Hosp. Ass’n v. Bowen*⁴⁵ and *Banner Heart Hospital v. Burwell*⁴⁶ in support of their position that these regulations are unlawful.⁴⁷

⁴² Case No. 22-1042GC, Medicare Administrative Contractor’s Substantive Claim Challenge at 4-6 (June 22, 2026).

⁴³ Case No. 22-1043G, Medicare Administrative Contractor’s Substantive Claim Challenge at 4-15 (June 22, 2026).

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

⁴⁵ 485 U.S. 399 (1988).

⁴⁶ 201 F.Supp.3d 131 (D.D.C. 2016)

⁴⁷ *E.g.*, Case 22-1041GC, Response to MAC’s Substantive Claim Challenge at 1-3 (July 12, 2026).

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

The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board’s findings with regard to whether or not a provider “include[d] in its cost report an appropriate claim for the *specific* item [under appeal] (as prescribed in § 413.24(j))”⁴⁸ may not be invoked or relied on by the Board to decline jurisdiction. *Instead*, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law as to whether an appropriate claim was included.

The Challenged Providers do not dispute that they failed to include an appropriate cost report claim for the Rural Floor issue under appeal. Based upon the records before it, the Board specifically finds that they did not.

3. Analysis Regarding Appealed Issue

As set forth below, the Board finds that the Secretary’s determination to “calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . . [42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103)”⁴⁹ was made through notice and comment in the form of an uncodified regulation.⁵⁰

Indeed, it is clear from the use of the following language in the preamble to the FFY 2020 IPPS Final Rule that the Secretary intended to bind the regulated parties and establish a binding uniform payment policy through formal notice and comment:

After consideration of the public comments we received, for the reasons discussed in this final rule and in the proposed rule, we are finalizing without modification our proposal to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103). Additionally, we are finalizing without modification our proposal, for purposes of applying the provisions of section 1886(d)(8)(C)(iii) of the Act, to remove the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103) from the calculation of “the wage index for rural areas in the State in which the county is located” referred to in section 1886(d)(8)(C)(iii) of the Act.⁵¹

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as the “Uncodified Regulations on Rural

⁴⁸ (Emphasis added.)

⁴⁹ 84 Fed. Reg. 42044 at 42336.

⁵⁰ See 84 Fed. Reg. 42044, 42325-36 “II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals.”

⁵¹ 84 Fed. Reg. at 42336.

Floor Calculation.” Indeed, this finding is consistent with the Secretary’s obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any “substantive legal standard governing . . . the payment of services” as a regulation.⁵²

While this appeal involves the FFY 2022 OPPTS Final Rule, CMS has adopted the FY 2020 IPPS Final Rule’s policy in its FY 2022 OPPTS Final Rule, meaning for FFY 2022 it will calculate the rural floor in a state without reference to the wage index that applies for any hospitals in that state which were reclassified as rural pursuant to Section 401.⁵³ Therefore, the Board finds that this policy is a binding but uncodified regulation for FFY 2022 for the purposes of the OPPTS.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulations on Rural Floor Calculation published in the FFY 2020 IPPS Final Rule (and as continued for FY 2022 for OPPTS) and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulations on Rural Floor Calculation which they allege (1) does not treat reclassified “Section 401” hospitals as being located in a rural area, as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).⁵⁴ As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in Cases 22-1041GC, 22-1042GC, and 22-1043G.

D. Board’s Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the Uncodified Regulations on Rural Floor Calculation Issue for the subject years in Cases 22-1041GC, 22-1042GC, and 22-1043G and that the Providers in the group appeals are entitled to a hearing before the Board;
- 2) The review process in 42 C.F.R. § 405.1873(a)-(b) has been triggered for the Challenged Providers and the Board specifically finds that the Challenged Providers failed to include “an appropriate claim for the specific item” that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1);

⁵² 42 U.S.C. § 1395hh(a)(2) states “[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation”

⁵³ 86 Fed. Reg. 63458, 63511 (Nov. 16, 2021) (stating “We are continuing to apply for the CY 2022 OPPTS wage index any adjustments for the FY 2022 IPPS post-reclassified wage index, including, but not limited to, the rural floor adjustment”).

⁵⁴ Consolidated Petition for Expedited Judicial Review at 1, 4-6.

- 3) The review process in 42 C.F.R. § 405.1873(a)-(b) has not been triggered for the remaining Non-Challenged Participants and, therefore, there are no findings regarding whether their cost reports included appropriate claims for the specific item at issue in these appeals;
- 4) Based upon the Providers' assertions regarding the rural wage index and rural floor calculations, there are no findings of fact for resolution by the Board;
- 5) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 6) It is without the authority to decide the legal questions of
 - a) Whether the codified Regulations on Rural Floor Calculation published in the FFY 2020 IPPS Final Rule (and carried forward to FFY 2022 for OPPTS) is valid; and
 - b) For the Challenged Providers, whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid.⁵⁵

Accordingly, the Board finds that the question of the validity of the Uncodified Regulations on Rural Floor Calculation implemented in the FFY 2020 IPPS Final Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject year.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes Case Nos. 22-1041GC, 22-1042GC, and 22-1043G and removes them from its docket.

⁵⁵ The Board recognizes that this question relates only to some of the participants in these groups and, as such, does not apply to all the full groups. As a result, it would appear to run afoul of 42 C.F.R. § 405.1837(g) and potentially require bifurcation. However, the Board finds that this is not so in this case. Compliance with 42 C.F.R. § 413.24(j) is substantive in nature (*i.e.*, directly impacts potential reimbursement), but does not affect the issue that is the subject of the appeal. Similar to review under 42 C.F.R. § 405.1840 of jurisdictional or claims-filing requirements, a provider's compliance with § 413.24(j) relates to the nature of the provider's *participation* in the group (as set forth in 42 C.F.R. § 405.1873) and is only triggered when, pursuant to § 405.1873(a) *as a procedural matter in the proceedings before the Board*, a party raises their hand and questions the provider's compliance with § 413.24(j). As a result, the Board finds that potential bifurcation has not been triggered under § 405.1837(f). This situation is akin to the Board denying jurisdiction over one participant in a group but granting EJR relative to the rest of the group. Judicial review remains available on appeal for these discreet group participation issues regardless of whether they relate the jurisdiction or claims-filing requirements under § 405.1840 or the substantive claims requirements under § 413.24(j).

Board Members Participating:

Kevin D. Smith, CPA

Ratina Kelly, CPA

Nicole E. Musgrave, Esq.

Shakeba DuBose, Esq.

Clayton J. Nix, Esq.

FOR THE BOARD:

8/4/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA

Board Chair

Signed by: KEVIN D. SMITH -A

Enclosures: Schedules of Providers

cc: Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Scott Berends, Esq., Federal Specialized Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Poplar Bluff Regional Medical Center (Prov. No. 26-0119), FYE 12/31/2021
Case No. 26-0014

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 26-0014. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider’s Disproportionate Share Hospital (“DSH”) Medicaid Eligible Days issue.

Background:

A. Procedural History for Case No. 26-0014

On **April 29, 2025**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end Dec. 31, 2021.

On **October 3, 2025**, the Board received the Provider’s individual appeal request. The Appeal Request was filed by the parent organization, Community Health Systems, Inc. (hereinafter “CHS”) and included six (6) issues:

1. DSH Pymt/SSI % (Provider Specific)¹
2. DSH SSI -Unduly Narrow Definition of SSI Entitlement²
3. DSH Pymt - Medicaid Eligible Days
4. Medicare Managed Care Part C Days – SSI & Medicaid Fraction³
5. Improper Rulemaking – SSI Dual Eligible Days⁴
6. Improper Rulemaking – Medicaid Fraction Dual Eligible Days⁵

¹ On May 28, 2026, this issue was withdrawn.

² On April 9, 2026, this issue was transferred to Case No. 26-2198GC.

³ On April 6, 2026, this issue was transferred to Case No. 24-1834GC.

⁴ On April 6, 2026, this issue was transferred to Case No. 24-1835GC.

⁵ On April 6, 2026, this issue was transferred to Case No. 24-1836GC.

On **October 27, 2025**, 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 (*hereinafter*, "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** state the material facts that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and provide arguments applying the material facts*** to the controlling authorities. This filing ***must include any exhibits the Provider will use to support its position*** and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.⁶

On **April 8, 2026**, CHS requested the representative be changed to Quality Reimbursement Services, Inc. ("QRS"). The Board effectuated the change to QRS on the following day.

On **May 29, 2026**, QRS timely filed the Provider's PPP.

On **June 24, 2026**, the Medicare Contractor ("MAC") filed a Motion to Dismiss the Medicaid Eligible Days issue.

B. Description of Issue 3 in the Individual Appeal Request

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

Statement of Issue

Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.

Statement of the Legal Basis

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

⁶ (Emphasis added.)

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

Audit Adjustment Number(s): 9, 10, 13, S-D
Estimated Reimbursement Amount: \$116,654

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case⁷ and HCFA Ruling 97-2, “all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage” of the DSH payment adjustment.⁸

MAC’s Contentions: Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC filed a Motion to Dismiss in which it argued the Board should dismiss the Medicaid Eligible Days issue. The MAC contends that the Provider failed to include an auditable list of additional Medicaid eligible days they expect to be included with their appeal or their PPP, even though the Provider advised that it would send a listing of additional Medicaid eligible days under separate cover and even though the MAC requested one on October 28, 2025.⁹ Thus, the Provider has failed to furnish documentation in support of its claim or describe why such documentation is unavailable per Board Rules 7. 25.2.1 and 25.2.2. The MAC contends the Provider has abandoned this issue.¹⁰

Provider’s Jurisdictional Response – Medicaid Eligible Days

Board Rule 44.3 specifies: “Unless the Board imposes a different deadline, an opposing party may file a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party.”¹¹ The Provider did not file a response to the Motion to Dismiss and the time for doing so has elapsed on *July 24, 2026*.

Board Analysis and Decision

The Board finds it appropriate to dismiss the DSH Payment – Medicaid Eligible Days issue.

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider’s issue statement for Issue 3 is stated, *supra*.

⁷ *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994).

⁸ Provider’s PPP at 8-9.

⁹ MAC’s Motion to Dismiss at 2.

¹⁰ MAC’s Motion to Dismiss at 5.

¹¹ Board Rule 44.3, v. 3.2 (Dec. 2023).

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

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.

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:

The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.

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

Furthermore, 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.*¹²

Similarly, with regard to position papers, Board Rule 25.2.1 requires that “the parties must exchange ***all available*** documentation as exhibits to fully support your position.”¹³ This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides instruction on the content of position papers as it relates to unavailable documentation/exhibits:

25.2.2 Unavailable and Omitted Documents¹⁴

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.¹⁵

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.

Relative to a Medicaid Eligible Days determination, it is well-established that adequate data to prove eligibility for each Medicaid patient day claimed is a complete and accurate (i.e., auditable) Medicaid eligible days listing, which upon timely submission by a provider, a MAC can examine to make applicable adjustments.

This appeal was initiated on October 3, 2025 (almost 10 months ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expected to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider’s PPP indicated that it would be sending the eligibility listing to the MAC under separate cover.

¹² (Emphasis added).

¹³ (Emphasis added).

¹⁴ PRRB Rules v. 3.2 (Dec. 2023)

¹⁵ (Italics and underline emphasis added.)

In summary, the Board finds that the Provider failed to satisfy the requirements of Board Rules 25.2.1 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. Accordingly, the Board finds that the Provider abandoned the Medicaid Eligible days issue by failing to properly develop its arguments and provide supporting documents, and by failing to explain why it did not produce those documents, as required by the regulations and the Board Rules.¹⁶

Based on the foregoing, the Board is dismissing the last remaining issue in this case: “DSH - Medicaid Eligible Days” - Issue 3. As no issues remain, the Board hereby closes Case No. 26-0014 and removes it from the Board’s docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

8/7/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

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.



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

Christopher Kenny
King & Spalding, LLP
1700 Pennsylvania Avenue NW, Suite 200
Washington, DC 20006-4706

RE: ***1115 Waiver Days issue - Abandoned***
Baptist Medical Center – Nassau (Provider Number 10-0140)
FYE: 09/30/2017
Case Number: 21-0153

Dear Mr. Kenny:

The Provider Reimbursement Review Board (“Board”) has reviewed the record in the above-referenced appeal. The Board finds that the Provider abandoned issue #9. DSH – Florida’s Section 1115 Medicaid Waiver and hereby dismisses it from the appeal.

Background

On **May 6, 2020**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end September 30, 2017.

On **October 30, 2020**, the Board received the Provider’s individual appeal request. The Individual Appeal Request contained nineteen (19) issues:

1. Supplemental Security Income Percentage – Systemic Errors¹
2. Improper Calculation of SSI Percentage Due to Issues Specific to the Provider²
3. Dual Eligible Medicare Managed Care Pt C Days to Medicaid Ratio³
4. DSH – Eligible Days Excludes Medicare Pt. C Managed Care⁴
5. DSH – Exhausted Medicare Benefits Medicaid Dual Eligible Days⁵
6. DSH Payment – No-Pay Part A Days⁶
7. DSH – Medicaid Eligible Observation Bed Days⁷
8. DSH – Medicaid Eligible Florida Charity Care Days⁸

¹ On September 15, 2021, this issue was transferred to PRRB Case No. 21-1586GC.

² On January 16, 2026, this issue was transferred to PRRB Case No. 21-1586GC.

³ On September 15, 2021, this issue was transferred to PRRB Case No. 21-1587GC.

⁴ On September 15, 2021, this issue was transferred to PRRB Case No. 21-1587GC.

⁵ On September 15, 2021, this issue was transferred to PRRB Case No. 21-1588GC.

⁶ On September 15, 2021, this issue was transferred to PRRB Case No. 21-1588GC.

⁷ This issue was withdrawn on April 27, 2026.

⁸ This issue was withdrawn on April 27, 2026.

9. DSH – Florida’s Section 1115 Medicaid Waiver Days
10. Self-Disallowance of Non-Medicaid Expansion Eligible Days⁹
11. Understatement of Eligible Days Because of the Self Disallowance of Days due to Past Improperly Applied CMS Policies¹⁰
12. American Taxpayer Relief Act (ATRA) Adjustment¹¹
13. ATRA Adjustment (DRG)¹²
14. St. Francis Predicated Facts DRG Operating Understatement¹³
15. St. Francis Predicated Facts DSH Operating Understatement¹⁴
16. Medicare Crossover Bad Debts¹⁵
17. Medicare Charity Care Bad Debts¹⁶
18. Medicare Bad Debts – Self Disallowed Due to Oversight¹⁷
19. Medicare Bad Debts for Accounts in Possession of Collection¹⁸

On **November 3, 2020**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties’ preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

Provider’s Preliminary Position Paper – *For each issue*, the position paper **must** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and provide arguments applying the material facts*** to the controlling authorities. This filing **must** *include any exhibits the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.¹⁹

On **June 24, 2021**, the Provider timely filed its preliminary position paper. With respect to Issue 9, the Provider suggested that a list of 1115 Medicaid Waiver days were “not available presently but will be provided at the time of filing of the final position papers.”²⁰ As a result, the Provider included, as an Exhibit, the original “estimated impact” for this issue based on an *estimated* 50 days.

⁹ This issue was withdrawn on April 27, 2026.

¹⁰ This issue was withdrawn on April 27, 2026.

¹¹ This issue was withdrawn on November 17, 2025.

¹² This issue was withdrawn on November 17, 2025.

¹³ On September 4, 2025, this issue was transferred to PRRB Case No. 25-5635GC.

¹⁴ On September 4, 2025, this issue was transferred to PRRB Case No. 25-5635GC.

¹⁵ This issue was withdrawn on April 11, 2023.

¹⁶ This issue was withdrawn on April 11, 2023.

¹⁷ This issue was withdrawn on April 11, 2023.

¹⁸ This issue was withdrawn on April 11, 2023.

¹⁹ (Bold, italics and underline emphasis added.)

²⁰ Provider’s Preliminary Position Paper at 23 (Jun. 24, 2021).

On **October 6, 2021**, the Medicare Contractor filed a Substantive Claim Challenge on several issues that remained at that time, of which only Issue No. 9 remains at present. The Provider failed to submit a response to the Substantive Claim Challenge.

On **November 18, 2025**, the Provider timely filed its final position paper. The Provider again failed to provide any listing of 1115 Medicaid Waiver Days in dispute.

On **April 27, 2026**, the Provider requested a change in representation to King & Spalding, LLP, and on **April 29, 2026**, five and a half years after the appeal was filed, they submitted an updated 1115 waiver days calculation increasing the amount in controversy from \$6,053 to \$144,814. The original protest was for 50 days and they are now requesting 955 days in the summary calculation filed at that time, which still does not identify specific claims/days.²¹

Issue Under Appeal:

The Provider described Issue No. 9 at the time of filing as follows:

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 this disproportionate patient percentage, set forth at 42 C.F.R. § 412.106(b) of the Secretary's Regulations. The MAC, contrary to the regulation, failed to include all Medicaid eligible days in the Medicaid Percentage of the Medicare DSH calculation.

The Provider contends that its finalized cost report did not accurately reflect its Medicaid paid and unpaid but eligible days under a waiver authorized under section 1115(a)(2) of the Social Security Act. Florida's 1115 waiver covers the costs of inpatient stays of uninsured and underinsured patients through the Low Income Pool. The information obtained from the State of Florida agencies did not reconcile with the Provider's underlying records. The finalized Medicaid days total did not include all section 1115 waiver paid and unpaid but eligible days.

Audit Adjustment Number(s): 1, 16, 17, 19
Estimated Reimbursement Amount: \$6,053²²

Decision of the Board

The Provider's appeal request did not include a list of the specific additional 1115 Medicaid waiver days that were in dispute in this appeal, nor did either of the position papers.

²¹ 10-0140 2017 Updated Impact – Supplemental Calculation Support at 1 (Jul. 29, 2026).

²² Case No. 21-0153 Issue Statement – Issue #9 (Oct. 30, 2020).

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.²³

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.²⁴

The regulation requires 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 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:

²³ PRRB Rules (v. 2.0) (Aug. 29, 2018).

²⁴ (Bold emphasis added.)

Rule 25 Preliminary Position Papers²⁵

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. . . . 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 (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 November 3, 2020, included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 9, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish *each Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

The hospital has the burden of furnishing data adequate to prove eligibility for *each* Medicaid patient *day claimed* under this paragraph, *and* of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.²⁶

²⁶ (Emphasis added.)

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 June 24, 2021, the Provider filed its preliminary position paper and stated that “[r]evised detailed listings are in process to comply with prescribed MAC format and, therefore not available presently but will be available at the time of filing of the final position papers.”²⁷ The Provider did not say why those lists were not available prior to the filing of the paper, or what efforts they were undertaking to make them available. Significantly, the position paper did *not* include *the material fact* of how many 1115 Medicaid waiver days remained in dispute in this case, but rather continued to reference the “estimated impact” included with its appeal request (*i.e.*, based on an estimated 50 days) even though they claimed to have “a revised calculation” based on a preliminary review of the additional eligible days.²⁸ The estimate in the appeal filing and the document at P-1-1 cited by the Provider as “revised,” were identical.

On November 18, 2025, the Provider filed its final position paper and again, included no listing of 1115 Medicaid waiver days.

However, on April 29, 2026 (over 5.5 years after the appeal was filed), the Provider’s Representative submitted an updated 1115 waiver days calculation from \$6,053 to \$144,814. The original protest was for 50 days and the new calculation now identifies 955 days. King & Spalding’s filing did not explain why the revised identification of so many days (again around 955 days) was being submitted at this late date, *more than 8 years after the fiscal year at issue*

²⁷ Provider’s Preliminary Position Paper at 23.

²⁸ Provider’s PPP at 23-24.

had closed. NOTE—the roughly 955 included in this belated listing is exponentially larger than the original estimate of 50 days included with the appeal request.

The Board finds 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 1115 Medicaid waiver 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)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the 1115 Medicaid waiver 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 revised calculation was filed two days after the Provider changed its designated representative to King & Spalding, LLP, does not excuse the Provider for its failure to include the information with its preliminary position paper, as is required by Board Rules, or with the final position paper, which was implied in the preliminary position paper. Board Rule 5.2 makes clear that “the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings.”

Finally, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof “to prove eligibility for *each* Medicaid patient day claimed”²⁹ 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 1115 Medicaid waiver day as being in dispute as part of the position paper filing (much less provide the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is \$0.

Based on the above, the Board finds that the Provider has failed to comply with the Board’s procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and of 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 and has failed to describe why said evidence is unavailable.³⁰

²⁹ (Emphasis added.)

³⁰ 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

* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – #9 - DSH – Florida’s Section 1115 Medicaid Waiver. As no issues remain, the Board hereby closes Case No. 21-0153 and removes it from the Board’s docket.³¹ Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

FOR THE BOARD

8/11/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA

Board Chair

Signed by: KEVIN D. SMITH -A

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

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.

³¹ As the last issue is being dismissed for abandonment of the issue, the Board need not rule on the substantive claim challenge filed by the MAC in this appeal, to which the Board notes the Provider failed to respond.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***

Baylor Scott & White Medical Center Centennial, Prov. No. 45-0885, FYE 03/31/2019
Case No. 23-0248

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0248. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days.

Background

A. Procedural History for Case No. 23-0248

On **May 31, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end March 31, 2019.

On **November 17, 2022**, Quality Reimbursement Services, Inc. ("QRS") filed an appeal on behalf of the Provider which included six (6) issues¹:

1. SSI Provider Specific²
2. SSI Unduly Narrow Definition of SSI Entitlement³
3. Medicaid Eligible Days
4. SSI MCD PT C⁴
5. SSI Fraction Dual Eligible Days⁵
6. Standardized Payment Amount⁶
7. Medicaid Fraction Dual Eligible Days⁷

¹ On June 28, 2023, the Board agreed to bifurcate Issue #5 (SSI MCD Dual) into two issues. The SSI Fraction Dual Eligible ("DE") Days issue remained as Issue #5 and a new issue was created for the Medicaid Fraction DE Days issue at #7.

² On June 17, 2026, this issue was withdrawn.

³ On July 3, 2023, the Provider transferred this issue to PRRB Case No. 23-1404GC.

⁴ On July 3, 2023, the Provider transferred this issue to PRRB Case No. 23-1405GC.

⁵ On July 3, 2023, the Provider transferred this issue to PRRB Case No. 23-1406GC.

⁶ On July 3, 2023, this issue was withdrawn.

⁷ On July 3, 2023, the Provider transferred this issue to PRRB Case No. 23-1407GC.

On **November 18, 2022**, the Board issued an Acknowledgement & Critical Due Dates letter providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

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 **July 4, 2023**, the Provider filed its PPP, and the MAC filed its PPP on **October 27, 2023**.

On **February 10, 2026**, the Board issued a Notice of Hearing scheduling the case for a hearing on **September 18, 2026**.

On **June 19, 2026**, the Provider filed its final PP, and on **July 16, 2026**, the MAC filed its final PP.

On **July 7, 2026**, the MAC filed a Jurisdictional Challenge over the last issue, ME Days.

Description of Issue 3 in the Appeal Request

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

Statement of Issue

Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.

Statement of the Legal Basis

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

⁸ (Emphasis added).

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.⁹

The Provider filed its PPP in which it indicated that it would be sending the eligibility listing under separate cover.¹⁰ The position paper did not identify how many Medicaid eligible days remained in dispute in this case. The following is the Provider's **complete** position on Issue 3 set forth therein:

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

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

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

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

Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is

⁹ Appeal Request at Issue 3.

¹⁰ Provider's PPP at 8.

whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).

Based on the Listing of Medicaid Eligible days being sent under separate cover, including Section 1115 waiver days, the Provider contends that the total number of days reflected in its 2018 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

With respect to section 1115 waiver days, the courts have firmly rejected CMS's interpretation of its regulations, holding instead that the plain language of the statute and the regulations require inclusion in the Medicaid Fraction of the days belonging to individuals who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool. See *Forrest General Hospital*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. 2018); *Bethesda Health Inc., v. Azar*, 389 F. Supp. 3d 32, (D.D.C. 2019), *aff'd*, 980 F.3d 121 (D.C. Cir. 2020). CMS has acquiesced in Bethesda and is now following the statute and the plain meaning of its own regulations (which regulations represent the official policy of CMS all along). See CMS Manual Instructions System, Change Request 12669, Transmittal No. 11912 (March 163, 2023) ("Transmittal 11912"), attached as Exhibit P-4.¹¹

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

The MAC contends that the Provider failed to properly develop its arguments within its PPP in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rules 25 and 27. The MAC argues the Provider has not submitted an auditable list of Medicaid Eligible days, nor did it explain why it could not produce the documents. Therefore, the MAC considers the issue to have been abandoned and requests the Board dismiss the issue.

Additionally, the MAC contends the Provider is attempting to improperly and untimely add the Section 1115 Waiver days issue. The Section 1115 Waiver days were not part of the initial appeal and were not mentioned until the PPP.

Provider's Jurisdictional Response

Pursuant to Board Rule 44.4.3, a Provider must respond to a MAC's jurisdictional challenge within 30 days of the 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.

¹¹ Provider's PPP at 9-10.

QRS failed to file a timely response to the MACs challenge by the 30-day deadline which elapsed on August 6, 2026 (*30 days after the challenge was filed on July 7, 2026*).

Decision of the Board

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

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

A. DSH Payment – Medicaid Eligible Days

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

With regard to the filing of an individual appeal, Board Rule 7 - Support for Appealed Final Determination, Availability of Issue-Related Information and Basis for Dissatisfaction (Dec. 2023) 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.¹²

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

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

Rule 25 - Preliminary Position Papers¹³

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.

¹² (Bold emphasis added.)

¹³ (Underline emphasis added to these excerpts and all other emphasis in original.)

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange *all* available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4.

Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, 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 <u>complete</u> 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 November 18, 2022 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish *each Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

The hospital has the burden of furnishing data adequate to prove eligibility for *each* Medicaid patient *day claimed* under this paragraph, *and* of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.¹⁴

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 July 4, 2023, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.¹⁵ Significantly, the PPP 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 \$35,471 based on an estimated 100 days). Excerpts from the Provider's PPP briefing the Medicaid Eligible days issue are stated *supra*.

¹⁴ (Emphasis added.)

¹⁵ Provider's PPP at 10.

In its July 7, 2026 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid Eligible days issue because the Provider failed to file complete position papers pursuant to Board Rules 25 and 27 and 42 C.F.R. § 405.1853. In addition, the Provider neglected to include all supporting documentation or alternatively, state the efforts made to obtain missing or unavailable documents in accordance with Board Rule 25.2.2. Thus, the MAC asserts that the Provider has essentially abandoned the issue.¹⁶

The Board concurs with the MAC- 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)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid Eligible days issue because the provider failed to identify any specific Medicaid Eligible days at issue (much less any supporting documentation for those days) in either its appeal request or its PPP. Finally, as the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the PPP filing (much less provide the supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is \$0.

B. Section 1115 Waiver Days

The Board also concurs with the MAC that the Section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. While the Provider appealed Medicaid Eligible days, this issue is separate and distinct from the Section 1115 Waiver days.

The appeal was filed with the Board in November 2022 and the regulations required the following:

(b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing...must be submitted in writing to the Board, and the request must include...

(2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final...determination under appeal,

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.

including an account of...

(i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]

(ii) How and why the provider believes Medicare payment must be determined differently for each disputed item...¹⁷

Board Rule 7.2.1 (2021) elaborated on this regulatory requirement, instructing providers:

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

- An issue title and a concise issue statement describing:
 - the adjustment, including the adjustment number,
 - the controlling authority,
 - why the adjustment is incorrect,
 - how the payment should be determined differently,
 - the reimbursement effect, and
 - the basis for jurisdiction before the [Board].

Board Rule 8 (Nov.2021) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "...each contested component must be appealed as a separate issue and described as narrowly as possible...". The Rule goes on:

Several examples are identified below, but these are not exhaustive lists of categories or issues.

A. Disproportionate Share Hospital Payments

Common examples include: . . . ***Section 1115 waiver days (program/waiver specific)***. . .¹⁸

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.¹⁹

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

(e) Adding issues to the hearing request. After filing a hearing request... a provider may add specific Medicare payment issues to

¹⁷ 42 C.F.R. § 405.1835(b).

¹⁸ (Bold and italic emphasis added).

¹⁹ See 73 Fed. Reg. 30190 (May 23, 2008).

the original hearing request by submitting a written request to the Board, only if –

...

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

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

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid Eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.²⁰ Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying Section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a Section 1115 Waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2019) states in pertinent part:

(4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

(ii) **Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through**

²⁰ 65 FR 47054, 47087 (Aug. 1, 2000).

a waiver approved under section 1115 of the Social Security Act.

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

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

Regardless, even if the Provider had included in its appeal request (*which it did not*), the Provider failed to properly develop the issue in its PPP filing as it does not identify the specific 1115 Waiver day program(s) at issue). In addition, the PPP does not discuss whether or not the Section 1115 Waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as “days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act” and the patients underlying those days are “deemed eligible for Medicaid” based on “the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered.” Rather, the PPP is perfunctory in that it only makes cursory conclusions.²¹ Again, the Provider failed to so develop its PPP, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Nov. 2021).

As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider “has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.” Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has 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.” The Provider’s briefing fails to establish the merits of its position on the *alleged* Section 1115 Waiver days sub-issue.

The Board’s finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of

²¹ For example, QRS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that “the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool.” However, QRS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is QRS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? QRS fails to brief the merits of its claims and fails to establish the Board’s jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the PPP references “uncompensated care pool.”

Columbia in *Evangelical Community Hospital, et al. v. Becerra*.²² In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he 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 . . ."²³ The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."²⁴ The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.²⁵ Here, the Board makes the same finding based on similar *overly generalized language*.

* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible days (Issue #3) including Section 1115 Waiver days. As no issues remain, the Board hereby closes Case No. 23-0248 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

8/11/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

²² No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

²³ *Id.* at *11.

²⁴ *Id.*

²⁵ *Id.*



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: *Notice of Dismissal*

Baylor Medical Center at Irving, Prov. No. 45-0079, FYE 06/30/2020
PRRB Case No. 24-1940

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 24-1940. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider’s Disproportionate Share Hospital (“DSH”) Medicaid Eligible Days/Section 1115 Waiver days issue.

Background

A. Procedural History for Case No. 24-1940

On **December 29, 2023**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end June 30, 2020.

On **June 18, 2024**, the Board received the Provider’s individual appeal request. The initial appeal request included nine (9) issues:

1. SSI - Provider Specific¹
2. SSI Unduly Narrow Definition of SSI Entitlement²
3. Medicaid Eligible Days
4. SSI MCD Pt C³
5. Improper Ruling – SSI Medicare Fraction Dual Eligible Days⁴
6. Improper Ruling – Medicaid Fraction Dual Eligible Days⁵

The Provider is commonly owned/controlled by Baylor Scott & White Health (hereinafter “BS&W”) and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R.

¹ On December 15, 2025, this issue was withdrawn.

² On January 31, 2025, this issue was transferred to Case No. 24-1926GC.

³ On January 31, 2025, this issue was transferred to Case No. 24-1930GC.

⁴ On January 31, 2025, this issue was transferred to Case No. 24-1928GC.

⁵ On January 31, 2025, this issue was transferred to Case No. 24-1929GC.

§ 405.1837(b)(1). For that reason, the Provider transferred issues 2, 4, 5 and 6 to BS&W CIRP Groups.

On **June 20, 2024**, 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 (*hereinafter* "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** state the material facts that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and provide arguments applying the material facts*** to the controlling authorities. This filing ***must include any exhibits the Provider will use to support its position*** and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.⁶

On **February 11, 2025**, the Provider timely filed its PPP and the Medicare Contractor ("MAC") filed its PPP on **June 9, 2025**.

On **November 26, 2025**, the MAC filed a jurisdiction challenge over the SSI Provider Specific & Medicaid Eligible Days issues. (SSI Provider Specific issue was subsequently withdrawn).

On **December 12, 2025**, the Provider filed a "Redacted Medicaid Eligible Days Listing" in OH CDMS.

On **December 13, 2025**, the Provider timely responded to the MAC's jurisdictional challenge.

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

The MAC contends the Provider failed to file a complete PPP including all supporting exhibits to document the merits of its argument and failed to properly develop its argument within its position papers in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rules 25 and 27. The Provider failed to timely submit a listing of additional Medicaid eligible days nor did it explain why it could not produce those documents.

Section 1115 Waiver Days

Finally, the MAC argues that the Provider is attempting to untimely and improperly add the Section 1115 Waiver days issue as a sub-issue via its PPP filed on February 11, 2025. The Provider originally characterized the Medicaid eligible days issue in its initial appeal request using the following language:

⁶ (Emphasis added.)

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.

The appeal request did not identify or mention the Section 1115 Waiver days issue. It was not until the PPP submission that the Provider raised the issue – (*which was more than 5.5 months after the regulatory deadline to add a new issue to the case.*) Therefore, the MAC contends that the Section 1115 Waiver days, which is a separate issue from the Medicaid eligible days issue, should be dismissed on the grounds that it was untimely and improperly added to the case.

Provider’s Jurisdictional Response

QRS filed its jurisdictional response brief on time, but only addressed the challenge related to the Section 1115 waiver days sub-issue. QRS argued that:

1. Based on the phrasing of the issue statement, the Provider timely appealed the Medicaid Eligible Days issue. The statement included the following language:

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. (Emphasis added.)

According to QRS, “[b]y definition, section 1115 waiver days are Medicaid eligible days. See 42 C.F.R. § 412.106(b)(4)(i) and (ii).”⁷

2. Regarding the MAC’s argument that the Provider abandoned the issue, QRS contends the MAC is required to accept and audit the Provider’s section 1115 waiver days per CMS instruction. QRS asserts that it submitted a redacted listing of section 1115 waiver days as a “supplement” to its August 12, 2025 position paper (via upload in OH CDMS) and submitted an unredacted version to the MAC.⁸

Decision of the Board

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

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

⁷ Jurisdictional Response at 1.

⁸ Jurisdictional Response at 3-4.

A. DSH Payment – Medicaid Eligible Days

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

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.⁹

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 (Dec. 2023) requires the Provider to file its complete, *fully* developed PPP with all available documentation and gives the following instruction on the content of position papers:

⁹ (Bold emphasis added.)

Rule 25 - Preliminary Position Papers¹⁰

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.

25.2.2 Unavailable and Omitted Documents

¹⁰ (Underline emphasis added to these excerpts and all other emphasis in original.)

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 June 20, 2024 Acknowledgement and Critical Due Dates notice issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish *each Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

The hospital has the burden of furnishing data adequate to prove eligibility for *each* Medicaid patient *day claimed* under this paragraph, *and of verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.¹¹

¹¹ (Emphasis added.)

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

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

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

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

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

On February 11, 2025, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.¹² Significantly, the PPP 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 \$44,993 based on an estimated 200 days).

The Provider’s complete briefing of this issue in its PPP 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

¹² Provider’s PPP at 10.

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.

Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider’s Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider’s Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).

Based on the listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its’ 2020 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.

With respect to section 1115 waiver days, the courts have firmly rejected CMS’s interpretation of its regulations, holding instead that the plain language of the statute and the regulations require inclusion in the Medicaid Fraction of the days belonging to individuals who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool. See *Forrest General Hospital*, 926 F.3d 221 (5th Cir. 2019);

HealthAlliance Hospitals, Inc. v. Azar, 346 F. Supp. 3d 43(D.D.C. 2018); Bethesda Health Inc., v. Azar, 389 F. Supp. 3d 32, (D.D.C. 2019), aff'd, 980 F.3d 121 (D.C. Cir. 2020). CMS has acquiesced in Bethesda and is now following the statute and the plain meaning of its own regulations (which regulations represent the official policy of CMS all along) and properly accounting for 1115 Waiver days as Medicaid Eligible days. See CMS Manual Instructions System, Change Request 12669, Transmittal No. 11912 (March 16, 2023) (“Transmittal 11912”), attached as Exhibit P-4.¹³

In its November 26, 2025 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid eligible days issue because:

- (1) the Provider was in violation of Board Rules 25.3 and 27.2 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary and final position 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.; and
- (2) the Provider failed to furnish an unredacted, auditable list of additional Medicaid eligible days with its PPP essentially abandoning 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 Board Rules.¹⁴
- (3) the Provider attempted to untimely, and improperly, add the Section 1115 waiver days issue by including it in its PPP submission.

On December 12, 2025, QRS uploaded a “Redacted Additional ME Days Listing” in the Office of Hearings Case and Document Management System (“OH CDMS”). The 3-page listing totaled roughly 446 “Additional ME Days.” The Listing does not explain why the number of days included was more than double the initial 200 days the Provider claimed in its appeal, nor did it explain why it was being submitted at this late date. Regardless, the filing ***was 10 months past the deadline for including it with the Provider’s PPP*** for which the deadline was February 13, 2025.

The Board concurs with the MAC - 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)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board also finds that the Provider failed to fully develop the merits of the

¹³ Provider’s PPP at 9-10.

¹⁴ 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.

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 Board rejects the Provider's attempts to include the eligible days listing uploaded to OH CDMS on December 12, 2025 (*purportedly, as a supplement to its PPP*) because:

1. The upload was filed **10 months after the deadline** for the exhibits to be included with the PPP filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)).
2. The uploaded exhibit fails to explain the following critical information: (a) *why* it was being filed so late (*i.e.*, upon what basis or authority should the Board accept the late filing); and (b) *why* the listing of the roughly 446 days were not previously available, *in whole or in part* (*i.e.*, it is not clear why the Provider failed to identify a single day at issue until almost a year and a half after this appeal was filed and almost 5.5 years after the fiscal year at issue had closed).
3. Neither the Board Rules, nor the June 20, 2024 Case Acknowledgment and Critical Due Dates notice, permit the Provider to file a "Supplement" to its PPP (nor did the Provider allege in the upload that they do).
4. Given that the *material* facts (*e.g.*, the days at issue) and all available exhibits were required to be part of the PPP filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its PPP or a supplement of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the appeal request, nor the PPP, identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the uploaded listing cannot be considered a refinement of the position paper since no specific days or listing were included with the PPP (indeed the *tentative* 446 days listed in the late exhibit is, without explanation, *significantly* larger than the original estimated 200 days included with the appeal request).¹⁵
5. Finally, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for **each** Medicaid patient day claimed"¹⁶ and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provide the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is \$0.

¹⁵ See, *e.g.*, Board Rule 27.3 (Nov. 2021) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."

¹⁶ (Emphasis added.)

B. Section 1115 Waiver Days

The Board has determined that the Section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the Section 1115 Waiver days.

The appeal was filed with the Board in June of 2024 and the regulations required the following:

(b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing...must be submitted in writing to the Board, and the request must include...

(2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final...determination under appeal, including an account of...

(i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]

(ii) How and why the provider believes Medicare payment must be determined differently for each disputed item...¹⁷

Board Rule 7.2.1 (2023) elaborated on this regulatory requirement, instructing providers:

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

- An issue title and a concise issue statement describing:
 - the adjustment, including the adjustment number,
 - the controlling authority,
 - why the adjustment is incorrect,
 - how the payment should be determined differently,
 - the reimbursement effect, and
 - the basis for jurisdiction before the [Board].

Board Rule 8 (2023) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "...each contested component must be appealed as a separate issue and described as narrowly as possible...". The Rule goes on:

Several examples are identified below, but these are not exhaustive lists of categories or issues.

¹⁷ 42 C.F.R. § 405.1835(b).

A. Disproportionate Share Hospital Payments

Common examples include: . . . *Section 1115 waiver days (program/waiver specific)*. . .¹⁸

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.¹⁹

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

(e) Adding issues to the hearing request. After filing a hearing request . . . a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –

. . .

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

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

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.²⁰ Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying Section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a Section 1115 Waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2019) states in pertinent part:

(4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

¹⁸ (Bold and italic emphasis added).

¹⁹ See 73 Fed. Reg. 30190 (May 23, 2008).

²⁰ 65 FR 47054, 47087 (Aug. 1, 2000).

(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

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

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

Regardless, even if the Provider had included in its appeal request (which it did not), the Provider failed to properly develop the issue in its PPP filing. First, the Provider's PPP does not identify the specific 1115 Waiver day program(s) at issue notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (2023). As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has 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." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 Waiver days sub-issue.

The Board's finding that neither the appeal request nor the PPP 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, et al. v. Becerra*.²¹ In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary

²¹ No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

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 . . .”²² The Court found that “[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently.”²³ The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.²⁴ Here, the Board makes the same finding based on similar *overly generalized language*.

* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible Days (Issue No. 3), including Section 1115 Waiver Days. As no issues remain, the Board hereby closes Case No. 24-1940 and removes it from the Board’s docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

8/11/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

²² *Id.* at *11.

²³ *Id.*

²⁴ *Id.*



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Flowers Hospital (Provider Number 01-0055)

FYE: 09/30/2019

Case Number: 24-0563

Dear Mr. Ravindran and Ms. Huggins,

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

Background:

A. Procedural History for Case No. 24-0563

On **June 29, 2023**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for the fiscal year ended September 30, 2019.

On **December 20, 2023**, the Board received the Provider’s individual appeal request. The initial Individual Appeal Request contained four (4) issues, and an additional issue was added on December 29, 2023, with an issue also being bifurcated in July, 2024. The final list of issues is as follows:

1. DSH Payment/SSI Percentage (Provider Specific)¹
2. DSH Payment – Medicaid Eligible Days
3. Medicare Managed Care Part C- SSI and Medicaid Fractions²
4. Dual Eligible Days- SSI Fraction^{3,4}
5. Capital DSH^{5,6}

¹ Issue withdrawn June 30, 2026.

² On July 24, 2024, the Provider transferred this issue to PRRB Case No. 23-0078GC.

³ On July 9, 2024, the Provider requested a bifurcation of this issue, and the Board granted on July 11, 2024.

⁴ On July 11, 2024, the Board dismissed this bifurcated SSI Fraction portion of the issue as it had already been directly added to PRRB Case No. 22-1006GC.

⁵ On December 29, 2023, the Provider added Capital DSH Issue.

⁶ On August 8, 2024, the Provider transferred this issue to PRRB Case No. 24-2216GC.

6. Dual Eligible Days- Medicaid Fraction⁷

On **January 9, 2024**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

Provider's Preliminary Position Paper – *For each issue, the position paper **must** state the material facts that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), **and provide arguments applying the material facts** to the controlling authorities. This filing **must include any exhibits the Provider will use to support its position** and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.⁸*

On **August 15, 2024**, the Provider filed its preliminary position paper ("PPP"), and the Medicare Contractor filed its preliminary position paper on **December 12, 2024**.

On **November 21, 2024**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 2. The Provider did not file a Jurisdictional Response.

On **November 25, 2024**, the Provider requested a Change of Representative, which the Board acknowledged on the same day.

As a result of transfers, and the withdrawal of issue #1 on June 30, 2026, there is one remaining issue in this appeal: Issue 2 (DSH Payment – Medicaid Eligible Days).

B. Description of Issue 2 in the Appeal Request

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

Statement of Issue

Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.

Statement of the Legal Basis

The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory

⁷ On July 24, 2024, the Provider transferred this bifurcated Medicaid Fraction issue to PRRB Case No. 23-0079GC.

⁸ (Bold, italics and underline emphasis added).

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 C.F.R. § 412.106(b) of the Secretary's Regulations.

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

Audit Adjustment Number(s): 5,17,18,19,22,23,24,30,32,33,S-D

Estimated Reimbursement Amount: \$106,834⁹

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the *Jewish Hospital* case¹⁰ and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated."¹¹

MAC's Contentions

Issue 3 – DSH Payment – Medicaid Eligible Days

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

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

Within its Provider's preliminary position paper, the Provider makes the broad allegation, ". . . the Provider contends that the total number of days reflected in its 2019 cost report does not reflect an accurate number of Medicaid eligible days. . ." ¹² The

⁹ Appeal Request at Issue 2 (Dec. 20, 2023).

¹⁰ *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994).

¹¹ Provider's Preliminary Position Paper at 8-9 (Aug. 15, 2024).

¹² See, Provider's Preliminary Position Paper at 9.

Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats their appeal request.¹³

With respect to Section 1115 waiver days, the MAC alleges that the Provider has attempted to untimely and improperly add the issue via its preliminary position paper, by adding the discussion of those days in the narrative.¹⁴

Provider's Jurisdictional Response

Board Rule 44.4.3 specifies: “[p]roviders must file a response within thirty (30) days of the Medicare contractor’s jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record.” The MAC filed its Jurisdictional Challenge on November 21, 2024. The Provider had until December 23, 2024, to file a timely response. To date, no response has been received.

Board Analysis and Decision:

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

As set forth below, the Board hereby dismisses the Provider’s Issue No. 2.

A. DSH Payment – Medicaid Eligible Days

The Provider did not include a list of the specific additional Medicaid eligible days that are in dispute in this case in either the initial appeal request or the PPP, including with the PPP only a redacted listing which does not contain all the necessary data fields, and does not identify Medicaid eligibility for the days in question.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Availability of Issue-Related Information and Basis for Dissatisfaction) (Dec. 2023) 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.

¹³ Medicare Administrative Contractor’s Jurisdictional Challenge at 10-11 (Nov. 21, 2024).

¹⁴ *Id.* at 12-13.

42 C.F.R. § 405.1853(b) 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.¹⁵

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 (Dec. 2023) requires the Provider to file its complete, *fully* developed PPP with all available documentation and gives the following instructions on the content of position papers:

Rule 25 - Preliminary Position Papers¹⁶

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.

¹⁵ (Bold emphasis added.)

¹⁶ (Underline emphasis added to these excerpts and all other emphasis in original.)

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the 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 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. . . .

25.2.3 List of Exhibits

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

25.3 Filing Requirements to Board

The Board requires the parties file a ***complete*** preliminary position paper that includes a fully developed narrative (Rule 25.1), all exhibits (Rule 25.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn.

COMMENTARY: Note that the change to require filing of the ***complete*** preliminary position paper was effective on August 29, 2018. Accordingly, failure to file a ***complete*** preliminary position paper with the Board will result in the Board dismissing your appeal or taking other actions in accordance with 42 C.F.R. § 405.1868. (See Rule 23.4.)

The January 9, 2024 Acknowledgement and Critical Due Dates notice issued to the Provider included instructions on the content of the Provider's PPP consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each Medicaid eligible day*** being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) (2021) 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.¹⁷

Along the same line, 42 C.F.R. § 405.1871(a)(3) (2020) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of

¹⁷ (Bold and italics emphasis added.)

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) (2021) 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 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.

On August 15, 2024, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.¹⁸ Significantly, the PPP 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 \$44,993 based on an estimated 200 days).

The Provider’s complete briefing of this issue in its PPP 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:

¹⁸ Provider’s PPP at 9.

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.

Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days (where applicable), which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider’s Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider’s Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days where applicable).

Based on the Listing of Medicaid Eligible days being sent under separate cover directly to the MAC (a redacted copy is attached), the Provider contends that the total number of days reflected in its 2019 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.¹⁹

In its November 21, 2024 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid eligible days issue because:

- (1) the Provider was in violation of Board Rules 25.3 and 27.2 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting

¹⁹ Provider’s PPP at 8-9.

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.; and²⁰

- (2) the Provider failed to furnish an unredacted, auditable list of additional Medicaid eligible days to the MAC with its PPP essentially abandoning 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 Board Rules.²¹
- (3) the Provider attempted to untimely, and improperly, add the Section 1115 waiver days issue by including it in its PPP submission.²²

The Board concurs with the MAC - 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)(4)(iii).

Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board also finds that the Provider 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).

B. Section 1115 Waiver Days

The Board has determined that the Section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the Section 1115 Waiver days.

The appeal was filed with the Board in June of 2024 and the regulations at that time required the following:

(b) Contents of request for a Board hearing on final contractor determination. The provider's request for a Board hearing...must be submitted in writing in the manner prescribed by the Board, and the request must include...

* * *

(2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final...determination under appeal, including an account of...

²⁰ Medicare Contractor's Jurisdictional Challenge at 10-12.

²¹ *Id.* at 12. 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 *Id.* at 12-16.

* * *

(i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]

(ii) How and why the provider believes Medicare payment must be determined differently for each disputed item...²³

Board Rule 7.2.1 (2023) elaborated on this regulatory requirement, instructing providers:

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

- An issue title and a concise issue statement describing:
 - the adjustment, including the adjustment number(s),
 - the controlling authority (*e.g.*, specific regulation, Federal register issuance, manual provision, or Ruling),
 - why the adjustment is incorrect,
 - how the payment should be determined differently,
 - the reimbursement effect, and
 - the basis for jurisdiction before the Board.

Board Rule 8 (2023) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and states:

...each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7. Several examples are identified below, but these are not exhaustive lists of categories or issues.

A. Disproportionate Share Hospital Payments

Common examples include, but are not limited to:

* * *

Section 1115 waiver days (program/waiver specific)²⁴

Effective August 21, 2008, following the appropriate notice and comment period, new regulations went into effect that limited the addition of issues to appeals.²⁵ As a result, 42 C.F.R. § 405.1835(c) was revised to state, in relevant part:

²³ 42 C.F.R. § 405.1835(b).

²⁴ (Bold and italic emphasis added).

²⁵ See 73 Fed. Reg. 30190 (May 23, 2008).

(e) Adding issues to the hearing request. After filing a hearing request... a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if the following requirements are met:

* * *

(4) The Board receives the request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) of this section.

Later revisions moved this portion of the regulation to 42 C.F.R. § 405.1835(e), but the substance remained unchanged. In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider properly or timely added the Section 1115 Waiver days issue to the case.

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.²⁶ Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying Section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a Section 1115 Waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2019) states, in pertinent part:

(4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

²⁶ 65 Fed. Reg. 47054, 47087 (Aug. 1, 2000).

(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

(iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.²⁷

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

Regardless, even if the Provider had included the issue in its appeal request (which it did not), the Provider failed to properly develop the issue in its PPP filing. First, the Provider's PPP does not identify the specific 1115 Waiver day program(s) at issue, notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (2023). As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has 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." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 Waiver days sub-issue.

The Board's finding that neither the appeal request nor the PPP 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, et al. v. Becerra*.²⁸ In that case, the provider's issue was tied to improper calculation of the DSH payment and read, in part, "[t]he 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."²⁹ The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."³⁰ The Court found that this description of the issue was a violation of Board rules and a proper basis on which the Board

²⁷ (Bold emphasis added.)

²⁸ No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

²⁹ *Id.* at *5.

³⁰ *Id.*

could dismiss the appeal.³¹ Here, the Board makes the same finding based on similar *overly generalized language*.

In summary, the Board dismisses the last remaining issue in this case – Medicaid Eligible Days (Issue No. 3), including Section 1115 Waiver Days. The Provider has failed to meet the Board requirements for submitting fully developed and complete position papers 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. 24-0563 and removes it from the Board’s docket.

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

Board Members Participating:

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

For the Board:

8/12/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A

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

³¹ *Id.*



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Heather Mogden
Hall, Render, Killian, Heath & Lyman, P.C.
330 East Kilbourn Avenue, Suite 1250
Milwaukee, WI 53202

RE: ***Notice of Dismissal***

Case Numbers: 22-0749G, 22-0750GC, 22-0753GC & 22-0755GC
FFY 2022 1115 Waiver Days Associated with Uncompensated Care Pool Groups

Dear Ms. Mogden:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests in Case Nos. 22-0749G, 22-0750GC, 22-0753GC and 22-0755GC. Set forth below is the decision of the Board.

Background:

The above-referenced group appeals were filed by the Providers' Representative (Hall, Render, Killian, Heath & Lyman, P.C.) on February 9, 2022, all timely filed from the August 13, 2021 IPPS Final Rule. All of the appeals are fully formed.

The group issue statement is framed as follows:

The Secretary of Health and Human Services (Secretary) has incorrectly interpreted and applied 42 C.F.R. § 412.106(b)(4) for qualified patients under 42 U.S.C. § 1315 (1115 Waiver Program) when determining a provider's Medicare Disproportionate Share Hospital (DSH) payment. Providers request a group appeal hearing in accordance with 42 C.F.R. §§ 405.1835 and 405.1837 to challenge the long withstanding policy CMS continues to implement to exclude patients eligible for a State's 1115 Waiver Uncompensated and/or Uninsured Care Pool Program when determining a provider's DSH payment for FY 2022. 86 Fed. Reg. 44774 (August 13, 2021).

As a result of the Secretary's incorrect interpretation of *eligible for Medicaid*, providers are receiving less DSH payments to which they are entitled to under 42 U.S.C. § 1396a(a)(13)(A). The Medicare Administrative Contractors ("MACs") and the Provider Reimbursement Review Board ("PRRB") have not permitted all § 1115 Waiver program inpatient days to be counted in provider's DSH Medicaid Fraction. The

Secretary takes the position that certain 1115 inpatient days are excluded from the Medicaid numerator's count of Medicaid eligible days when determining a provider's DSH payment unless the patient directly receives inpatient hospital insurance coverage on that day authorized under the 1115 Waiver Program. However, the Secretary's interpretation of 42 C.F.R. § 412.106(b)(4)(i), as stated below, is not only incorrect but arbitrary and capricious:

(b) Determination of a hospital's disproportionate patient percentage—

(4) Second computation. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

(i) For purposes of this computation, ***a patient is deemed eligible for Medicaid*** on a given day only if the patient is eligible for inpatient hospital services ***under an approved State Medicaid plan*** or under a waiver authorized under section 1115(a)(2) of the Act on that day, ***regardless of whether particular items or services were covered or paid under the State plan*** or the authorized waiver.

42 C.F.R. § 412.106(b)(4)(i).

The statutory language is clear: the patient is to be counted in the numerator of the Medicaid fraction of the DSH formula if the patient is eligible for inpatient hospital services under an approved 1115 waiver program, which includes a state's 1115 Waiver Uncompensated and/or Uninsured Care Pool programs. In recent years, Courts have examined the Secretary's interpretation and application of 42 C.F.R. § 412.106(b)(4) in *Health Alliance*, *Forrest General*, and *Bethesda*, as discussed below. All three cases have rendered favorable decisions that provide precedent to advance and support the Providers' position. The Providers assert that the certain states that have been granted approval by the Secretary for a 1115 Waiver Program under 42 U.S.C. § 1315 and are harmed by the Secretary's violation of 42 C.F.R. § 412.106(b)(4). In particular, the Secretary's interpretation of "*Medicaid eligible patients*" is clearly contrary to the plain and unambiguous text of 42 C.F.R. § 412.106(b)(4).

First, in *Health Alliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. 2018), the Court held the Secretary's interpretation of 42 C.F.R. § 412.106(b)(4) was arbitrary and capricious when the PRRB deemed

Massachusetts' Commonwealth Care patients ineligible for inpatient hospital services under the 1115 Waiver Program. Thus, patient days for Commonwealth Care were excluded from the provider's DSH calculation, resulting in a substantial loss of entitled payment for FY 2017 and beyond. The Court found that the plain language of the applicable regulations unambiguously requires that all patient days attributable to individuals receiving health insurance through Medicaid or through a roughly equivalent authorized 1115 Waiver Program (as evidenced by the provision of 'inpatient hospital services') must be counted in the Medicaid fraction's numerator.

Similarly, in *Forrest General Hospital v. Azar*, 926 F. 3d 221 (5th Cir. 2019), the Court held the Secretary's decision to exclude patient days covered by a state's 1115 Waiver Program from the Medicaid fraction's numerator was also arbitrary and capricious. The Court found that the unambiguous statute means that patients who are not actually Medicaid-eligible ***still count*** towards the Medicaid fraction's numerator if they are considered or deemed to be capable of receiving a 1115 Waiver Program's helpful or useful effects by reason of a 1115 Waiver Program's authority.

Finally, in *Bethesda Health, Inc. v. Azar*, 980 F. 3d 121 (D.C. Cir. 2020), the Court held that patient days for uninsured and underinsured patients whose uncompensated inpatient hospital services were reimbursed through Florida's demonstration project were includable in DSH calculations. The Court found the Secretary's own regulation states that, for the purposes of calculating the Medicaid fraction, "hospitals may include all days attributable to populations eligible for [Medicaid] matching payments through a [demonstration project]" so long as the services provided under the demonstration project include "inpatient hospital services." 42 C.F.R. § 412.106(b)(4). Although the Secretary argued the text of the regulation allows hospitals to include days of care provided under a demonstration project only if the project entitles specific patients to a specific inpatient benefit package, the Court rejected this argument. Rather, the patient must have been "eligible for inpatient services," meaning the demonstration project enabled the patient to receive inpatient services, regardless whether the project gave the patient a *right* to these services or allowed the patient to enroll in an insurance plan that provided inpatient services and made payment specifically on the patients behalf. *Bethesda Health*, 980 F. 3d at 113.

On May 10, 2021, the Centers for Medicare & Medicaid Services (CMS) published the, [sic] proposing to exclude certain section 1115 waiver days from the DSH Medicaid fraction. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term

Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2022 Rates, 86 Fed. Reg. 25070, 25457-59 (May 10, 2021). CMS contends that days for which hospitals receive payment from the section 1115 demonstration project uncompensated/uninsured care pool programs should be excluded from the numerator of the Medicaid fraction because the 1115 waiver payment was not made specifically on the patients behalf. Similarly, CMS contends that days for which patients receive premium assistance under a section 1115 demonstration project should be excluded from the numerator of the Medicaid fraction. To this end, CMS proposed to amend 42 C.F.R. § 412.106(b)(4)(i) to “state explicitly that a patient is deemed eligible for Medicaid for the purposes of the DSH calculation on a given day, and the corresponding patient day is included in the numerator of the Medicaid fraction, only if the patient . . . directly receives inpatient hospital insurance coverage on that day under a waiver authorized under section 1115(a)(2) of the Act.” In the Final Rule, CMS has failed to instruct MACs to include such 1115 Waiver uncompensated/uninsured care pool patient days in the DSH Medicaid Fraction in accordance with the above referenced precedent and statutory language of 42 C.F.R. § 412.106(b)(4). 86 Fed. Reg. 44774, 45249 (August 13, 2021). As a result, CMS has intentionally ignored clear and unambiguous language and the D.C. Court of Appeals determination in Bethesda, in which CMS did not seek review by the Supreme Court, to reduce a Provider’s DSH payment. Instead CMS indicated “Due to the number and nature of the comments that we received on our proposal, we intend to address the public comments in a separate document. We refer individuals interested in reviewing the background information and the discussion regarding these policies to the FY 2022 IPPS/LTCH PPS proposed rule (86 FR 25457 through 25459).” 86 Fed. Reg. 44774, 45259 (August 13, 2021).

Providers assert the Secretary’s application of 42 C.F.R. § 412.106(b)(4), based on court precedent and statutory construction, is incorrectly excluding patients who receive inpatient services under a state’s 1115 Waiver Uncompensated and/or Uninsured Care Pool Program in the Medicaid numerator’s count of Medicaid eligible days when determining a provider’s DSH payment. This agency position is not entitled to any agency deference.¹

¹ E.g., Case No. 22-0749G, Group Issue Statement at 1-3 (Feb. 9, 2022).

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”).² Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.³

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.⁴ 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.⁵

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage (“DPP”).⁶ 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.⁷ The DPP is defined as the sum of two fractions expressed as percentages.⁸ 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

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.⁹

² See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

³ *Id.*

⁴ See 42 U.S.C. § 1395ww(d)(5).

⁵ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

⁶ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

⁷ See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

⁸ See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

⁹ 42 C.F.R. § 412.106(b)(2)-(3).

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.

In determining under [this subclause] 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 Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under subchapter XI.

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.¹⁰

Until its recent amendment, the implementing regulation at 42 C.F.R. § 412.106(b)(4) (2021) read, with regard to computing the Medicaid Fraction:

(4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

¹⁰ 42 C.F.R. § 412.106(b)(4).

(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

B. Background on Medicaid State Plans and § 1115 Waivers

Medicaid is a joint Federal and state program, established in Title XIX of the Social Security Act (the “Act”).¹¹ To participate in the Medicaid program and receive federal matching funds (commonly referred to as federal financial participation or “FFP”),¹² a state must enter into an agreement (“State Plan”) with the Federal government, describing the individuals covered, services provided, reimbursement methodologies for providers, and other administrative activities.¹³

Federal law provides states flexibility in operating Medicaid programs through multiple waivers of federal law and demonstration programs. To address the medical needs of its residents, a State may choose to apply for, and include in its State Plan, a demonstration program under § 1115 of the Act which allows CMS to waive various Federal Medicaid eligibility and benefits requirements. These projects expand Medicaid eligibility to populations who would ordinarily be disqualified from receiving benefits under the State Plan. The costs of such a demonstration project, including the costs of patient treatment, are regarded as expenditures under the State Plan and thus eligible for Federal matching funds.¹⁴ The Secretary has delegated the administration of these demonstration projects to CMS which approves, and provides federal matching funds for, various waivers that expand both the populations who qualify for Medicaid and the health services available under a waiver.¹⁵

In 2000, the Secretary published an interim rule to address the DSH adjustment calculation policy in reference to § 1115 waiver days.¹⁶ Prior to this interim rule, “hospitals were to include in the Medicare DSH calculation only those days for populations under the section 1115 waiver who were or could have been made eligible under a State plan.”¹⁷ Patient days for any expanded populations were to be excluded.¹⁸ The interim rule revised this policy “to allow hospitals to include the patient days of all populations eligible for Title XIX matching payments in a State's section 1115 waiver in calculating the hospital's Medicare DSH adjustment.”¹⁹

¹¹ 42 U.S.C. § 1396; 42 C.F.R. § 430.0.

¹² 42 U.S.C. § 1396b.

¹³ 42 U.S.C. § 1396a.

¹⁴ 42 U.S.C. § 1315(a)(2)(A).

¹⁵ *Id.*

¹⁶ 65 Fed. Reg. 3136 (Jan. 20, 2000). The interim rule was followed by a final rule, as well. 65 Fed. Reg. 47054, 47086-87 (Aug. 1, 2000).

¹⁷ 65 Fed. Reg. at 3136.

¹⁸ *Id.*

¹⁹ *Id.* at 3136-3137. *See also* 65 Fed. Reg. at 47086-47087 (Aug. 1, 2000).

In 2003, however, the Secretary amended the DSH regulation to specify that a patient shall be “deemed eligible for Medicaid on a given day only if the patient is *eligible for inpatient hospital services* under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2).”²⁰ The rationale was that “certain section 1115 demonstration projects . . . serve expansion populations with benefit packages so limited that the benefits are not similar to the medical assistance available under a Medicaid State plan.”²¹ The purpose of the refinement was to include in the Medicaid Fraction only days of waiver populations where they were provided inpatient hospital benefits equivalent to the care provided to beneficiaries under a Medicaid State Plan.²² To achieve this, the DSH regulation at 42 C.F.R. § 412.106(b)(4)(i) was amended to specify that “a patient is deemed eligible for Medicaid on a given day **only if the patient is eligible for inpatient hospital services** under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day”²³

In 2006, Congress passed the Deficit Reduction Act of 2005, which amended 42 U.S.C. § 1395ww(d)(5)(F)(vi)²⁴ by adding the following language below subclause (II):

In determining under subclause (II) 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 title XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI.

The Secretary has interpreted this amendment as confirming that the days of waiver day groups are not automatically “eligible for Medicaid under a State plan,” that she has the discretion to determine the extent to which patients are “not so eligible,” and to what extent, if any, they may be “regarded as eligible” and thus included in the Medicaid fraction.²⁵

To this end, the Secretary has noted a rise in § 1115 waiver demonstrations which “authorize funding a limited and narrowly circumscribed set of payments to hospitals . . . [such as § 1115 demonstrations which] include funding for uncompensated/undercompensated care pools.”²⁶ These pools do not extend health insurance to such individuals or benefits similar to Medicaid beneficiaries under a State plan. Instead, they provide funds directly to hospitals to offset

²⁰ 68 Fed. Reg. 45346, 45470 (Aug. 1, 2003).

²¹ *Id.* at 45420.

²² See 88 Fed. Reg. 58460, 59014 (Aug. 28, 2023).

²³ (2021) (emphasis added).

²⁴ Pub. L. 109-171, § 5002, 120 Stat. 4, 31 (2006).

²⁵ 88 Fed. Reg. at 59014.

²⁶ *Id.* at 59015.

treatment costs for uninsured and underinsured patients.²⁷ As such, these days have been typically excluded from the Medicaid fraction of the DSH calculation because the days associated with these § 1115 demonstrations do not create inpatient hospital eligibility.

The Secretary acknowledged that several court decisions have disagreed with this approach and ruled that 42 C.F.R. § 412.106(b)(4) requires the inclusion of days for which hospitals received payment from a uncompensated/undercompensated care pool authorized by a § 1115 waiver.²⁸ Thus, in the FY 2022 IPPS/LTCH PPS proposed rule,²⁹ the Secretary proposed to revise the regulation to more clearly state that “the only section 1115 days that may be counted in the numerator of the Medicaid fraction are the days of patients for whom a section 1115 waiver provides inpatient hospital insurance coverage benefits directly to that patient on that day.”³⁰ After reviewing comments on the proposal, the Secretary proposed different revisions to the regulations in the FY 2023 IPPS/LTCH PPS proposed rule,³¹ but opted not to finalize them after reviewing comments on the proposal.³²

Decision of the Board

Pursuant to 42 C.F.R. § 405.1837(a), a group of providers generally have the right to a hearing before the Board “with respect to a final contractor or Secretary determination *for the provider’s cost reporting period*”³³ if each individual provider satisfies the requirements for a Board hearing under § 405.1835(a) and the group’s amount in controversy is \$50,000 or more. Per 42 C.F.R. § 405.1835(a), an individual provider generally has a right to a hearing before the Board “with respect to a final contractor or Secretary determination *for the provider’s cost reporting period*”³⁴ if:

- It “is dissatisfied *with the contractor’s final determination of the total amount of reimbursement due the provider*, as set forth in the contractor’s written notice specified under § 405.1803”³⁵ In other words, providers must appeal from a “final determination” that impacts payment for the period under appeal.³⁶

²⁷ *Id.*

²⁸ *Id.* (citing *Bethesda Health, Inc. v. Azar*, 980 F.3d 121 (D.C. Cir. 2020); *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. 2018)).

²⁹ 86 Fed. Reg. 25070 (May 10, 2021).

³⁰ *Id.* at 25459.

³¹ 87 Fed. Reg. 28108 (May 10, 2022).

³² 87 Fed. Reg. 48780, 49051 (Aug. 10, 2022).

³³ (Emphasis added).

³⁴ (Emphasis added).

³⁵ 42 C.F.R. § 405.1835(a)(1) (emphasis added).

³⁶ See also 42 U.S.C. § 1395oo(a)(1)(A); *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-146 (D.C. Cir. 1986) (stating: “Viewing the amendments as a whole, we are inescapably drawn to the same conclusion as the District Court: § 1395oo (a) ‘clearly contemplates two different kinds of appeal. One begins when the intermediary issues an NPR; the other, when the intermediary issues a notice of *what will be paid under the PPS system*.’ . . . Under PPS, in contrast, *payment amounts* are independent of current costs and *can be determined with finality* prior to the beginning of the cost

- The request for a hearing is filed within 180 days of the date of receipt of the final determination.³⁷

42 C.F.R. § 405.1837(c)(1) specifically notes that the hearing request must include “[a] demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) [which includes the requirements of 42 C.F.R. § 405.1835(a)].” As noted above, Section 405.1835(a) states, in pertinent part, that a provider has a right to a Board hearing:

[w]ith respect to a final ... determination ***for the provider’s cost reporting period***, if – (1) The provider is dissatisfied with the contractor’s final *determination* of total amount of *reimbursement due the provider*, as set forth in the contractor’s written notice specified under § 405.1803.³⁸

42 C.F.R. § 405.1801(a) defines the term “contractor determination” including the following:

(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.

(3) For purposes of appeal to the Provider Reimbursement Review Board, the term is synonymous with the phrases “intermediary's final determination,” “final determination of the organization serving as its fiscal intermediary,” “Secretary's final determination” and “final determination of the Secretary,” as those phrases are used in section 1878(a) of the Act, and with the phrases “final contractor determination” and “final Secretary determination” as those phrases are used in this subpart.

Similarly, paragraph (c)(2) of 42 C.F.R. § 405.1837 requires certain information relative to each specific item under appeal with respect to the final determination under appeal:

year. Id. § 412.71(d). Thus a year-end cost report is not a report which is necessary ***in order for the Secretary to make PPS payments***, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal.” (emphasis added and citations omitted)).

³⁷ 42 U.S.C. § 1395oo(a)(3); 42 C.F.R. §§ 405.1835 – 1840.

³⁸ (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.

42 C.F.R. § 405.1837(a)(3) also states that a group must demonstrate that the amount in controversy is \$50,000 or more. Satisfying the criteria set out in 42 C.F.R. §§ 405.1835(a) and 1837(a) is required before the Board can exercise jurisdiction over an appeal.³⁹

The Providers are appealing the Final Rule published on August 13, 2021. 42 U.S.C. § 1395oo(a)(1)(A)(i) allows for a hearing before the Board if a provider:

is dissatisfied **with a final determination of the organization serving as its fiscal intermediary** pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report.⁴⁰

The Board notes that the “final determination” being appealed in this case is a final rule published in the federal register, which is not a final determination of the Providers’ fiscal intermediary.

42 U.S.C. § 1395oo(a)(1)(A)(ii) does, however, allow for an appeal from a Secretary determination. The statute allows an appeal if a Provider:

³⁹ 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled “Board Jurisdiction” but it also addresses certain claim filing requirements such as timelines or filing deadlines. However, whether an appeal was timely is not a jurisdictional requirement but rather is a claim filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013). See also Board Rule 4.1 (“The Board will dismiss appeals that fail to meet the timely filing requirements **and/or** jurisdictional requirements.”) Similarly, the Board notes that 42 C.F.R. § 405.1835(b) addresses claim filing requirements.

⁴⁰ (Emphasis added.)

(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 title⁴¹

The Medicare statute authorizes providers to seek hearings before the PRRB in two sets of circumstances: First, where the provider is dissatisfied with “the amount of total program reimbursement” as set forth in a Notice of Program Reimbursement (NPR); and second, where the provider is dissatisfied with a “final determination” “as to the amount of the payment” under the prospective payment system. In this case, the Providers in these groups have not yet received NPRs and have based their appeals, pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(ii), on their dissatisfaction with the 2022 Final Rule.

The district court in *Battle Creek*⁴² first observed that the challenged Transmittal and publication of data there “provided, with some finality, advance knowledge of the amount of [the DSH] payment.”⁴³ On appeal, however, the Court of Appeals for the D.C. Circuit very recently disagreed with the lower court’s reasoning, and reversed that decision finding:

According to the Board, the hospitals needed to wait until they knew the final amount of their DSH adjustment rather than just the determination of one component of it. The district court disagreed and concluded that the hospitals’ challenge could go forward. Because we agree with the Board, we reverse the district court.⁴⁴

The Court also distinguished *Battle Creek* from *Washington Hospital Center*,⁴⁵ and continued:

This case is different. Here, the Medicare fraction had been published and the hospitals sought to challenge its calculation. But other components of the DSH adjustment (and thus of the per-patient payment amount) had yet to be finalized. Indeed, the hospitals could not know that they would be eligible for a DSH adjustment based on the Medicare fraction alone. The Medicaid fraction remained outstanding, and so too, therefore, did the disproportionate-patient percentage, and ultimately the hospitals’ eligibility for, and amount of, any DSH adjustment. See pp. ———, ———, supra. Those are finally settled upon issuance of an NPR. Unlike in *Washington Hospital Center*, then, in this case there had been no “final determination of the Secretary as to the

⁴¹ (Emphasis added).

⁴² *Battle Creek Health System v. Becerra*, 2023 WL 7156125 (D.D.C. 2023).

⁴³ *Id.* at *5.

⁴⁴ *Battle Creek Health System v. Kennedy*, 151 F.4th 464, 465 (D.C. Cir. 2025).

⁴⁵ *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139 (D.C. Cir. 1986).

amount of the payment” under the PPS. 42 U.S.C. § 1395oo(a)(1)(A)(ii).⁴⁶

The Board agrees and has found that the publication of the challenged Final Rule and does not definitively inform whether a provider qualifies for the DSH adjustment much less the amount of DSH reimbursement that a provider could receive.

The Board maintains that the Court of Appeals decision in *Battle Creek*, and the 2022 decision in *Memorial Hospital v. Becerra*,⁴⁷ are better-reasoned decisions. The court in *Memorial Hospital* ultimately agreed with the Board that CMS’ publication of Medicare/SSI Fractions was not an appealable final determination. In that decision, the court distilled the parties’ positions as “boil[ing] down to a dispute about whether Plaintiffs have conflated a determination by the Secretary about one of several undetermined elements that eventually flows into the amount of payment and ‘a final determination of the Secretary as to the amount of payment.’”⁴⁸ The court held that CMS’ publication of Medicare/SSI Fractions, even if the publication of such fractions had been issued as “final,” could and would not be a final determination “as to the amount of payment” because the Medicare/SSI Fractions are “just one of the variables that determines whether hospitals receive a DSH payment and, if so, for how much.”⁴⁹ For the court, “[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).’”⁵⁰

For the instant appeals, the providers appealed from the August 13, 2021 Final Rule, which “continues to . . . exclude patients eligible for a State’s 1115 Waiver Uncompensated and/or Uninsured Care Pool Program when determining a provider’s DSH payment for FY 2022.”⁵¹ In these cases, the providers are appealing a final rule in which, “CMS has failed to instruct MACs to include such 1115 Waiver uncompensated/uninsured care pool patient days in the DSH Medicaid Fraction in accordance with . . . precedent and statutory language of 42 C.F.R. § 412.106(b)(4).”⁵² The August 13, 2021 Final Rule being appealed in the instant cases is **not** the only determination or variable on which the Providers’ DSH payments depend. Just like the publication of SSI ratios, the policy at issue impacts one of many variables in calculating the Provider’s DSH payment and is thus not an appealable final determination.

As discussed above, the Board finds that the August 13, 2021 Final Rule appealed in the instant cases 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. Since satisfying the criteria set out in 42 C.F.R.

⁴⁶ *Battle Creek Health System v. Kennedy* at 471.

⁴⁷ 2022 WL 888190 (D.D.C. Mar. 25, 2022).

⁴⁸ *Id.* at *8.

⁴⁹ *Id.* at *9.

⁵⁰ *Id.* at *8.

⁵¹ *E.g.*, Case No. 22-0749G, Group Issue Statement at 1.

⁵² *Id.* at 3.

§ 405.1835 is required before the Board can exercise jurisdiction over an appeal,⁵³ and since the Providers have failed to demonstrate in their hearing requests that those criteria have been met for the year under appeal (*i.e.*, FY 2022), the Board is permitted under § 405.1835(b) to “dismiss with prejudice the appeal or take any other remedial action it considers appropriate.”⁵⁴ In this instance, the Board finds it is appropriate to dismiss the appeals ***with prejudice*** and remove them from the Board’s docket. The Board finds this to be an appropriate remedial action based on its findings that the August 13, 2021 Final Rule is not an appealable final determination.

* * * * *

Based on the foregoing, the Board dismisses with prejudice Case Nos. 22-0749G, 22-0750GC, 22-0753GC and 22-0755GC.

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

Board Members Participating:

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

For the Board:

8/14/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A

cc: Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Cecile Huggins, Palmetto GBA (J-J)
Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson C. Leong, FSS

⁵³ 42 C.F.R. § 405.1840(a), (b).

⁵⁴ 42 C.F.R. § 405.1835(b).



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Nan Chi, Director of Budget & Compliance
Houston Methodist Hospital System
8100 Greenbriar, GB 240
Houston, TX 77054

RE: Own Motion ***Dismissal and Order to File New CIRP Group***
Houston Methodist Willowbrook Hospital (Prov. No. 45-0844), FYE 12/31/2018
Case No. 23-1006

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 23-1006. Set forth below is the decision of the Board to dismiss the issue in this appeal challenging the Provider’s Disproportionate Share Hospital (“DSH”) Payment SSI (Provider Specific) and an order to form a new group for the DSH Payment -SSI Systemic Errors issue.

Background:

On **August 29, 2022**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end December 31, 2018. The Provider is commonly owned by Houston Methodist Hospital System (“Houston Methodist”).

On **February 22, 2023**, Houston Methodist filed the Provider’s individual appeal request which included seven (7) issues:

1. DSH Payment (Provider Specific)
2. DSH Payment (SSI Systemic Errors)¹
3. DSH Payment (Medicare Part C Days)²
4. DSH Payment (Medicare Dual Eligible Days)³
5. DSH Payment (Medicaid Part C Days)⁴
6. DSH Payment (Medicaid Dual Eligible Days)⁵
7. Standardized Payment Amount⁶

¹ On September 6, 2023, this issue was transferred to PRRB Case No. 23-1635GC.

² On September 6, 2023, this issue was transferred to PRRB Case No. 23-1637GC.

³ On September 6, 2023, this issue was transferred to PRRB Case No. 23-1636GC.

⁴ On September 6, 2023, this issue was transferred to PRRB Case No. 23-1637GC.

⁵ On September 6, 2023, this issue was transferred to PRRB Case No. 23-1638GC.

⁶ On September 6, 2023, this issue was transferred to PRRB Case No. 21-1569GC.

Since the Provider is commonly owned/controlled, it 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 **September 6, 2023**, Houston Methodist transferred Issues 2 through 7 to CIRP groups.⁷

On **February 23, 2023**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties’ preliminary position papers (*hereinafter* “PPP”).

On **October 19, 2023**, the Provider timely filed its PPP followed by the Medicare Contractor’s (“MAC”) PPP on **January 26, 2024**.

On **December 4, 2024**, the Board denied the Provider’s request to transfer the SSI Systemic Errors issue to the “DSH SSI Unduly Narrow Definition of SSI Entitlement” in Case No. 23-1635GC for four providers, including Houston Methodist Willowbrook Hospital. The Board found that the Providers appealed distinctly different issues in their individual appeals from which they transferred that the issue under appeal in the group. As a result, the issue was returned to the individual appeals: Case Nos. 23-1006, 23-1209, 23-1466 and 23-1728.

A. Description of Issue 1 in the Appeal Request and PPP

In its Individual Appeal Request and PPP, the Provider summarizes its DSH Payment (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 and the subsequent audit adjustment to the Provider’s cost report by the MAC are both flawed.

The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that

⁷ As a result of the transfers, and after the denial of the transfer of Issue 2, there are two (2) remaining issues in this appeal: Issue 1 - DSH Payment (Provider Specific) and Issue 2 – DSH Payment (SSI Systemic Errors).

CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).⁸

B. Description of Issue 2 in the Appeal Request and PPP

In its Appeal Request and PPP, the Provider summarizes its DSH Payment-SSI-Systemic Errors issue as follows:

Statement of the Issue:

Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage.

Statement of the Legal Basis

The Providers 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)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Reports does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.

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

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.⁹

The amount in controversy in the Provider's individual appeal request for Issue 1 is \$17,289 and for Issue 2 is \$17,288.

⁸ Issue Statement at 1 and PPP at 1-2.

⁹ Issue Statement at 2 and PPP at 2-3.

Board Analysis and Decision:

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

As set forth below, the Board hereby dismisses the Provider's Issue No. 1.

A. DSH Payment (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider's disagreement with how the MAC 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's disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the SSI (Systemic Errors) issue at Issue No. 2.

The SSI (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.”¹⁰ Per the appeal request, the Provider's legal basis for its SSI Percentage (Provider Specific) issue asserts 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).”¹¹ The Provider argues that “its[sic] 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 SSI (*Systemic Errors*) issue at Issue No. 2 also alleges that the MAC and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to several factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the SSI (Provider Specific) issue (No. 1) in Case No. 23-1006 is duplicative of the SSI (*Systemic Errors*) issue (No. 2). Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by

¹⁰ Issue Statement at 1.

¹¹ *Id.*

¹² *Id.*

PRRB Rule 4.6¹³, the Board dismisses this aspect of the DSH Payment SSI (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.¹⁴ Accordingly, the Provider's reference to Issue No. 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue No. 2.

To this end, the Board also reviewed the Provider's PPP to see if it further clarified Issue No. 1 and No. 2. The Provider's PPP used the same language as the issue statements filed with the individual appeal request and did not provide any basis upon which to distinguish the two issues. Moreover, the Board finds that the Provider's PPP failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be *fully* developed and include *all available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of any alleged "errors" in its PPP and include *all* exhibits.

In addition, 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 (Nov. 1, 2021)

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

¹³ PRRB Rules v. 3.1 (Nov. 2021).

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

¹⁵ (Italics and underline emphasis added.)

The Board notes that there have been developments on the availability of data underlying the SSI fraction, such as MEDPAR data. For example, as noted in the FY 2006 IPPS Final Rule:

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

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

<https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh>.¹⁶

Accordingly, *based on the record before it*, the Board finds that the component of the SSI Provider Specific issue related to whether the MAC used the correct SSI Percentage in the DSH calculation is duplicative of the SSI Systemic Errors issue (No. 2) in the instant appeal.¹⁷ 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 SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

The second aspect of the 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.

¹⁶ Last modified on July 31, 2026.

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 Houston Methodist Hospital System CIRP group per 42 C.F.R. § 405.1837(b)(1).

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" Moreover, without this written request, the MAC cannot issue a final determination with which the Provider can be dissatisfied for Board appeal purposes. There is nothing in the record to indicate the MAC has made a final determination regarding DSH SSI Percentage realignment. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

B. DSH Payment – SSI- Systemic Errors

As the Parties are aware, the Provider initially transferred its SSI Systemic Errors issue (No. 2) to an Unduly Narrow CIRP group (Case No. 23-1635GC). In a determination issued on December 4, 2024, the Board found that the group issue under appeal in Case No. 23-1635GC related to the exclusion of unpaid SSI days from the Medicare Fraction numerator and discussed the definition/interpretation of the word "entitled."¹⁸ Conversely, the issue statements in the individual appeals for the four participants that had transferred to the group were NOT consistent with the Unduly Narrow Definition of SSI Entitlement issue under appeal in the group. Instead, all four providers appealed the "Baystate" aspect of the SSI Accuracy issue which involves SSI data matching and the potential errors in that process.¹⁹ Accordingly, the Board denied the transfer of the SSI Systemic Errors issue for Houston Methodist ("HM") Willowbrook, HM San Jacinto, HM West and HM St. John from their respective individual appeals, Case Nos. 23-1006, 23-1209, 23-1466 and 23-1728. Therefore, the SSI Systemic issue was returned to each individual appeal and is currently pending in Case Nos. 23-1006, 23-1209, 23-1466 and 23-1728.

The regulation at 42 C.F.R. § 405.1837(b)(1), requires that commonly owned or controlled providers file group appeals for each common issue of fact, law or rulings (*i.e.*, file common issue related party group appeals ("CIRPs")). See also Board Rules 12 and 13 regarding the formation of group appeals. In its December 2024 determination, the Board directed Houston Methodist or QRS (the group rep of the Unduly Narrow CIRP) to file a new SSI Systemic Errors CIRP group to which the providers could transfer. On **December 23, 2024**, QRS formed the "Houston Methodist CY 2018 SSI Percentage CIRP Group" under Case No. 25-1169GC. The group was formed in the Office of Hearings Case & Document Management System ("OH CDMS") without any participants. On **March 4th, 2025**, after more than 71 days without a transfer or direct add, the Board dismissed the group.

Within 15 days of this notification, the Board is, once again, ordering Houston Methodist to form a new CIRP group for the CY 2018 SSI Systemic Errors issue in OH CDMS. Immediately upon formation, Houston Methodist must effectuate the transfer of the SSI Systemic issue from Case Nos. 23-1006, 23-1209, 23-1466 and 23-1728. Failure to establish the new CIRP group and effectuate the transfers will result in dismissal of the SSI Systemic issues from Case Nos. 23-1006, 23-1209, 23-1466 and 23-1728 as the issues will considered to have been abandoned.

¹⁸ The group issue cited *Becerra v. Empire Health Found.*, 142 S. Ct. 2354 (2022).

¹⁹ *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008)

Based on the foregoing, the Board is dismissing the DSH Payment SSI (Provider Specific) - Issue No. 1. The individual appeal will remain pending for an additional 15 days to allow the establishment of the SSI Systemic CIRP group and the effectuation of the transfer of Issue No. 2.

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

Board Members Participating:

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

For the Board:

8/17/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Wilson C. Leong, Esq., Federal Specialized Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Dismissal of DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues***

Baptist Health – Fort Smith (Provider No. 04-0055), FYE 10/31/2018, Case No. 23-0917

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 23-0917. Set forth below is the background of the case and the Board’s decision related to the issues challenging the SSI-Provider Specific and Medicaid Eligible Days issues.

Background:

A. Procedural History for Case No. 23-0917

On **August 31, 2022**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end Oct. 31, 2018.

On **February 9, 2023**, Community Health Systems, Inc. (“CHS”) filed the Provider’s appeal request. The request included five (5) issues:

1. DSH Pymt/ SSI% (Provider Specific)
2. DSH Pymt/ SSI% (Systemic Errors)¹
3. DSH Pymt - Medicaid Eligible Days
4. Medicare Managed Care Part C Days – SSI & Medicaid Fraction²
5. Dual Eligible Days –SSI & Medicaid Fraction³

The Provider is commonly owned by CHS so it is subject to the mandatory common issue related party (“CIRP”) group regulation at 42 C.F.R. § 405.1837(b)(1).

¹ On September 13, 2023, this issue was transferred to an SSI Percentage Group, Case No. 21-1206GC. On August 4, 2026, the Board denied that transfer. On August 5, 2026, QRS transferred the issue to a CHS CY 2018-2019 Unduly Narrow CIRP group, Case No. 26-2711GC.

² On September 13, 2023, this issue was transferred to Case No. 20-2149GC.

³ On September 13, 2023, this issue was transferred to Case No. 21-0066GC.

On **February 10, 2023**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** state the material facts that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and provide arguments applying the material facts*** to the controlling authorities. This filing ***must include any exhibits the Provider will use to support its position*** and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.⁴

On **October 4, 2023**, CHS timely filed the Provider's PPP and on **January 26, 2024**, the Medicare Contractor ("MAC") timely filed its PPP.

On **April 3, 2026**, the Board issued a Notice of Hearing scheduling the case for a hearing on **September 11, 2026**.

On **June 12, 2026**, CHS filed the Provider's final PP and on **July 9, 2026**, the Medicare Contractor ("MAC") filed its final PP.

On **June 22, 2026**, CHS requested a change of representation to Quality Reimbursement Services, Inc. ("QRS"), which the Board granted on **June 25, 2025**.

On **July 9, 2026**, the MAC filed a jurisdictional challenge over the DSH SSI Provider Specific & Medicaid eligible days issues in the case.

B. Description of Issue 1 in the Individual Appeal Request

In its Individual Appeal Request, the Provider summarizes its DSH SSI 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.

⁴ (Emphasis added).

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

On October 4, 2023, the Board received the Provider's PPP in Case No. 23-0917. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Provider Specific

The Provider contends that its' [sic] SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in 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

⁵ Issue Statement at 1.

Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of *Advocate Christ Medical Center, et al, v Xavier Becerra* (Appellants’ reply brief included as Exhibit P-3).⁶

The amount in controversy listed for both the SSI Percentage Provider Specific (Issue 1) and the Unduly Narrow Definition of SSI Entitlement (Issue 2) in the Provider’s individual appeal request is \$89,184.

C. Description of Issue 3 in the Individual Appeal Request

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

Statement of Issue

Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital (“DSH”) calculation.

Statement of the Legal Basis

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

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

Audit Adjustment Number(s): 7, 37, 38, 41, S-D
Estimated Reimbursement Amount: \$77,752

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case⁷ and HCFA Ruling 97-2, “all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage” of the DSH payment adjustment.⁸

⁶ Provider’s PPP at 8-9.

⁷ *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994).

⁸ Provider’s PPP at 9.

In addition, for the first time, the Provider mentions Section 1115 Waiver days:

Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).

Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its 2018 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.⁹

MAC's Contentions: Issue 1 – DSH Percentage (SSI Provider Specific)

In its Jurisdictional Challenge, the MAC argues that the Board lacks jurisdiction over the DSH – SSI Provider Specific issue. The MAC argues that within Issue 1 and Issue 2, the Provider is disputing CMS's policy concerning individuals who are eligible for SSI but did not receive SSI payment. This sub-issue is duplicative of the issue that was transferred to a CIRP group.¹⁰ In addition, the MAC maintains that the realignment aspect of the issue should be considered abandoned as the Provider failed to file a complete PPP with all supporting documents. The MAC also noted that there has been no final determination over the realignment making the appeal premature as the Provider has not exhausted all available remedies.¹¹

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

The MAC argues that the Provider abandoned the Medicaid Eligible Days issue when it failed to properly develop its arguments within the PPP in accordance with Board Rules 25 and 27. Additionally, the Provider failed to provide a list of additional Medicaid eligible days or any other supporting documents and did not provide an explanation for why it could not produce those documents.¹²

⁹ Provider's PPP at 9-10.

¹⁰ The MAC initially referenced the SSI Percentage group to which the issue was transferred (Case No. 21-1206GC), but that transfer was denied on August 4, 2026. Issue 2 was subsequently transferred to an DSH/SSI - Unduly Narrow Definition of SSI Entitlement CIRP group under Case No. 26-2711GC.

¹¹ MAC's Jurisdictional Challenge at 2.

¹² MAC's Jurisdictional Challenge at 2.

Provider’s Jurisdictional Response

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.”¹³ The Provider failed to file a response by the deadline and the time for doing so elapsed as the deadline was August 8, 2026 (*i.e.*, 30 days after the July 9, 2026 filing).

A. SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider’s disagreement with how the MAC 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’s disagreement with how the MAC computed the SSI percentage because of CMS’ policy of excluding patients that were entitled to SSI from the numerator of the Medicare fraction—is duplicative of the Unduly Narrow Definition of SSI Entitlement issue that is being pursued as Issue #2.

The SSI- 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 SSI Percentage (Provider Specific) issue asserts 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).”¹⁵ The Provider argues that “its[sic] SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . .” and it “. . . disagrees with the [Medicare Contractor]’s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary’s Regulations.”¹⁶ Finally, the Provider argues that CMS inconsistently interprets the term “entitled” as used in the statute because it 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

¹³ Board Rule 44.4.3, v. 3.1 (Nov. 2021).

¹⁴ Issue Statement at 1.

¹⁵ *Id.*

¹⁶ *Id.*

but did not receive an SSI payment.” These arguments are restated in Issue No. 2 where the Provider points to CMS’ policy of applying different interpretations to the term “entitled.”¹⁷

Thus, the Board finds that aspects of the issue described as SSI - Provider Specific in Case No. 23-0917 are duplicative of the Unduly Narrow issue described at Issue No. 2. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6¹⁸, the Board dismisses this aspect of the SSI - Provider Specific issue.

Additionally, the Board finds that the Provider’s PPP failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers “to be **fully** developed and include **all available** documentation necessary to provide a *thorough understanding* of the parties’ positions.” Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of any alleged “errors” in its PPP 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 Documents¹⁹

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.²⁰

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

Beginning 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

¹⁷ Issue Statement at 2.

¹⁸ PRRB Rules v. 3.1 (Nov. 2021).

¹⁹ PRRB Rules v. 3.1 (Nov. 2021)

²⁰ (Italics and underline emphasis added.)

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

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

<https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh>.²¹

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.

Accordingly, *based on the record before it*, the Board finds that SSI Percentage- Provider Specific issue in the instant appeal includes a duplicative argument of the argument in the DSH SSI - Unduly Narrow Definition of SSI Entitlement issue in the appeal. 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 SSI - Provider Specific issue.

2. Second Aspect of Issue 1

The second aspect of the 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” Moreover, without this written request, the MAC cannot issue a final determination with which the Provider can be dissatisfied for Board appeal purposes. There is nothing in the record to indicate the MAC has made a final determination regarding DSH SSI Percentage realignment. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

²¹ Last modified July 31, 2026.

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's issue statement for Issue 3 is stated, *supra*.

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

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.

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

The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal consistent with 42 C.F.R. 405.1835(b) or (d) as applicable. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.

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

Furthermore, 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

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). Also consistent with that regulation, Board Rule 25.2.2 provides instruction on the content of position papers as it relates to unavailable documentation/exhibits, as discussed *supra*.

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.

Relative to a Medicaid Eligible Days determination, it is well-established that adequate data to prove eligibility for each Medicaid patient day claimed is a complete and accurate (i.e., auditable) Medicaid eligible days listing, which upon timely submission by a provider, a MAC can examine to make applicable adjustments.

This appeal was initiated on February 9, 2023 (more than 3 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expect to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider’s PPP indicated that it would be sending the eligibility listing under separate cover.²⁵

On June 12, 2026, the Provider included a redacted listing of “Additional ME Days” as an exhibit to its final PP. The 64-page listing showed 9,515 “Additional ME Days” and included the caveat that the “Listing [is] pending finalization upon receipt of State eligibility data.” The Provider’s filing did not explain why the listing, which included substantially more than the 150 days noted in the initial appeal, was being submitted at this late date or why it was not final despite having been submitted more than seven and a half years after the fiscal year at issue had

²² (Emphasis added).

²³ The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.

²⁴ (Emphasis added).

²⁵ Provider’s PPP at 10.

closed. Regardless, this filing was more than two and a half years past the deadline for including it with its PPP since that deadline was October 7, 2023.

The Board concurs with the MAC - 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)(4)(iii).

Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board also finds that the Provider 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 Board rejects the Provider's attempts to include the eligible days listing filed as an exhibit with its final PP because:

1. The upload was filed more than two and a half years *after the deadline* for the exhibits to be included with the PPP filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)).
2. The uploaded exhibit fails to explain the following critical information: (a) *why* it was being filed so late (*i.e.*, upon what basis or authority should the Board accept the late filing); and (b) *why* the listing 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 3 years and 3 months after this appeal was filed and more than seven and a half years after the fiscal year at issue had closed).
3. Neither the Board Rules, nor the February 10, 2023 Case Acknowledgment and Critical Due Dates notice, permit the Provider to file a "Supplement" to its PPP (nor did the Provider allege in the final PP that they do).
4. Given that the *material facts* (*e.g.*, the days at issue) and all available exhibits were required to be part of the PPP filing, if the Board were to accept the Exhibit as a "Supplement" to the PPP, it would need to be either be a *refinement* of its PPP or a supplement of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the appeal request, nor the PPP, identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the uploaded listing cannot be considered a refinement of the position paper since no specific days or listing were included with the PPP.²⁶

²⁶ See, *e.g.*, Board Rule 27.3 (Nov. 2021) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."

5. Finally, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof “to prove eligibility for *each* Medicaid patient day claimed”²⁷ 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 PPP filing (much less provide the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is \$0.

C. 1115 Waiver Days

Additionally, the Board finds that the Section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the Section 1115 Waiver days.

The regulations in effect when this appeal was filed with the Board in February 2023 required the following:

(b) *Contents of request for a Board hearing on final contractor determination.* The provider’s request for a Board hearing...must be submitted in writing in the manner prescribed by the Board, and the request must include...

(2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final...determination under appeal, including an account of...

(i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]

(ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.²⁸

Board Rule 7.2.1 elaborated on this regulatory requirement, instructing providers:

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

- An issue title and a concise issue statement describing:
 - the relevant adjustment(s), including the adjustment number(s),

²⁷ (Emphasis added.)

²⁸ 42 C.F.R. § 405.1835(b).

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

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

Several examples are identified below, but these examples are not exhaustive lists of categories or issues.

A. Disproportionate Share Hospital Payments

Common examples include: . . . ***Section 1115 waiver days (program/waiver specific)***. . .²⁹

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.³⁰

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

(e) Adding issues to the hearing request. After filing a hearing request... a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –

. . .

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

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

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.³¹ Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to

²⁹ (Bold and italic emphasis added).

³⁰ See 73 Fed. Reg. 30190 (May 23, 2008).

³¹ 65 FR 47054, 47087 (Aug. 1, 2000).

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

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

(4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

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

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

Finally, Provider's PPP fails to identify what § 1115 Waiver program(s) are involved and whether or not the § 1115 Waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(4)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital

services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered.” Rather, the PPP is perfunctory in that it only makes perfunctory conclusions. Again, the Provider failed to so develop its position paper notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Nov. 2021) as applied via Board Rule 27.2.

The Board’s finding that neither the appeal request nor the PPP 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, et al. v. Becerra*.³² In that case, the provider’s issue was tied to improper calculation to DSH payment and read in part, “[t]he 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 . . .”³³ The Court found that “[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently.”³⁴ The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.³⁵ Here, the Board makes the same finding based on similarly *overly generalized language*.

Based on the foregoing, the Board is dismissing the SSI Percentage - Provider Specific - Issue No.1 and Medicaid Eligible Days (*including Section 1115 Waiver Days*)- Issue No. 3 from this case. As there are no remaining issues, Case No. 23-0917 is hereby closed and removed from the Board’s docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

For the Board:

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

8/17/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Wilson C. Leong, Esq., Federal Specialized Services

³² No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

³³ *Id.* at *11.

³⁴ *Id.*

³⁵ *Id.*



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***

West Virginia University Hospitals, Inc., Prov. No. 51-0001, FYE 12/31/2017
Case No. 23-0058

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 23-0058. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider’s Disproportionate Share Hospital (“DSH”) Medicaid Eligible Days.

Background

A. Procedural History for Case No. 23-0058

On **April 22, 2022**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end December 31, 2017.

On **October 11, 2022**, Quality Reimbursement Services, Inc. (“QRS”) filed an appeal on behalf of the Provider which included six (6) issues¹:

1. SSI Provider Specific²
2. SSI Unduly Narrow Definition of SSI Entitlement³
3. Medicaid Eligible Days
4. SSI MCD PT C⁴
5. SSI Fraction Dual Eligible Days⁵

¹ On July 18, 2023, the Board agreed to bifurcate Issue #5 (SSI MCD Dual) into two issues. The SSI Fraction Dual Eligible (“DE”) Days issue remained as Issue #5 and a new issue was created for the Medicaid Fraction DE Days issue at #7.

² On October 12, 2023, this issue was withdrawn.

³ On June 2, 2023, the Provider transferred this issue to an SSI Percentage Group, PRRB Case No. 22-1450GC. On May 20, 2024, the Board denied the transfer of this issue to the SSI Percentage group and returned it to the individual case. On May 20, 2026, the issue was transferred to an Unduly Narrow Group, PRRB Case No. 25-4522GC.

⁴ On June 5, 2023, the Provider transferred this issue to PRRB Case No. 22-1452GC.

⁵ On July 19, 2023, the Provider transferred this issue to PRRB Case No. 22-1454GC.

6. Standardized Payment Amount⁶
7. Medicaid Fraction Dual Eligible Days⁷

On **October 13, 2022**, the Board issued an Acknowledgement & Critical Due Dates letter providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP").⁸ This Notice also gave the following instructions to the Provider regarding the content of its PPP:

Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** state the material facts that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and provide arguments applying the material facts*** to the controlling authorities. This filing ***must*** include ***any exhibits the Provider will use to support its position*** and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.⁹

On **June 5, 2023**, the Provider filed its PPP, and the MAC filed its PPP on **September 6, 2023**.

On **July 18, 2023**, the Board issued a determination that Case No. 23-0058 was duplicative of an earlier appeal filed by Bass, Berry & Sims, PLC that was pending for the same Provider and same CY under Case No. 23-0016. The Board advised that, before action would be taken to consolidate Case No. 23-0058 into Case No. 23-0016, it had to first address QRS' bifurcation request. The Board's determination agreed to bifurcate the combined SSI & Medicaid Fraction Dual Eligible Days issue into separate issues and allowed the Representative ninety days (*by October 16, 2023*) to effectuate any relevant transfers. All but two of the issues were transferred by the deadline, leaving only the SSI Provider Specific and Medicaid Eligible Days issues remaining in Case No. 23-0058. Unfortunately, the consolidation of these two issues was not effectuated in the Office of Hearings Case & Document Management System ("OH CDMS") so they remained pending in Case No. 23-0058.

On **September 26, 2023**, the MAC filed a Jurisdictional Challenge over the SSI Provider Specific (which was subsequently withdrawn on October 12, 2023) and ME Days issues.

B. Description of Issue 3 in the Appeal Request

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

Statement of Issue

⁶ On June 5, 2023, the Provider transferred this issue to PRRB Case No. 22-1451GC.

⁷ On July 19, 2023, the Provider transferred this issue to PRRB Case No. 22-1453GC.

⁸ On March 20, 2023 an updated Critical Due Dates notification was sent.

⁹ (Emphasis added).

Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.

Statement of the Legal Basis

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

The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.¹⁰

The Provider filed its PPP in which it indicated that it would be sending the eligibility listing under separate cover.¹¹ The position paper did not identify how many Medicaid eligible days remained in dispute in this case. The following is the Provider's **complete** position on Issue 3 set forth therein:

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

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

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

[T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all

¹⁰ Appeal Request at Issue 3.

¹¹ Provider's PPP at 8.

inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.

Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).

Based on the Listing of Medicaid Eligible days being sent under separate cover, including Section 1115 waiver days, the Provider contends that the total number of days reflected in its 2018 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.¹²

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

The MAC contends that the Provider failed to properly develop its arguments within its PPP in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25. The MAC argues the Provider has not submitted an auditable list of Medicaid Eligible days, nor did it explain why it could not produce the documents. Therefore, the MAC considers the issue to have been abandoned and requests the Board dismiss the issue.

Additionally, the MAC contends the Provider is attempting to improperly and untimely add the Section 1115 Waiver days issue. The Section 1115 Waiver days were not part of the initial appeal and were not mentioned until the PPP.

Provider's Jurisdictional Response

Pursuant to Board Rule 44.4.3, a Provider must respond to a MAC's jurisdictional challenge within 30 days of the 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.

QRS failed to file a timely response to the MACs challenge by the 30-day deadline which elapsed on October 26, 2023 (*30 days after the challenge was filed on September 26, 2026*).

¹² Provider's PPP at 9-10.

Decision of the Board

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

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

A. DSH Payment – Medicaid Eligible Days

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

With regard to the filing of an individual appeal, Board Rule 7 - Support for Appealed Final Determination, Availability of Issue-Related Information and Basis for Dissatisfaction (Dec. 2023) 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.¹³

¹³ (Bold emphasis added.)

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

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

Rule 25 - Preliminary Position Papers¹⁴

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

¹⁴ (Underline emphasis added to these excerpts and all other emphasis in original.)

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

COMMENTARY: Note that this is a change in previous Board practice. Failure to file a <u>complete</u> 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 October 13, 2022 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish *each Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the

Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

The hospital has the burden of furnishing data adequate to prove eligibility for *each* Medicaid patient *day claimed* under this paragraph, *and of verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.¹⁵

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 June 5, 2023, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.¹⁶ Significantly, the PPP 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 \$132,882 based on an estimated 300 days). Excerpts from the Provider’s PPP briefing the Medicaid Eligible days issue are stated *supra*.

In its September 26, 2023 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid Eligible days issue because the Provider failed to file complete position papers pursuant to Board Rules 25 and 42 C.F.R. § 405.1853. In addition, the Provider neglected to

¹⁵ (Emphasis added.)

¹⁶ Provider’s PPP at 10.

include all supporting documentation or alternatively, state the efforts made to obtain missing or unavailable documents in accordance with Board Rule 25.2.2. Thus, the MAC asserts that the Provider has essentially abandoned the issue.¹⁷

The Board concurs with the MAC- 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)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid Eligible days issue because the provider failed to identify any specific Medicaid Eligible days at issue (much less any supporting documentation for those days) in either its appeal request or its PPP. Finally, as the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the PPP filing (much less provide the supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is \$0.

B. Section 1115 Waiver Days

The Board also concurs with the MAC that the Section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. While the Provider appealed Medicaid Eligible days, this issue is separate and distinct from the Section 1115 Waiver days.

The appeal was filed with the Board in October 2022 and the regulations required the following:

(b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing...must be submitted in writing to the Board, and the request must include...

(2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final...determination under appeal, including an account of...

(i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]

¹⁷ 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.

(ii) How and why the provider believes Medicare payment must be determined differently for each disputed item...¹⁸

Board Rule 7.2.1 (2021) elaborated on this regulatory requirement, instructing providers:

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

- An issue title and a concise issue statement describing:
 - the adjustment, including the adjustment number,
 - the controlling authority,
 - why the adjustment is incorrect,
 - how the payment should be determined differently,
 - the reimbursement effect, and
 - the basis for jurisdiction before the [Board].

Board Rule 8 (Nov.2021) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "...each contested component must be appealed as a separate issue and described as narrowly as possible...". The Rule goes on:

Several examples are identified below, but these are not exhaustive lists of categories or issues.

A. Disproportionate Share Hospital Payments

Common examples include: . . . ***Section 1115 waiver days (program/waiver specific)***. . .¹⁹

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.²⁰

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

(e) Adding issues to the hearing request. After filing a hearing request... a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –

...

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

¹⁸ 42 C.F.R. § 405.1835(b).

¹⁹ (Bold and italic emphasis added).

²⁰ See 73 Fed. Reg. 30190 (May 23, 2008).

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

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid Eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.²¹ Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying Section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a Section 1115 Waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2019) states in pertinent part:

(4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

(ii) **Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**

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

²¹ 65 FR 47054, 47087 (Aug. 1, 2000).

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

Regardless, even if the Provider had included in its appeal request (*which it did not*), the Provider failed to properly develop the issue in its PPP filing as it does not identify the specific 1115 Waiver day program(s) at issue). In addition, the PPP does not discuss whether or not the Section 1115 Waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as “days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act” and the patients underlying those days are “deemed eligible for Medicaid” based on “the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered.” Rather, the PPP is perfunctory in that it only makes cursory conclusions. Again, the Provider failed to so develop its PPP, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Nov. 2021).

As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider “has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.” Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has 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.” The Provider’s briefing fails to establish the merits of its position on the *alleged* Section 1115 Waiver days sub-issue.

The Board’s finding that neither the appeal request nor the PPP 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, et al. v. Becerra*.²² In that case, the provider’s issue was tied to improper calculation to DSH payment and read in part, “[t]he 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 . . .”²³ The Court found that “[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently.”²⁴ The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.²⁵ Here, the Board makes the same finding based on similar *overly generalized language*.

²² No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

²³ *Id.* at *11.

²⁴ *Id.*

²⁵ *Id.*

Notice of Dismissal

West Virginia University Hospital, Prov. No. 51-0001, FYE 2017

Case No. 23-0058

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* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible days (Issue #3) including Section 1115 Waiver days. As no issues remain, the Board hereby closes Case No. 23-0058 and removes it from the Board’s docket.

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

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
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For the Board:

8/17/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Dana Johnson, Palmetto GBA c/o National Government Services (J-M)
Leslie Goldsmith, Bass, Berry & Sims, PLC (Rep of Case 23-0016)
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DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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RE: *Expedited Judicial Review Determination*

The University of Chicago Medical Center (Provider Number 14-0088)
Case Numbers: 23-1489 and 25-3101
Fiscal Years Ending (“FYE”): 6/30/2018 and 6/30/2019

Dear Mr. Roth:

The Provider Reimbursement Review Board (“Board”) has reviewed the Provider’s **August 11, 2026** requests for expedited judicial review (“EJR”) in the above-referenced individual appeals. The decision with respect to EJR is set forth below.

Issue under Dispute

In this case, the Provider is challenging:

Whether the denial of a Medicare Capital disproportionate share hospital (“DSH”) payment for fiscal years (“FYs”) 2018 and 2019 to the Hospital, which is which is physically located in an urban area but elected to acquire “rural” status for purposes of payment for its operating costs under the Medicare Hospital Inpatient Hospital Prospective Payment System (“IPPS”) methodology for FYs 2018 and 2019, was proper.¹

Background

Under the inpatient prospective payment system (“IPPS”), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for operating costs (“operating IPPS”) as set forth at § 1395ww(d); and one for capital costs (“capital IPPS”) as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.² This case focuses on the capital IPPS.

¹ Case Nos. 23-1489 and 25-3101, Request for Expedited Judicial Review on Capital DSH Issue at 1 (Aug. 11, 2026) (“Request for EJR”). See also Issue Statements – Capital DSH (the issue statements for both Cases 23-1489 and 25-3101 are materially identical).

² Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), available at <https://oig.hhs.gov/oas/reports/region1/11700500.pdf> (last visited Aug. 3, 2026) (“Significant Vulnerabilities”).

1. Geographic Reclassification

In 1989, Congress created the Medicare Geographic Classification Review Board (“MGCRB”) which implemented a geographic reclassification system in which IPPS hospitals can be reclassified to a different wage index area³ for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.⁴ This includes an IPPS hospital reclassifying from a rural to an urban labor market, or vice versa.

2. Operating DSH Adjustment Under Operating IPPS

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

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.⁷ One of the adjustments is the hospital-specific Disproportionate Share Hospital (“DSH”) adjustment as set forth at 42 U.S.C. § 1395ww(d)(5)(F), which requires the Secretary to provide an adjustment (*i.e.*, an increase in the operating IPPS payment) to hospitals that “serve [] a significantly disproportionate number of low-income patients.”⁸

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

³ See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html> (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts “for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.” This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas (“CBSAs”) established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10)).

⁴ Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). See also *Significant Vulnerabilities* at 4-5.

⁵ See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

⁶ *Id.*

⁷ See 42 U.S.C. § 1395ww(d)(5).

⁸ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

⁹ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

¹⁰ See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

3. Capital DSH Adjustment Under Capital IPPS

A hospital's *capital* costs are paid separately under capital IPPS (*i.e.*, separate and apart from payment for a hospital's *operating* costs under the operating IPPS). Specifically, on December 22, 1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987 ("OBRA-87") and OBRA-87 § 4006(b) required the Secretary to establish the capital IPPS for cost reporting periods beginning in FY 1992.¹¹ OBRA-87 § 4006(b) was codified at 42 U.S.C. § 1395ww(g) which states, in pertinent part:

(g) Prospective payment for capital-related costs; return on equity capital for hospitals

(1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall*, for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .

(B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;

(ii) *may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located;*

(iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

(iv) may provide for suitable adjustment to reflect hospital occupancy rate.

(C) In this paragraph, the term "capital-related costs" has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.¹²

Significantly, the statute governing capital IPPS does not specifically mandate or address the use of a capital DSH adjustment. Rather, it specifies generally that the Secretary "may provide for

¹¹ Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).

¹² (Underline and italics emphasis added.)

an adjustment to account variations in relative costs.” As described below, the Secretary exercised his discretion to establish the *capital* DSH adjustment at issue in this case which is limited in that it **only** applies to *urban* hospitals with 100 or more beds and that serve low income patients.¹³

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

To this end, the Secretary published a final rule on August 30, 1991 to establish the capital IPPS.¹⁴ In implementing the capital IPPS, the Secretary recognized that he had discretion on whether to apply many of the adjustments statutorily required under operating IPPS to capital IPPS:

We are persuaded by the argument advanced by some commenters, including ProPAC, that in the long run the **same** adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. *While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process), we have the latitude to develop adjustments based on combined costs for the capital prospective payment system.*

We do not believe that it would be appropriate to use the current operating payment adjustments in the capital prospective payment system either permanently or on an interim basis until legislation is enacted changing the operating adjustments to the level appropriate for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME) exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should reflect only the higher Medicare costs associated with teaching activity and treating low income patients.¹⁵

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

¹³ 42 C.F.R. § 412.320(a)(1). See also MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics* at 2 (rev. Nov. 2021), available at https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Aug. 3, 2026).

¹⁴ 56 Fed. Reg. 43356 (Aug. 30, 1991).

¹⁵ *Id.* at 43369-70 (emphasis added).

In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to $(\{1 + \text{DSHP}\}^{0.4176} - 1)$, where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.

Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.¹⁶

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

Comment: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.

Response: In the final rule, we are providing that urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level than other hospitals. For FY 1992, the minimum payment level is 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also be eligible for the higher minimum payment level. We are not extending the special protection to other hospitals that receive disproportionate share payments under the operating prospective payment system. In urban areas, we believe that our criteria properly focuses on those hospitals that serve a large disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income

¹⁶ *Id* at 43377.

patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries.**¹⁷

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

As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1, 1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(1){ii} of the regulations.¹⁸

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

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

¹⁷ *Id.* at 43409-10 (bold and underline emphasis added).

¹⁸ *Id.*

for each class of hospital that is currently receiving an operating payment adjustment. We believe that only those hospitals that merit the adjustment according to our regression analysis should receive additional capital payments for serving low income patients. The regression results did not indicate any significant relationship between total costs per case and disproportionate share patient percentage for any of the special groups mentioned above.¹⁹

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

We examined closely the possibility of using a disproportionate share patient percentage threshold in our total cost regression analysis. We were unable to find any threshold level of disproportionate share percentage below which no payment adjustment was merited, or a threshold above which a higher adjustment was merited. As a result, we believe that it is most equitable to make a capital disproportionate share payment to all qualifying hospitals with a positive patient percentage, rather than penalize some hospitals that have a higher cost of treating low income patients but whose patient percentage is below the artificial level we would set.²⁰

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

We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We believe that it is appropriate for Medicare's payment to recognize these higher Medicare patient care costs.²¹

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

Comment: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.

¹⁹ *Id.* at 43378.

²⁰ *Id.* at 43379.

²¹ (Emphasis added.)

Response: Any hospital that is reclassified to an urban area by the MGCRB for purposes of its standardized amount is considered to be urban for all prospective payment purposes other than the wage index. As such, if any hospital reclassified by the MGCRB to an urban area for purposes of the standardized amount has at least 100 beds, it would be eligible for capital disproportionate share payments. We note that a rural hospital reclassified for purposes of the wage index only is still considered a rural hospital, and as such, will not be eligible for capital disproportionate share payments.²²

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

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).

(b) *Payment adjustment factor.* (1) If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments, the disproportionate share payment adjustment factor equals $[e \text{ raised to the power of } (.2025 \times \text{the hospital's disproportionate patient percentage as determined under } § 412.106(b)(5)), -1]$, where e is the natural antilog of 1.

(2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.²³

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

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (“BBRA”) and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if

²² *Id.*

²³ *Id.* at 43452-53.

an application is submitted to the MGCRB and certain criteria are met.²⁴ IPPS hospitals are reclassified per BBRA § 401 are often referred to as “§ 401 hospitals.”

On August 1, 2000, the Secretary published the interim final rule to, in part, implement BBRA § 401 and stated in the preamble that a hospital reclassified as rural pursuant to § 401 is treated as rural for all purposes under operating IPPS, including the DSH adjustment for operating IPPS:

*A hospital that is reclassified as rural under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, is treated as rural for all purposes of payment under the Medicare inpatient hospital prospective payment system (section 1886(d) of the Act), including standardized amount (§§ 412.60 et seq.), wage index (§ 412.63), and disproportionate share calculations (§ 412.106) as of the effective date of the reclassification.*²⁵

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

In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. *That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes.* In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.

²⁴ BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).

²⁵ 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added.)

Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).

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

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

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

*We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary. **Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify.*** As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.²⁶

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

§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.

(a) *General criteria.* A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:

1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration which is available via the ORHP website at [http:// www.nal.usda.gov/orph](http://www.nal.usda.gov/orph) or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9-05, Rockville, MD 20857.

(2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.

²⁶ 65 Fed. Reg. 47054, 47088-89 (Aug. 1, 2000).

(3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.²⁷

Neither the August 1, 2000 interim final rule nor the FY 2001 IPPS Final Rule explicitly discussed the impact on capital DSH adjustments under capital IPPS. However, through operation of the cross-reference in 42 C.F.R. § 412.320(a) to § 412.63(a) in the phrase “the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area”,²⁸ it would appear that hospitals reclassified from urban to rural were *not* eligible for capital DSH adjustments under capital IPPS. In this regard, the Board notes that, following the 2000 rulemaking process, § 412.63(a)-(b) (2001) read, in pertinent part:

(a) *General rule.* (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.

(2) **Each such rate is determined for hospitals located in urban or rural areas** within the United States and within each such region respectively, **as described in paragraphs (b) through (g)** of this section.

(b) *Geographic classifications.* (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, **except that**, effective January 1, 2000, **a hospital reclassified as rural may mean** a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or **a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103.**²⁹

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

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

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”) and MMA § 401 to equalize operating IPPS payments

²⁷ *Id.* at 47048.

²⁸ 56 Fed. Reg. at 43452.

²⁹ (Bold and underline emphasis added.)

between urban and rural hospitals.³⁰ Specifically, § 401 specifies that, beginning with FY 2004, all IPPS hospitals are paid on the basis of the large urban standardized amount under operating IPPS.

The Office of Management and Budget publishes information on core-based statistical areas (“CBSAs”) and the Secretary has used this information for purposes of defining labor market areas for use in the wage index for operating IPPS.³¹ On June 6, 2003, OMB announced the new CBSAs, comprised of metropolitan statistical areas (“MSAs”) and the new Micropolitan Areas based on Census 2000 data.³²

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

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

(a) *General rule.* CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.

(b) *Geographic classifications.* (1) For purposes of this section, the following definitions apply:

(i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.

(ii) The term *urban area* means—

(A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security

³⁰ Pub. L. 108–173.

³¹ 69 Fed. Reg. 48916, 49026 (Aug. 11, 2004).

³² *Id.*

³³ 69 Fed. Reg. 48916 (Aug. 11, 2004).

Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(C) The term *rural area* means any area outside an urban area.

(D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

(2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.

(3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.

(4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result of redesignation of an MSA by the Executive Office of Management and Budget.³⁴

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

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: “A hospital is classified as a ‘disproportionate share hospital’ for the purposes of capital prospective payments if the hospital is located, *for purposes*

³⁴ *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).

of receiving payment under § 412.63(a), in an urban area.”³⁵ As a result of the FY 2005 IPPS Final Rule, § 412.320(a) was updated to reference § 412.64 as it relates to FYs 2005 forward:

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital’s location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64.³⁶

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

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

Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB’s new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.

The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the

³⁵ (Emphasis added.)

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

new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.

As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.³⁷

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

In the FY 2007 Proposed IPPS Rule, the Secretary³⁸ announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.³⁹

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and

³⁷ 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004).

³⁸ of the Department of Health and Human Services.

³⁹ 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).

Budget's ("OBM's") new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005.⁴⁰

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

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

These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.⁴¹

In adopting these changes, the Secretary noted that it did not receive any public comments on the proposed change as published in the proposed rule published on May 17, 2006.⁴²

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

⁴⁰ *Id.*

⁴¹ 71 Fed. Reg. 47870, 48104 (Aug. 18, 2006).

⁴² *Id.* at 48105.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.

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

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

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

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

In *Toledo*, U.S. District Court for the District of Columbia (“D.C. District Court”) outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage

⁴³ (Bold emphasis added.)

⁴⁴ 621 F.Supp.3d 13 (D.D.C. 2021).

⁴⁵ *Id.* at *25 (citations omitted).

reimbursement rate.⁴⁶ The Court also noted how Congress enacted legislation in 1999⁴⁷ allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into an urban labor market area for the purposes of fixing its wage index.⁴⁸ The Court also noted the separate IPPS payment for a hospital's *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R. § 412.320 for large urban hospitals (the capital DSH payment).⁴⁹ The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.⁵⁰

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

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

1. "if the Secretary had any policy concerning Section 401 reclassifications before 2006, he never announced such a policy, much less explained the basis for it."⁵³
2. The Secretary's decision to not provide a capital DSH adjustment was arbitrary because:
 - "The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006."⁵⁴
 - "[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he

⁴⁶ *Id.* at *18-19.

⁴⁷ 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a "§ 401" hospital.

⁴⁸ *Toledo* at *19.

⁴⁹ *Id.* at *19-20.

⁵⁰ *Id.* at *21.

⁵¹ *Id.* at *22.

⁵² *Id.* at *23-25.

⁵³ *Id.* at *29.

⁵⁴ *Id.*

cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements.”⁵⁵

- “The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp.*, 797 F.3d at 1161 (upholding Secretary's regulation where the Secretary explained why ‘added precision’ ‘would not justify the added complication’) (quotation omitted).”⁵⁶
- “The agency cannot ‘entirely fail[] to consider’ the “relevant data” and the factors that Congress directed it to review. *State Farm*, 63 U.S. at 43. 103 S. Ct. 2856. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did he take costs into account at all.”⁵⁷

Notwithstanding these findings, the D.C. District Court declined to vacate 42 C.F.R. § 412.320(a)(1)(iii) because “vacatur of a rule is not an appropriate remedy on review of an adjudication.”⁵⁸ Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants’ eligibility for a capital DSH adjustment.⁵⁹

CMS has since amended its regulations and, for discharges on or after October 1, 2023, urban hospitals that reclassified as rural are no longer considered rural for purposes of determining eligibility for capital DSH payments.⁶⁰

Provider’s Requests for EJR

The Provider is challenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural.⁶¹ It claims the regulation was challenged in *Toledo* and the court found it to be “arbitrary and capricious . . . and that CMS could not rely on it to deny the Capital DSH payment.”⁶² The Provider notes that CMS changed its regulations to specify that hospitals reclassified as rural can receive Capital DSH payments, but only for discharges on or after October 1, 2023.⁶³ Since 42 C.F.R. § 412.320(a)(1)(iii) still denies the Provider’s Capital DSH payments for FYs 2018 and 2019, and since the Board is bound by this regulation, the Provider is seeking EJR, asserting the regulation is “arbitrary, capricious, and otherwise contrary to law, in violation of the Administrative Procedure Act (“APA”) (*see, e.g.*, 5 U.S.C.

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.* at *30.

⁵⁹ *Id.*

⁶⁰ 42 C.F.R. § 412.103 (2024); 88 Fed. Reg. 58640, 59117 (Aug. 28, 2023).

⁶¹ *E.g.*, Case No. 23-1489, Issue Statement: Improper Denial of Capital DSH payment at 1.

⁶² *Id.*

⁶³ Request for EJR at 2.

§706(2)(A)), and other authorities and, thus cannot be applied to deny the Hospital a Capital DSH payment for FYs 2018 and 2019.”⁶⁴

Since the Board is bound by the regulations being challenged,⁶⁵ namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), it lacks the authority to decide the legal question presented in the Providers’ Request for EJ, and since the additional criteria for EJ have also been met, the Provider requests the Board grant EJ over the Capital DSH issue.⁶⁶

On **August 13, 2026**, the Medicare Contractor’s designated representative, Federal Specialized Services, filed a Response to the Request for EJ. It did not take a position on the request for EJ and simply noted it “will not file a jurisdictional challenge in either case” but that “[s]ubstantive claim challenges were filed in both cases, on 7/1/24 in 23-1489 and on 2/13/16 for 25-3101.”⁶⁷

Board Decision

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

1. Jurisdiction

In the November 13, 2015 Final Outpatient Prospective Payment Rule,⁶⁸ the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.⁶⁹ The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider’s cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement (“NPR”) issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the “claim-specific dissatisfaction requirement”). Since the Provider’s two fiscal years under appeal began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable for purposes of jurisdiction.

⁶⁴ *Id.*

⁶⁵ *See* 42 C.F.R. § 405.1867.

⁶⁶ Request for EJ at 4-5.

⁶⁷ Response to Provider’s Request for Expedited Judicial Review at 1 (Aug. 13, 2026).

⁶⁸ 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).

⁶⁹ *Id.* at 70555.

The Provider has filed two appeals from original NPRs for its fiscal years ending June 30, 2018 and June 30, 2019. Based on its review of the record, the Board finds that the Provider filed its appeals within 180 days of the issuance of its NPRs as required by 42 C.F.R. § 405.1835(a)(3), and that the Board is not precluded by regulation or statute from reviewing the issue in this appeal. Finally, in both cases, the amount in controversy meets the \$10,000 amount in controversy requirement for an individual appeal pursuant to 42 C.F.R. § 405.1835(a)(2). The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

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

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

(j) Substantive reimbursement requirement of an appropriate cost report claim—

(1) *General requirement.* In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), must include an appropriate claim for the specific item, by either—

(i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or

(ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.

(2) *Self-disallowance procedures.* In order to properly self-disallow a specific item, the provider must—

(i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and

(ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.

In conjunction with the regulation above, 42 C.F.R. § 405.1873(a) addresses when the Board must examine a provider's compliance with § 413.24(j), stating:

(a) *General.* In order to receive or potentially receive reimbursement for a specific item, the provider must include in its cost report an appropriate claim for the specific item (as prescribed in § 413.24(j) of this chapter). **If the provider files an appeal to the Board seeking reimbursement for the specific item and *any party* to such appeal *questions whether the provider's cost report included an appropriate claim for the specific item*, the Board must address such question in accordance with the procedures set forth in this section.**⁷⁰

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

The Medicare Contractor filed Substantive Claim Challenges, alleging noncompliance with the requirements of § 413.24(j), in Case 23-1489 on July 1, 2024 and in Case 25-2301 on February 13, 2026.

A. Substantive Claim Challenges

i. Case 23-1489

In **Case 23-1489**, the Medicare Contractor filed a Substantive Claim Challenge on **July 1, 2024**. It claims that the Provider did not include an amount for the denial of the Capital DSH payment in its as-filed cost report, pursuant to 42 C.F.R. § 413.24(j)(1)(i). The amended cost report

⁷⁰ (Bold emphasis added.)

claims “N” for whether the Provider qualifies for a capital DSH payment.⁷¹ While the audit adjustments cited by the Provider in this appeal reference the removal of protested amounts, the Medicare Contractor argues the Provider still did not properly self-disallow the Capital DSH issue, pursuant to 42 C.F.R. § 413.24(j)(1)(ii). It claims the Provider failed to “include a description of how the estimated reimbursement amount was determined as required by 42 C.F.R. § 413.24(j)(2)(ii).”⁷² The cost report identified protested amounts and was accompanied by a Summary of Protested Items which listed “Capital DSH” as a protested item for \$898,490 with a narrative regarding the issue.⁷³ The Medicare Contractor argues this is insufficient because there is no explanation on how the \$898,490 was calculated.⁷⁴ Finally, it argues that the Board should not consider the supporting documentation filed with the Provider’s appeal request since 42 C.F.R. § 413.24(j)(3) requires the Board to evaluate the Provider’s compliance by referencing the as-filed cost report.⁷⁵

The Provider filed a Response to the Substantive Claim Challenge on **July 31, 2024** requesting the Board deny the challenge for three reasons. First, it argues that the substantive claim requirement is invalid and not legally enforceable under the holdings of “*Bethesda Hosp. Ass’n v. Bowen*, 485 U.S. 399 (1988) (“*Bethesda*”) and *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131 (D.D.C. 2016) (“*Banner Heart Hospital*”).”⁷⁶

Second, the Provider argues that its Summary of Protested Items, the specific protested amount of \$898,490, and the narrative of the Capital DSH issue were sufficient to satisfy any substantive claim requirement. While it may not have included an explanation of the estimated reimbursement impact, the Capital DSH formula is set forth in regulation and “the Hospital’s calculation was the product of the straight-forward application of that formula using the Hospital’s Capital DRG payments as set forth on the cost report.”⁷⁷ It specifically argues that:

[S]uch an explanation was not necessary because the estimated reimbursement amount was the product of the Hospital’s straight-forward application of the formula that CMS set forth in 42 C.F.R. §§412.312 and 412.320(b)(1) for calculating Capital DSH payments, which is an adjustment to the total Capital PPS payment amount.⁷⁸

The Provider argues that the submissions with its cost report “put the MAC on notice that the Hospital was protesting the Capital DSH Issue” and that “the MAC could readily discern from the Hospital’s as-filed FY 2018 Medicare cost report that the Hospital had performed a rote calculation using CMS’s formula to estimate the reimbursement impact for the Capital DSH Issue, which did not require further explanation.”⁷⁹ It also takes issue with the fact that the

⁷¹ Medicare Administrative Contractor’s Substantive Claim Challenge at 4 (July 1, 2024).

⁷² *Id.* at 4.

⁷³ *Id.* (citing Ex. C-3 at 1, 7).

⁷⁴ *Id.*

⁷⁵ *Id.* at 5.

⁷⁶ Hospitals’ Response to MAC’s July 1, 2024 Substantive Claim Challenge at 1 (July 31, 2024).

⁷⁷ *Id.* at 1-2.

⁷⁸ *Id.* at 3.

⁷⁹ *Id.* at 8.

Medicare Contractor did not identify this deficiency and inquire about it.⁸⁰

Finally, the Provider briefly states that the substantive claim requirement “is otherwise substantively and/or procedurally invalid” and imposes an “unreasonably excessive” sanction.⁸¹ It gives the Board notice of its intention to challenge the validity of 42 C.F.R. § 413.24(j) in the event the Board finds it did not make an appropriate cost report claim.⁸²

The Board finds that the Provider failed to make an appropriate claim on its cost report for the Capital DSH Issue. The documents and support included with the cost report are not disputed. A protested amount was included on the cost report in an attempt to self-disallow the issue, pursuant to 42 C.F.R. § 413.24(j)(1)(ii). In order to self-disallow the item, the Provider was required to include an estimated reimbursement amount for the specific item (Capital DSH).⁸³ The Provider did this. It was also required, however, to

Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.**⁸⁴

The regulatory requirements are clear in that the work sheet submitted with the cost report itself must describe how the provider calculated its estimated reimbursement impact. The fact that the data may be available somewhere for the Medicare Contractor to discern the Provider’s calculation is irrelevant, and putting the Medicare Contractor “on notice” of a desire to comply with the regulations is insufficient. The Board finds that the Provider here failed to comply with the requirements of 42 C.F.R. § 413.24(j).

ii. Case 25-3101

In **Case No. 25-3101**, the Medicare Contractor filed a Substantive Claim Challenge on **February 13, 2026**. Its claims are similar to those for Case 23-1489, first noting that the audit adjustments cited by the Provider simply remove protested amounts or update the Capital DRG to the most recent PS&R report.⁸⁵ The Medicare Contractor agrees that the Provider submitted a Summary of Protested Amounts which listed Capital DSH as an item with a protested amount and narrative, but once again “the Provider failed to include a separate worksheet demonstrating how it calculated the estimated protested amount.”⁸⁶

The Provider filed a Response to the Substantive Claim Challenge on **March 9, 2026** making the same three arguments as in Case 23-1489. First, it argues that the substantive claim requirement

⁸⁰ *Id.*

⁸¹ *Id.* at 2.

⁸² *Id.* at 8.

⁸³ 42 C.F.R. § 413.24(j)(2)(i).

⁸⁴ 42 C.F.R. § 413.24(j)(2)(ii) (emphasis added).

⁸⁵ Medicare Administrative Contractor’s Substantive Claim Challenge at 3-4 (Feb. 13, 2026).

⁸⁶ *Id.* at 4.

is invalid and not legally enforceable under the holdings of “*Bethesda Hosp. Ass’n v. Bowen*, 485 U.S. 399 (1988) (“*Bethesda*”) and *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131 (D.D.C. 2016) (“*Banner Heart Hospital*”).”⁸⁷

Second, it makes similar arguments that merely identifying the Capital DSH issue and the resulting impact amount should be sufficient since “[t]he explanation for the calculation of the estimated impact of the Capital Issue was implicit from the cost report and the protest worksheets—the Capital DSH formula is well-established established by statute and regulation[.]”⁸⁸ It continues that “[t]he regulation does not contain any express requirement for a hospital to reproduce its ‘calculation’ of the estimated reimbursement impact, but instead requires a worksheet that ‘describes how’ the hospital calculated the protest item.”⁸⁹

Finally, the Provider once again gives the Board notice of its intention to challenge the validity of 42 C.F.R. § 413.24(j) in the event the Board finds it did not make an appropriate cost report claim.⁹⁰

Just as in Case No. 23-1489, the Board finds that the Provider here failed to comply with the requirements of 42 C.F.R. § 413.24(j). “Describing how” a reimbursement amount was calculated is more than listing an amount and a general narrative describing the issue. The Provider must specifically describe how the amount was calculated in order to satisfy the requirements of 42 C.F.R. § 413.24(j)(1)(ii).

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

The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board’s findings with regard to whether or not a provider “include[d] in its cost report an appropriate claim for the *specific* item [under appeal] (as prescribed in § 413.24(j))”⁹¹ may not be invoked or relied on by the Board to decline jurisdiction. *Instead*, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement, rather than a jurisdictional one. Nevertheless, when granting EJRs, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

The Board finds that the Provider failed to make an appropriate claim for the Capital DSH issue on its cost report, as required by 42 C.F.R. § 413.24(j), in both Cases 23-1489 and 25-3101.

3. Board’s Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the Provider in Case Nos.

⁸⁷ Hospitals’ Response to MAC’s February 13, 2026 Substantive Claim Challenge at 1 (Mar. 9, 2026).

⁸⁸ *Id.* at 10.

⁸⁹ *Id.*

⁹⁰ *Id.* at 11.

⁹¹ (Emphasis added.)

23-1489 and 25-3101 is entitled to a hearing before the Board;

- 2) The review process in 42 C.F.R. § 405.1873(a)-(b) has been triggered for the Provider in both Cases 23-1489 and 25-3101 and the Board specifically finds that the Provider failed to include “an appropriate claim for the specific item” that is the subject of its two individual appeals, as required under 42 C.F.R. § 413.24(j)(1).
- 3) Based upon the Provider’s assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), there are no findings of fact for resolution by the Board;
- 4) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 5) It is without the authority to decide the legal questions of
 - a. Whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid, and
 - b. Whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider’s EJR Request for the issue and the subject years. The Board also finds that the question of the validity of the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider’s request for EJR for the issue and the subject years. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since an additional issue remains open in Case No. 25-3101, it will stay open on the Board’s docket. Since this is the last remaining issue in Case No. 23-1489, the Board hereby closes the case and removes it from the Board’s docket.

Board Members Participating:

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

FOR THE BOARD:

8/25/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A

cc: Pamela VanArsdale, National Government Services, Inc. (J-6)



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***

Mountain View Regional Medical Center, Prov. No. 32-0085, FYE 03/31/2019
Case No. 23-0888

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 23-0888. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider’s Disproportionate Share Hospital (“DSH”) Medicaid Eligible Days.

Background

A. Procedural History for Case No. 23-0888

On **August 29, 2022**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end March 31, 2019.

On **February 6, 2023**, the Board received the Provider’s individual appeal request. The initial Individual Appeal Request contained five (5) issues¹:

1. DSH Payment/SSI Percentage (Provider Specific)²
2. DSH/SSI – Unduly Narrow Definition of SSI Entitlement³
3. DSH Payment – Medicaid Eligible Days
4. Medicare Managed Care Part C – SSI and Medicaid Fractions⁴
5. SSI Fraction Dual Eligible Days⁵
6. Medicaid Fraction Dual Eligible Days⁶

¹ On December 8, 2023, the Board agreed to bifurcate the SSI & Medicaid Fraction Dual Eligible (“DE”) Days issue into separate “fraction specific” issues. The SSI Fraction DE Days was left at issue #5 and the Medicaid Fraction DE days issue was created as issue #6.

² On June 29, 2026, this issue was withdrawn.

³ On September 13, 2023, this issue was transferred to an SSI Percentage group, PRRB Case No. 22-1031GC. On August 17, 2026, the Board denied the transfer. Subsequently, on August 21, 2026 the issue was transferred to the Unduly Narrow CIRP group, PRRB Case No. 26-2711GC.

⁴ On September 13, 2023, this issue was transferred to PRRB Case No. 23-0078GC.

⁵ On May 15, 2024, this issue was transferred to PRRB Case No. 22-1006GC

⁶ On May 15, 2024, this issue was transferred to PRRB Case No. 23-0079GC

After the transfers and the withdrawal of issues, the sole remaining issue in this appeal is DSH Payment – Medicaid Eligible Days (Issue No. 3.)

On **February 9, 2023**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** state the material facts that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and provide arguments applying the material facts*** to the controlling authorities. This filing ***must include any exhibits the Provider will use to support its position*** and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.⁷

On **October 2, 2023**, the Provider filed its PPP.

On **November 27, 2023**, the Medicare Contractor ("MAC") filed a copy of its request to the Provider for DSH Medicaid Eligible Days support in OH CDMS.

On **January 18, 2024**, the MAC filed a jurisdictional challenge, requesting the dismissal of Issue Nos. 1 and 3.

On **January 19, 2024**, the MAC filed its PPP.

On **February 5, 2024**, Quality Reimbursement Services, Inc. ("QRS") became the authorized representative for Case No. 23-0888.

On **April 3, 2026**, the Board scheduled Case No. 23-0888 for a hearing on **October 12, 2026**.

On **July 13, 2026** and **July 21, 2026**, the Provider and MAC filed their respective final PPs.

MAC's Contentions- Issue #3 - DSH – Medicaid Eligible Days

The MAC contends that the Provider abandoned the Medicaid Eligible Days issue when it failed to include a list of additional Medicaid eligible days it expected to be included with its appeal or is PPP. Therefore, the PPP was not filed in accordance with Board Rule 25.2 and 42 CFR § 405.1853.

In addition, the MAC contends the Provider is attempting to untimely and improperly add the issue of Section 1115 waiver days as a sub-issue via its PPP, filed on October 2, 2023. The MAC

⁷ (Emphasis added).

asserts that prior to the PPP, the Provider had not formally added the dispute to the appeal, nor had it otherwise raised the issue of Section 1115 waiver days.⁸ The MAC contends that the Provider's attempt to add the issue within its PPP is improper and untimely, citing 42 C.F.R. § 405.1835(e), which governs when specific Medicare payment issues may be added to the original hearing request, including a timeframe of no later than 60 days after the expiration of the applicable 180-day deadline to file an appeal.⁹ In addition, the MAC indicates the provider is a participant in Case No. 23-0688GC, the "CHS CY 2019 Section 1115 Waiver Days New Mexico CIRP Group."¹⁰ Therefore, even if the issue had been properly appealed in this case, it would be duplicative of the issue already being pursued in the group.¹¹ Finally, the MAC argues that Section 1115 waiver days issue is one component of the DSH issue - and is a separate and distinct issue from Medicaid eligible days issue so it must be identified and appealed separately.¹²

Provider's Jurisdictional Response

Board Rule 44.4.3 requires that: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed on February 17, 2024.

Decision of the Board

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

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

A. DSH Payment – Medicaid Eligible Days

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

With regard to the filing of an individual appeal, Board Rule 7 - Support for Appealed Final Determination, Availability of Issue-Related Information and Basis for Dissatisfaction (Dec. 2023) states:

⁸ MAC Jurisdiction Challenge at 11.

⁹ *Id* at 12-13.

¹⁰ Case No. 23-0688GC was withdrawn and closed on October 1, 2024

¹¹ *Id.*

¹² *Id.* at 14-15.

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.¹³

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

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

¹³ (Bold emphasis added.)

Rule 25 - Preliminary Position Papers¹⁴

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.

25.2.2 Unavailable and Omitted Documents

¹⁴ (Underline emphasis added to these excerpts and all other emphasis in original.)

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 February 9, 2023 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish *each Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

The hospital has the burden of furnishing data adequate to prove eligibility for *each* Medicaid patient *day claimed* under this paragraph, *and* of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.¹⁵

¹⁵ (Emphasis added.)

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 October 2, 2023, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.¹⁶ Significantly, the PPP 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 \$87,862 based on an estimated 150 days). The Provider’s complete briefing of this issue in its PPP 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

¹⁶ Provider’s PPP at 10.

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.

Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider’s Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider’s Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).

Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its’ 2019 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

With respect to section 1115 waiver days, the courts have firmly rejected CMS’s interpretation of its regulations, holding instead that the plain language of the statute and the regulations require inclusion in the Medicaid Fraction of the days belonging to individuals who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool. *See Forrest General Hospital*, 926 F.3d 221 (5th Cir. 2019);

HealthAlliance Hospitals, Inc. v. Azar, 346 F. Supp. 3d 43(D.D.C. 2018); *Bethesda Health Inc., v. Azar*, 389 F. Supp. 3d 32, (D.D.C. 2019), *aff'd*, 980 F.3d 121 (D.C. Cir. 2020). CMS has acquiesced in *Bethesda* and is now following the statute and the plain meaning of its own regulations (which regulations represent the official policy of CMS all along). See CMS Manual Instructions System, Change Request 12669, Transmittal No. 11912 (March 16, 2023) (“Transmittal 11912”), attached as Exhibit P-4.¹⁷

In its January 18, 2024 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid Eligible days issue because 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) with its appeal request or its PPP in violation of 42 CFR §405.1853 and Board Rule 25.3. Thus, the MAC 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 Board Rules.¹⁸ In addition, the MAC indicated the Provider was attempting to untimely and improperly add the issue of Section 1115 waiver days by including the issue in its PPP. Furthermore, the MAC pointed out that, although the waiver days issue is a component of the Medicaid Eligible days issue, it is considered a separate issue and that issue was already under appeal for this Provider in a group in Case No. 23-0688GC.¹⁹

The Board concurs with the MAC- 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)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid Eligible days issue because the provider failed to identify any specific Medicaid Eligible days at issue (much less any supporting documentation for those days) in either its appeal request or its PPP.

Although the Provider’s final PP indicated a redacted listing was attached, the Provider failed to upload a copy of the redacted listing as an Exhibit to the PP.²⁰ Even if it had, the Board would reject an attempt to file the Eligible Days listing as part of the final PP because:

¹⁷ Provider’s PP at 9-10.

¹⁸ See also Board’s jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency’s calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

¹⁹ The group was subsequently withdrawn and closed on October 1, 2024.

²⁰ Instead of a redacted listing being uploaded as Exhibit P-1, an additional copy of the “PFPP list of Exhibits.pdf” was uploaded.

1. It would have been filed past the deadline for the exhibits to be included with the PPP filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)) (*which was due on October 4, 2023*); and
2. 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”²¹ and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its PP 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 PPP filing (much less provider the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is \$0.

B. Section 1115 Waiver Days

The Board also concurs with the MAC, that the Section 1115 waiver days issue is not a part of this appeal as it was not properly or timely added. While the Provider appealed Medicaid Eligible days, this issue is separate and distinct from the Section 1115 waiver days.

The appeal was filed with the Board in February of 2023 and the regulations required the following:

(b) *Contents of request for a Board hearing on final contractor determination.* The provider’s request for a Board hearing...must be submitted in writing to the Board, and the request must include...

(2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final...determination under appeal, including an account of...

(i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]

(ii) How and why the provider believes Medicare payment must be determined differently for each disputed item...²²

Board Rule 7.2.1 (2021) elaborated on this regulatory requirement, instructing providers:

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

²¹ (Emphasis added.)

²² 42 C.F.R. § 405.1835(b).

- An issue title and a concise issue statement describing:
 - the adjustment, including the adjustment number,
 - the controlling authority,
 - why the adjustment is incorrect,
 - how the payment should be determined differently,
 - the reimbursement effect, and
 - the basis for jurisdiction before the [Board].

Board Rule 8 (Nov. 2021) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and “...each contested component must be appealed as a separate issue and described as narrowly as possible...”. The Rule goes on:

Several examples are identified below, but these are not exhaustive lists of categories or issues.

A. Disproportionate Share Hospital Payments

Common examples include: . . . ***Section 1115 waiver days (program/waiver specific).*** . . .²³

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.²⁴

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

(e) Adding issues to the hearing request. After filing a hearing request... a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –

...

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

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

In this regard, the Board notes that Section 1115 waiver days are not traditional Medicaid Eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.²⁵ Rather, these days relate to Medicaid expansion programs and are only includable in the

²³ (Bold and italic emphasis added).

²⁴ See 73 Fed. Reg. 30190 (May 23, 2008).

²⁵ 65 FR 47054, 47087 (Aug. 1, 2000).

DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 waiver days. Indeed, not every state Medicaid program has a qualifying Section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a Section 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2019) states in pertinent part:

(4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

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

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

Regardless, even if the Provider had included in its appeal request (*which it did not*), the Provider failed to properly develop the issue in its PPP filing as it does not identify the specific 1115

waiver day program(s) at issue). In addition, the PPP does not discuss whether or not the Section 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as “days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act” and the patients underlying those days are “deemed eligible for Medicaid” based on “the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered.” Rather, the PPP is perfunctory in that it only makes cursory conclusions.²⁶ Again, the Provider failed to so develop its PPs, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Nov. 2021).

As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider “has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.” Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has 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.” The Provider’s briefing fails to establish the merits of its position on the *alleged* Section 1115 waiver days sub-issue.

The Board’s finding that neither the appeal request nor the PPs 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, et al. v. Becerra*.²⁷ In that case, the provider’s issue was tied to improper calculation to DSH payment and read in part, “[t]he 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 . . .”²⁸ The Court found that “[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently.”²⁹ The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.³⁰ Here, the Board makes the same finding based on similar *overly generalized language*.

Finally, the Board notes that the provider was directly added as a participant to the “CHS CY 2019 Section 1115 Waiver Days New Mexico CIRP Group” under Case No. 23-0688GC. Case No. 23-0688GC was withdrawn on September 30, 2024 and the case was closed on October 1,

²⁶ For example, QRS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that “the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool.” However, QRS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is QRS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? QRS fails to brief the merits of its claims and fails to establish the Board’s jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the PPP references “uncompensated care pool.”

²⁷ No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

²⁸ *Id.* at *11.

²⁹ *Id.*

³⁰ *Id.*

2024. Therefore, the Provider withdrew any rights to appeal the Section 1115 waiver days issue once the group was withdrawn.

* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible days (Issue #3) including Section 1115 waiver days. As no issues remain, the Board hereby closes Case No. 23-0888 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

8/26/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: Determination re: Filing Requirements

Cambridge Health Alliance (22-0011)
Appealed Period: FYE 06/30/2022
PRRB Case No.: 26-2931

Dear Mr. Ravindran:

The above-captioned appeal was filed with the Provider Reimbursement Review Board ("Board") via the Office of Hearings Case and Document Management System ("OH CDMS"). After review of the facts outlined below, the Board has determined that the appeal request was not filed in accordance with the Board Rules and regulations. The Board's review and determination is set forth below.

BACKGROUND:

On August 10, 2026, Quality Reimbursement Services ("QRS") filed, on behalf of the Provider, the above referenced appeal. On the Determinations page within OH CDMS, QRS entered the Fiscal Year End in dispute as June 30, 2022 and entered the Date of the Final Determination (the Notice of Program Reimbursement ("NPR")) as February 11, 2026. The appeal request identified a sole issue in dispute:

Reclassification of Wage Index

After review, the Board notes that the NPR uploaded is dated December 1, 2025 and is for the FYE June 30, 2021. The Controversy Amount was entered into OH CDMS as \$326,244 but the Calculation Support document uploaded states the controversy amount as \$722,113. The Board notes that here again the information pertains to FYE June 30, 2021. In addition, the uploaded supporting documentation for the Audit Adjustment pages and Protested Support are for FYE June 30, 2021.

The Board emphasizes that although the Provider entered that the subject appeal was for FYE June 30, 2022, all the accompanying supporting jurisdictional documentation are for FYE June 30, 2021.

RULES/REGULATIONS:

Pursuant to 42 C.F.R. § 405.1835(b), if a Provider's appeal request does not meet the requirements of paragraph (b)(3) of the same section, the Board may dismiss with prejudice the appeal, or take any other remedial action it considers appropriate. Paragraph (b)(3) states in part that the following must be included in the Provider's request:

A copy of the determination, including any other documentary evidence the provider considers necessary to satisfy the hearing request requirements.

Board Rule 4.1 General Requirements

See 42 C.F.R. §§ 405.1835 - 405.1840.

The Board will dismiss appeals that fail to meet the timely filing requirements and/or jurisdictional requirements. A jurisdictional challenge (see Rule 44.4) may be raised at any time during the appeal; however, for judicial economy, the Board strongly encourages filing any challenges as soon as possible. The Board may review jurisdiction on its own motion at any time. The parties cannot waive jurisdictional requirements.

Board Rule 6.1 Initial Filing

6.1.1 Request and Supporting Documentation To file an individual appeal, the case representative must log onto OH CDMS and follow the prompts. Reference Rules 7 and 9 as well as Model Form A – Individual Appeal Request (Appendix A) for guidance on all required OH CDMS data fields and supporting documentation. **The Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b) or (d), as relevant.**

Board Rule 7.1 Final Determination

7.1.1. General Requirements

Identify the appealed period. This is typically the fiscal year end ("FYE") covered by the cost report but may include an alternative period such as a calendar year ending 12/31, a federal fiscal year ending 9/30, or another period for which you must identify the beginning and ending dates. If the period is something other than a traditional cost report FYE, you must identify the cost reporting periods affected by the determination.

Example: Provider has a 6/30 FYE and is appealing a Federal Register notice applicable to 9/30/18. The impacted cost reporting periods would be FYE 6/30/18 (based on the portion of the FFY from 10/1/17 through 6/30/18) and FYE 6/30/19 (based on the remainder of the FFY from 7/1/18 through 9/30/18).

Include a copy of the final determination, such as the NPR, revised NPR, exception determination letter, Federal Register notice, or quality reporting payment reduction decision. Note that preliminary determinations are not appealable. (See Rule 7.5 for appeals based on the lack of a timely issued determination.)

Identify the date the final determination was issued. Ensure the appeal is filed timely based on the appeal period in Rule 4.3.

BOARD DETERMINATION:

The Board has determined that the appeal, as filed, is jurisdictionally deficient and does not meet the regulatory requirements for filing since the Provider failed to submit the **correct final determination** (the NPR dated February 11, 2026 for FYE 06/30/2022) on which the appeal is based. The Board requires the final determination on which the appeal is based in order to determine whether the appeal is jurisdictionally valid. In addition, all the supporting jurisdictional documentation filed is for a different FYE (June 30, 2021).

The Board has determined that the Provider failed to meet the minimum filing requirements as set forth in 42 C.F.R. §§ 405.1835 - 405.1840 and the Board Rules cited above. As a result, the Board hereby dismisses case number 26-2931, in its entirety, and removes it from its docket.

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

Board Members:

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

FOR THE BOARD:

8/31/2026

X Ratina Kelly

Ratina Kelly, CPA

Board Member

Signed by: PIV

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***

Abilene Regional Medical Center, Prov. No. 45-0558, FYE 08/31/2019
Case No. 23-0278

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 23-0278. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider’s Disproportionate Share Hospital (“DSH”) for Medicaid Eligible Days.

Background

A. Procedural History for Case No. 23-0278

On **June 7, 2022**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end August 31, 2019. The Provider is commonly owned by Community Health Systems, Inc. (“CHS”).

On **November 21, 2022**, CHS filed the Provider’s individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. DSH Payment/SSI Percentage (Provider Specific)¹
2. DSH/SSI Unduly Narrow Definition of SSI Entitlement²
3. DSH Payment – Medicaid Eligible Days
4. DSH Payment – Medicare/SSI and Medicaid Fractions – Medicare Managed Care Part C Days³
5. DSH Payment – SSI/Medicare and Medicaid Fractions – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)⁴

¹ On June 18, 2026, this issue was withdrawn.

² On June 9, 2023, this issue was transferred to Case No. 22-1031GC.

³ On June 9, 2023, this issue was transferred to Case No. 23-0078GC.

⁴ On December 8, 2023, the Board granted the Provider’s request to bifurcate this issue into Dual Eligible Days – SSI Fraction, which remained at Issue No. 5. Issue No. 6 was created, which was Dual Eligible Days – Medicaid Fraction. On June 18, 2026, Issue No. 5 was transferred to Case No. 22-1006GC and Issue No. 6 to Case No. 23-0079GC.

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party (“CIRP”) group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **June 9, 2023**, the Provider transferred Issues 2 and 4 to CHS CIRP groups.

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

On **November 22, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties’ preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

Provider’s Preliminary Position Paper – *For each issue*, the position paper ***must*** state the material facts that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and provide arguments applying the material facts*** to the controlling authorities. This filing ***must*** include ***any exhibits*** the Provider will use to support its position and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.⁵

On **July 5, 2023**, the Provider timely filed its preliminary position paper. With respect to Issue 3, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent directly to the Medicare Contractor and advised a redacted version would be included with the final position paper. However, 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, including Section 1115 waiver days, the Provider contends that the total number of days reflected in its 2019 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.” As a result, the Provider included, as an Exhibit, the original “estimated impact” for this issue of \$61,523 based on an *estimated* 100 days.

On **October 27, 2023**, the Medicare Contractor filed its preliminary position paper. With regard to Issue 3, the Medicare Contractor’s position paper noted that the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position.

On **June 26, 2026**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. (“QRS”).

On **June 29, 2026**, QRS filed the Provider’s Final Position Paper and included a redacted listing as an exhibit, adding the *caveat* that the “Listing [is] *pending finalization* upon receipt of State

⁵ (Emphasis added.)

eligibility data.”⁶ The Listing was 52 pages with roughly 6,597 Medicaid eligible days. QRS’ filing did not explain why the listing of so many days (again around 6,597 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, ***nearly 7 years after the fiscal year at issue had closed***. NOTE—the roughly 6,597 days included in this belated listing is *significantly* larger than the original *estimated* impact of 100 days included with the appeal request.

On **July 23, 2026**, the Medicare Contractor filed a Motion to Dismiss with the Board over Issue 3, requesting that the Board dismiss the issue and the appeal. Pursuant to Board Rule 44.3, the Provider had 30 days in which to file a response to the Motion to Dismiss. However, the Provider ***failed*** to file any response.

B. Description of Issue 3 in the Appeal Request

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

Statement of Issue

Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital (“DSH”) calculation.

Statement of the Legal Basis

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

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

Audit Adjustment Number(s): 7,8,9,S-D.

Estimated Reimbursement Amount: \$61,523⁷

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the Jewish Hospital case⁸ and HCFA Ruling 97-2, “all patient days for

⁶ Ex. P-1 (emphasis added).

⁷ Appeal Request at Issue 3.

⁸ *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994).

which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage” of the DSH payment adjustment.⁹ The Provider then, for the first time in this appeal, states it is seeking reimbursement for section 1115 waiver days as a part of the Medicaid eligible day issue. Specifically, the Provider states:

[M]edicaid eligible days (including section 1115 waiver days (which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider’s Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider’s Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).¹⁰

MAC’s Contentions

The MAC contends that the Provider failed to properly develop its arguments within its preliminary position paper in accordance with Board Rule 7, 25.2.1 and 25.2.2. The MAC argues the Provider has not submitted a Medicaid eligible days listing and therefore, requests the Board dismiss the issue.

Provider’s Response

The Board Rules require that responses to motions must be filed within thirty (30) days of the filing of the motion.¹¹ The Provider has not filed a response to the Motion to Dismiss and the time for doing so has elapsed. Board Rule 44.3 specifies: “Unless the Board imposes a different deadline, an opposing party may file a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party.”

Decision of the Board

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

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

⁹ Provider’s Preliminary Position Paper at 9 (Jul. 5, 2023).

¹⁰ *Id.* at 9-10.

¹¹ Board Rule 44.3, v. 3.1 (Nov. 2021).

A. DSH Payment – Medicaid Eligible Days

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

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.

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.¹²

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 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:

¹² (Bold emphasis added.)

Rule 25 Preliminary Position Papers¹³

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.

...

¹³ (Underline emphasis added to these excerpts and all other emphasis in original.)

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange *all* available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4.

Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

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

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

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

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 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.

COMMENTARY:

Note that the change to require filing of the *complete* preliminary position paper was effective on August 19, 2018. Accordingly, failure to file a *complete* preliminary position paper with the Board will result in the Board dismissing your appeal or taking 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 November 22, 2022 included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish *each Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

The hospital has the burden of furnishing data adequate to prove eligibility for *each* Medicaid patient *day claimed* under this paragraph, *and* of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.¹⁴

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),

¹⁴ (Emphasis added.)

- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On July 5, 2023, 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 to the Medicare Contractor.¹⁵ 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 \$61,523 based on an estimated 100 days). The Provider’s complete briefing of this issue in its position paper is as follows:

Issue #3: Medicaid Eligible Days

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

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

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.

¹⁵ Provider’s Preliminary Position Paper, Ex. P-1.

Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).

Based on the Listing of Medicaid Eligible days being sent under separate cover, including Section 1115 waiver days, the Provider contends that the total number of days reflected in its 2019 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

With respect to section 1115 waiver days, the courts have firmly rejected CMS's interpretation of its regulations, holding instead that the plain language of the statute and the regulations require inclusion in the Medicaid Fraction of the days belonging to individuals who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool. *See Forrest General Hospital*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. 2018); *Bethesda Health Inc., v. Azar*, 389 F. Supp. 3d 32 (D.D.C. 2019), *aff'd*, 980 F.3d 121 (D.C. Cir. 2020). CMS has acquiesced in *Bethesda* and is now following the statute and the plain meaning of its own regulations (which regulations represent the official policy of CMS all along). *See* CMS Manual Instructions System, Change Request 12669, Transmittal No. 11912 (March 163 [sic], 2023) ("Transmittal 11912"), attached as Exhibit P-4.

On **June 29, 2026**, QRS filed the Provider's Final Position Paper and included a redacted listing as an exhibit, adding the *caveat* that the "Listing [is] *pending finalization* upon receipt of State eligibility data."¹⁶ The Listing was 52 pages with roughly 6,597 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 6,597 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, ***nearly 7 years after the fiscal year at issue had closed***. NOTE—the roughly 6,597 days included in this belated listing is *significantly* larger than the original *estimated* impact of 100 days included with the appeal request.

¹⁶ Ex. P-1 (emphasis added).

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)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

Finally, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof “to prove eligibility for *each* Medicaid patient day claimed”¹⁷ and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the preliminary position paper filing (much less provider the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is \$0.

Based on the above, the Board finds that the Provider has failed to comply with the Board’s procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.¹⁸

B. 1115 Waiver Days

The Board finds that the section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. The Provider failed to include section 1115 Waiver days as a cost issue in its appeal request and failed to timely and properly add this additional issue to the

¹⁷ (Emphasis added.)

¹⁸ 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.

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

The appeal was filed with the Board in November of 2022 and the regulations required the following:

(b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing...must be submitted in writing to the Board, and the request must include...

(2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final...determination under appeal, including an account of...

(i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]

(ii) How and why the provider believes Medicare payment must be determined differently for each disputed item...¹⁹

Board Rule 7.2.1 elaborated on this regulatory requirement, instructing providers:

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

- An issue title and a concise issue statement describing:
 - the relevant adjustment(s), including the adjustment number(s),
 - the controlling authority (*e.g.*, specific regulation, Federal Register issuance, manual provision, or Ruling),
 - why the adjustment(s) is incorrect,
 - how the payment should be determined differently,
 - the reimbursement effect, and
 - the basis for jurisdiction before the Board.

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

Several examples are identified below, but these are not exhaustive lists of categories or issues.

¹⁹ 42 C.F.R. § 405.1835(b).

A. Disproportionate Share Hospital Payments

Common examples include, but are not limited to:

*. . . Section 1115 waiver days (program/waiver specific). . .*²⁰

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

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

(e) Adding issues to the hearing request. After filing a hearing request... a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –

. . .

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

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

In this regard, the Board notes that section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.²² Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program and not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

(4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same

²⁰ (Bold and italic emphasis added).

²¹ See 73 Fed. Reg. 30190 (May 23, 2008).

²² 65 FR 47054, 47087 (Aug. 1, 2000).

period. For purposes of this second computation, the following requirements apply:

(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

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

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

Finally, even in the Provider's preliminary position paper, the Provider fails to identify what § 1115 waiver program(s) are involved and whether or not the § 1115 waive days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the preliminary position paper is perfunctory in that it only makes perfunctory conclusions.²³ Again, the Provider failed to develop its position paper notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 as applied via Board Rule 27.2.

²³ For example, QRS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that "the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." However, QRS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is QRS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? QRS fails to brief the merits of its claims and fails to establish the Board's jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the final position paper references "uncompensated care pool."

The Board’s finding that neither the appeal request nor final position paper 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, et al. v. Becerra*.²⁴ In that case, the provider’s issue was tied to improper calculation to DSH payment and read in part, “[t]he 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 . . .”²⁵ The Court found that “[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently.”²⁶ The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.²⁷ Here, the Board makes the same finding based on similarly *overly generalized language*.

* * * * *

Based on the foregoing, the Board has dismissed the remaining issue in this case – (Issue 3). As no issues remain, the Board hereby closes Case No. 23-0278 and removes it from the Board’s docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

8/31/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

²⁴ No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

²⁵ *Id.* at *11.

²⁶ *Id.*

²⁷ *Id.*



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***

Alliance Health Ponca City (Prov. No. 37-0006), FYE 05/31/2019, Case No. 23-0091

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0091. Set forth below is the decision of the Board to dismiss the two remaining issues in this appeal: the SSI Provider Specific and Medicaid Eligible Days issues.

Background

A. Procedural History for Case No. 23-0091

On **May 6, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2019.

On **October 17, 2022**, Community Health Systems, Inc. ("CHS") filed the Provider's appeal request. The request included five (5) issues:

1. DSH Pymt/ SSI% (Provider Specific)
2. DSH Pymt/ SSI% (Systemic Errors)¹
3. DSH Pymt - Medicaid Eligible Days
4. Medicare Managed Care Part C Days – SSI & Medicaid Fraction²
5. Dual Eligible Days –SSI & Medicaid Fraction³

The Provider is commonly owned by CHS so it is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1).

On **October 19, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position

¹ On May 30, 2023, this issue was transferred to Case No. 22-1031GC.

² On May 30, 2023, this issue was transferred to Case No. 23-0078GC.

³ On May 30, 2023, this issue was transferred to Case No. 23-0080GC.

papers (*hereinafter* “PPP”). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

Provider’s Preliminary Position Paper – *For each issue*, the position paper ***must*** state the material facts that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and provide arguments applying the material facts*** to the controlling authorities. This filing ***must include any exhibits the Provider will use to support its position*** and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.⁴

On **June 12, 2023**, CHS timely filed the Provider’s PPP and on **September 7, 2023**, the Medicare Contractor (“MAC”) timely filed its PPP.

On **August 25, 2023**, the MAC filed a jurisdictional challenge over the DSH SSI Provider Specific & Medicaid eligible days issues in the case.

On **August 31, 2023**, CHS requested a change of representation to Quality Reimbursement Services, Inc. (“QRS”), which the Board granted on **September 1, 2023**.

On **November 27, 2023**, QRS filed a “Supplement to Position Paper/Redacted Medicaid Eligible Days” listing in the Office of Hearings Case & Document Management System (“OH CDMS”).

On **August 12, 2024**, QRS filed a late response to the MAC’s jurisdictional challenge.

B. Description of Issue 1 in the Appeal Request and the Provider’s Participation in Case No. 22-1031GC - CHS CY 2019 DSH SSI Percentage CIRP Group

In its Individual Appeal Request, the Provider summarizes its DSH SSI Provider Specific issue as follows:

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

The Provider contends that its’ SSI percentage published by the Centers for Medicare and Medicaid Services (“CMS”) was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.

⁴ (Emphasis added).

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.⁵

The Group issue Statement in Case No. 22-1031GC, to which the Provider transferred Issue No. 2, reads, in part:

Statement of the Issue:

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

Statement of the Legal Basis

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

⁵ Issue Statement at 1.

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 June 12, 2023, the Board received the Provider's PPP in Case No. 23-0091. The following is the Provider's **complete** position on Issue 1 set forth therein:

Provider Specific

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

The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The [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).⁷

⁶ Group Appeal Issue Statement in Case No. 22-1031GC.

⁷ Provider's PPP at 8-9.

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is \$22,041.

C. *Description of Issue 3 in the Appeal Request*

In its Individual Appeal Request, the Provider questions whether the MAC properly excluded Medicaid eligible days from the DSH calculation. The Statement of the Legal Basis is as follows:

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

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

Audit Adjustment Number(s): 5, 21, 22, S-D
Estimated Reimbursement Amount: \$17,885

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case⁸ and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.⁹

The Provider goes on to state:

Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's [or Providers'] Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's [or Providers'] Medicaid Fraction of the

⁸ *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994).

⁹ Provider's PPP at 10.

disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).¹⁰

MAC's Contentions - Issue 1 –SSI Provider Specific

In its jurisdictional challenge, the MAC argues that the Board lacks jurisdiction over the SSI Provider Specific issue, which has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2 which was transferred to a CIRP group (Case No. 22-1031GC).

In addition, the component related to SSI realignment should be considered abandoned because the Provider did not brief it in the PPP. Alternatively, the Board should find that it lacks jurisdiction over the realignment portion of the issue because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.¹¹

MAC's Contentions - Issue 3 – Medicaid Eligible/Section 1115 Waiver Days

In its Jurisdictional Challenge, the MAC advised that the Provider failed to include a list of additional Medicaid eligible days it expected to be included (even though the Provider's PPP included a statement indicating a listing of additional Medicaid eligible days would be sent under separate cover.)¹²

In addition, the MAC challenged jurisdiction over the Section 1115 Waiver Days issue, arguing that the Provider attempted to untimely and improperly add the issue in its PPP, which was beyond the due date to add issues to the case, and that the 1115 Waiver Days is a separate and distinct issue from the Eligible days issue initially appealed.¹³

The MAC also asserted that the Section 1115 waiver days is one component of the DSH issue that must be appealed as a separate issue. The MAC referenced Board Rule 8 which explains that one issue can have multiple components. Within Board Rule 8, some of the disproportionate share hospital (DSH) components are identified. Specifically, the Board identifies Section 1115 waiver days as a distinct DSH component that the Provider must appeal separately.¹⁴

Finally, the MAC contends that the Provider has failed to file a complete PPP in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25."¹⁵

¹⁰ Provider's PPP at 9-10.

¹¹ MAC's Jurisdictional Challenge at 10.

¹² *Id.* at 10.

¹³ MAC's jurisdictional challenge at 13-14.

¹⁴ MAC's jurisdictional challenge at 15.

¹⁵ *Id.* at 15.

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.¹⁶ The Provider failed to file a timely response. 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."¹⁷

Decision of the Board

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

As set forth below, the Board hereby *dismisses* the Provider's SSI Provider Specific and Medicaid Eligible Days issues.

A. SSI Provider Specific

The Provider's main argument regarding Issue No. 1 concerns its disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage. This issue appears to be duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Case No. 22-1031GC.

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

The DSH/SSI Percentage (Systemic Errors) issue in group Case No. 22-1031GC, in which the Provider is a participant, also alleges that the MAC and CMS improperly determined the DSH

¹⁶ Board Rule 44.4.3, v. 3.1 (Nov. 2021).

¹⁷ The Provider's Response to the Jurisdictional Challenge was not filed until August 12, 2024, which was almost a year late.

¹⁸ Issue Statement at 1.

¹⁹ *Id.*

²⁰ *Id.*

SSI Percentage, the DSH SSI Percentage is improper due to several factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F).

The Board has previously noted that CMS' interpretation of the SSI percentage regulation 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.²¹ Accordingly, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in the group case in which the Provider is a participant, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 22-1031GC.

To this end, the Board also reviewed the Provider's PPP 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. 22-1031GC but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, the Provider fails to explain how it can ascertain from State records, the entitlement of individuals, 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. Moreover, the Board finds that the Provider's PPP failed to comply with Board Rule 25 (Nov. 2021) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Nov. 2021), 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" 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 (Nov. 21, 2021)

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.

²¹ 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.²²

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

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

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

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

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 discuss claims that it should have access to, or why this is not a common issue already covered by the CIRP group under Case No. 22-1031GC.

²² (Italics and underline emphasis added.)

²³ Last modified July 31, 2026.

Accordingly, *based on the record before it*,²⁴ the Board finds that the SSI Provider Specific issue in Case No. 23-0091 and the group issue in the CHS CIRP group under Case No. 22-1031GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the ***Board dismisses this component of the SSI Provider Specific*** issue from Case No. 23-0091.

The other aspect of the SSI Provider Specific issue, related to the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period, is also 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 . . .". Moreover, without this written request, the MAC cannot issue a final determination with which the Provider can be dissatisfied for Board appeal purposes. There is nothing in the record to indicate the MAC has made a final determination regarding an SSI Percentage realignment. In accordance with 42 C.F.R. § 405.1835(a)(1), the ***Board dismisses this aspect of the SSI Provider Specific issue*** from the appeal.

B. DSH Payment – Medicaid Eligible Days

1. Medicaid Eligible Days

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

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:

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**

²⁴ Again, the Board notes that the Provider failed to timely respond to the Jurisdictional Challenge so the Board must make its determination based on the record before it.

of the provider's Medicare payment claims for each remaining issue.

(3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.²⁵

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

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

Rule 25 Preliminary Position Papers²⁶

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.

²⁵ (Bold emphasis added.)

²⁶ (Underline emphasis added to these excerpts and all other emphasis in original.)

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

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The October 19, 2022 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish *each Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

The hospital has the burden of furnishing data adequate to prove eligibility for *each* Medicaid patient *day claimed* under this paragraph, *and of verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.²⁷

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

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

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

²⁷ (Emphasis added.)

- the last known address, or
- upon failure to appear for a scheduled hearing.

On June 12, 2023, the Provider filed its PPP paper in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.²⁸ Significantly, the PPP did *not* include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather the exhibit at P-2 continued to reference the “estimated impact” included with its appeal request (i.e., the estimated impact of \$15,508- which according to the issue statement filed with the appeal, was based on an estimated 25 days). The Provider’s complete briefing of this issue in its PPP is as follows:

Calculation of Medicaid Eligible Days

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

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

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

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

²⁸ Provider’s PPP at 10.

Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's [or Providers'] Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's [or Providers'] Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).

Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2019 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.²⁹

In its August 25, 2023 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid Eligible Days issue 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 PPP in violation of Board Rule 25. Thus, the MAC asserts that the Provider failed to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the Board Rules.³⁰ As noted, the Provider failed to respond to the Jurisdictional Challenge within the 30-day time period, which expired on September 24, 2023.

After review, the Board concurs with the MAC, 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)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days) in either its appeal request or its PPP.

²⁹ Provider PPP at 9-10.

³⁰ 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.

Further, the Board rejects the Provider's attempt to "Supplement" the PPP by filing a Redacted Eligible Days listing on November 27, 2023 because:

1. The listing was filed past the deadline for the exhibits to be included with the PPP filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)) (*which was due on June 14, 2023*).
2. Given that the *material* facts (e.g., the days at issue) and all available exhibits were required to be part of the PPP, if the Board were to accept the June 14, 2023 listing of days (an auditable copy of which the MAC asserts it does not have), it would need to be either be a *refinement* of its PPP or a supplement of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the PPP nor the subsequent listing identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the redacted listings cannot be considered a refinement of the PPP since no specific days or listing were included with the PPP.³¹
3. Finally, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for *each* Medicaid patient day claimed"³² and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its PP 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 PPP filing (much less provider the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is \$0.

2. Section 1115 Waiver Days

The Board finds that the Section 1115 waiver days issue is not a part of this appeal as it was not included as a cost issue in the appeal, nor was it properly or timely added. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from Section 1115 waiver days.

The appeal was filed with the Board in October of 2022 and the regulations required the following:

b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing...must be submitted in writing to the Board, and the request must include...

³¹ See, e.g., Board Rule 27.3 (Nov. 2021) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."

³² (Emphasis added.)

(2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final...determination under appeal, including an account of...

(i) why the provider believes Medicare payment is incorrect for each disputed item...[and]

(ii) how and why the provider believes Medicare payment must be determined differently for each disputed item...³³

Board Rule 7.2.1 (Nov. 2021) elaborated on this regulatory requirement instructing providers:

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

- An issue title and a concise issue statement describing:
 - the adjustment, including the adjustment number,
 - the controlling authority,
 - why the adjustment is incorrect,
 - how the payment should be determined differently,
 - the reimbursement effect, and
 - the basis for jurisdiction before the Board.³⁴

Board Rule 8 (Nov. 2021) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and “...each contested component must be appealed as a separate issue and described as narrowly as possible...”. The Rule goes on:

Several examples are identified below, but these examples are not exhaustive lists of categories or issues.

A. Disproportionate Share Hospital Payments

Common examples include...***Section 1115 waiver days (program/waiver specific)***³⁵

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.³⁶

³³ 42 C.F.R. § 405.1835(b).

³⁴ v. 3.1 (Nov. 2021).

³⁵ (Bold and italic emphasis added).

³⁶ See 73 Fed. Reg. 30190 (May 23, 2008).

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

(c) *Adding issues to the hearing request.* After filing a hearing request... a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
...

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

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

In this regard, the Board notes that Section 1115 waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.³⁷ Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program *and* not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction.²⁰ In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2019) states in pertinent part:

(4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

³⁷ 65 FR 47054, 47087 (Aug. 1, 2000).

(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

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

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

Regardless, even if the Provider had included the Section 1115 waiver days issue in its appeal request (which it did not), the Provider failed to properly develop the issue in its PPP filing. The Provider's PPP does not identify the specific 1115 waiver day program(s) at issue notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (2021). Pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has 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." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 waiver days sub-issue.

The Board's finding that neither the appeal request nor the PPP 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, et al. v. Becerra*.³⁸ In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he 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 . . ."³⁹ The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."⁴⁰ The Court found that this description of the

³⁸ No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

³⁹ *Id.* at *11.

⁴⁰ *Id.*

issue was a violation of Board rules and a proper basis for the Board to dismiss the appeal.⁴¹ Here, the Board makes the same finding based on similar *overly generalized language*.

Based on the above, the Board finds that ***the appeal did not include the alleged Section 1115 waiver days sub-issue*** consistent with 42 C.F.R. §§ 405.1835(b)(2)-(3), 412.106(b)(4)(iii), and 405.1871(a)(3) and Board Rules 7.1, 8, 25, and 27.2.⁴² In the alternative, the Board finds that, even if it had been included as part of the appeal, the issue was not properly developed in the PPP process.

* * * *

Based on the foregoing, the Board is ***dismissing the SSI Provider Specific and Medicaid Eligible Days/Section 1115 Waiver Days issues*** in this case. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

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

For the Board:

8/31/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

⁴¹ *Id.*

⁴² If section 1115 waiver days were found to be part of the appeal request and had been properly briefed, the Board would still need to address an additional jurisdictional issue – review whether it had jurisdiction over the section 1115 waiver days. For example, the Board has found that when a class of days (*e.g.*, 1115 waiver days) is excluded due to choice, error, and/or advertence from the as-filed cost report, then that class of days is an unclaimed cost for which the Board would lack jurisdiction under 42 U.S.C. § 1395oo(a). *See, e.g.*, PRRB Jurisdictional Decision, Case Nos. 06-1851, 061852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days from the appeal because no days were claimed with the as-filed cost report due to choice, error and/or inadvertence and, as such, the practical impediment standard or futility concept in the *Norwalk* and *Danbury* Board decisions is not applicable).



DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Nan Chi, Director of Budget & Compliance
Houston Methodist Hospital System
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RE: ***Own Motion Dismissal***

Case No. 23-1209-Houston Methodist San Jacinto Hospital (45-0424), FYE 12/31/2018
Case No. 23-1466 -Houston Methodist West Hospital (67-0077), FYE 12/31/2018
Case No. 23-1728 -Houston Methodist St. John Hospital (45-0709), FYE 12/31/2018

Dear Ms. Chi:

The Provider Reimbursement Review Board (“Board”) has reviewed the referenced appeal requests. Set forth below is the decision of the Board to dismiss the Disproportionate Share Hospital (“DSH”) Payment SSI (Provider Specific) issue from each case.

Background:

Case No.	Provider/No.	Appeal Filed	NPR Date
23-1209	Houston Methodist San Jacinto Hospital (45-0424)	3/22/2023	9/23/2022
23-1466	Houston Methodist West Hospital (67-0077)	6/26/2023	1/13/2023
23-1728	Houston Methodist St. John Hospital (45-0709)	9/21/2023	3/28/2023

Houston Methodist Hospital System (“Houston Methodist”), the parent organization, filed individual appeals for each of the referenced Providers. Each appeal included various issues, two of which were related to the SSI Percentage, specifically the DSH Payment SSI Provider Specific (“Issue 1”/“SSI Provider Specific”) and the DSH Payment SSI Systemic (“Issue 2”/“SSI Systemic”) issues.

Since the Providers are commonly owned/controlled by the Houston Methodist organization, they are subject to the mandatory common issue related party (“CIRP”) group regulation at 42 C.F.R. § 405.1837(b)(1). On December 4, 2024, the Board denied the Provider’s request to transfer the SSI Systemic Errors issue for the referenced providers to the “DSH SSI Unduly Narrow Definition of SSI Entitlement CIRP Group” under Case No. 23-1635G. The Board found that the Providers appealed distinctly different issues in their individual appeals from which they transferred that the issue under appeal in the group. As a result, the SSI Systemic Errors issue was returned to the individual appeals: Case Nos. 23-1209, 23-1466 and 23-1728.¹

¹ The Systemic Errors issue was also returned to the appeal for Houston Methodist Willowbrook Hospital, Case No. 23-1006.

Subsequently, on August 25, 2026, QRS formed a new “Houston Methodist CY 2018 DSH Supplemental Security Income (Systemic Errors) CIRP Group” to which it transferred the SSI Systemic Errors issues from Case Nos. 23-1006, 23-1209, 23-1466 and 23-1728, ultimately leaving the SSI Provider Specific issue as the last issue in each appeal (except in Case No. 23-1209 where there is an additional DGME Payment (Fellows Penalty) issue remaining.

In each case, the Board issued a Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties’ preliminary position papers (*hereinafter* “PPP”).

The Parties filed PPPs as follows:

Case No.	Provider PPP	MAC PPP
23-1209	11/14/2023	3/8/2024
23-1466	2/20/2024	6/14/2024
23-1728	5/17/2024	9/11/2024

A. Description of Issue 1 in the Appeal Requests and PPPs

In each individual appeal and the PPP, the Provider summarizes its DSH Payment (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 and the subsequent audit adjustment to the Provider’s cost report by the MAC are both flawed.

The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that

CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).²

B. Description of Issue 2 in the Appeal Request and PPPs

In each Appeal Request and PPP, the Provider summarizes its DSH Payment-SSI-Systemic Errors issue as follows:

Statement of the Issue:

Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage.

Statement of the Legal Basis

The Providers 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)(I). The Providers further contend(s) that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Reports does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.

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

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

The amount in controversy in each Provider's individual appeal request is the same for both Issues 1 and 2. (Case No. 23-1209 – shows an impact of \$12,734; Case No. 23-1466 shows an impact of \$46,023; and Case No. 23-1728 shows an impact of \$13,261 for Issue 1 (and \$13,262 for Issue 2).

² Issue Statements at 1 and PPPs at 2.

³ Issue Statements in Case Nos. 23-1209, 23-1466 and 23-1728 at 2 and PPPs at 2-3.

Board Analysis and Decision:

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

As set forth below, the Board hereby dismisses Issue No. 1 from each of the respective Providers' appeals.

A. DSH Payment (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider's disagreement with how the MAC 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

In each case, the first aspect of Issue No. 1—the Provider's disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the SSI (Systemic Errors) issue at Issue No. 2 which was transferred to a CIRP group.

The SSI (Provider Specific) issue in these appeals concerns “[w]hether the Medicare Administrative Contractor (“MAC”) used the correct Supplemental Security Income (“SSI”) percentage in the Disproportionate Share Hospital (“DSH”) calculation.”⁴ Per the appeal requests, the Providers' legal basis for its SSI Percentage (Provider Specific) issue asserts 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).”⁵ The Providers argue that “its'[sic] 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.”⁶

The Providers' SSI (*Systemic Errors*) issue described at Issue No. 2 in each case and in the new CIRP group, Case No. 26-2993GC, also alleges that the MAC and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to several factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the SSI (Provider Specific) issue (No. 1) is duplicative of the SSI (*Systemic Errors*) issue (No. 2) in all three cases which was subsequently transferred to the CIRP group,

⁴ Issue Statements in Case Nos. 23-1209, 23-1466 and 23-1728 at 1.

⁵ *Id.*

⁶ *Id.*

Case No. 26-2993GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6⁷, the Board dismisses this aspect of the DSH Payment SSI (Provider Specific) issue from Case Nos. 23-1209, 23-1466 and 23-1728.

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 Providers have failed to explain how this argument is *specific to each respective 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.⁸ Accordingly, in each case, the Provider's reference to Issue No. 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Providers have failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue No. 2.

To this end, the Board also reviewed the Providers' PPPs in the three cases to see if it further clarified Issue No.1 and No. 2. The Providers' PPPs all used the same language as the issue statements filed with the individual appeal requests and did not provide any basis upon which to distinguish between the two issues. Moreover, the Board finds that the Providers' PPPs failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be *fully* developed and include *all available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Providers failed to *fully* develop the merits of their position on Issue 1 and explain the nature of any alleged "errors" in their PPPs and include *all* exhibits.

In addition, the Providers have 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 (Nov. 1, 2021)

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.⁹

⁷ PRRB Rules v. 3.1 (Nov. 2021).

⁸ 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).

⁹ (Italics and underline emphasis added.)

The Board notes that there have been developments on the availability of data underlying the SSI fraction, such as MEDPAR data. For example, as noted in the FY 2006 IPPS Final Rule:

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

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

<https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh>.¹⁰

Accordingly, *based on the records in these cases*, the Board finds that the component of the SSI Provider Specific issue related to whether the MAC used the correct SSI Percentage in the DSH calculation is duplicative of the SSI Systemic Errors issue (No. 2) in each of the instant appeals.¹¹ 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 SSI Percentage (Provider Specific) issue.

¹⁰ Last modified on July 31, 2026.

¹¹ 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 Houston Methodist Hospital System CIRP group per 42 C.F.R. § 405.1837(b)(1).

2. Second Aspect of Issue 1

The second aspect of the SSI Percentage (Provider Specific) issue—the Providers preserving their right to request realignment of the SSI percentage from the federal fiscal year to their respective cost reporting periods—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” Moreover, without this written request, the MAC cannot issue a final determination with which the Provider can be dissatisfied for Board appeal purposes. There is nothing in these records to indicate the MAC has made a final determination regarding DSH SSI Percentage realignment for the three subject Providers. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the issue from Case Nos. 23-1209, 23-1466 and 23-1728.

Based on the foregoing, the Board is dismissing the DSH Payment SSI (Provider Specific) - Issue No. 1 from Case Nos. 23-1209, 23-1466 and 23-1728. Case Nos. 23-1466 and 23-1728 are hereby closed as there are no remaining issues. Case No. 23-1209 will remain pending for pursuit of the DGME Payment (Fellows Penalty) issue.

Review of this determination in Case Nos. 23-1466 and 23-1728 may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877, and in Case No. 23-1209 upon final disposition of the case.

Board Members Participating:

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

For the Board:

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

8/31/2026

cc: James Ravindran, QRS
Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Wilson C. Leong, Esq., Federal Specialized Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
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150 N. Santa Anita Avenue, Suite 570A
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RE: ***Notice of Dismissal***

South Baldwin Regional Medical Center, Prov. No. 01-0083, FYE 09/30/2018
Case No. 23-0703

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 23-0703. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider’s Disproportionate Share Hospital (“DSH”) Medicaid Eligible Days.

Background

A. Procedural History for Case No. 23-0703

On **August 17, 2022**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end September 30, 2018.

On **January 31, 2023**, the parent organization, Community Health Systems, Inc. (hereinafter “CHS”) filed the Provider’s individual appeal request which included five (5) issues:

1. DSH Pymt/SSI % (Provider Specific)¹
2. DSH SSI – Unduly Narrow Definition of SSI Entitlement²
3. DSH Pymt - Medicaid Eligible Days
4. Medicare Managed Care Part C – SSI & Medicaid Fractions³
5. Dual Eligible Days – SSI & Medicaid Fractions⁴

On **February 1, 2023**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties’ preliminary position

¹ On June 30, 2026, this issue was withdrawn.

² On August 7, 2023, this issue was transferred to Case No. 21-1206GC, which is a group appeal for the SSI Percentage issue. The Board denied the transfer to Case No. 21-1206GC on August 7, 2026 and the issue was subsequently transferred to an Unduly Narrow group, Case No. 26-2711GC on August 7, 2026.

³ On August 7, 2023, this issue was transferred to Case No. 20-2149GC.

⁴ On August 7, 2023, this issue was transferred to Case No. 21-0066GC.

papers (*hereinafter*, “PPP”). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

On **February 1, 2023**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties’ preliminary position papers (*hereinafter*, “PPP”). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

Provider’s Preliminary Position Paper – *For each issue*, the position paper ***must*** state the material facts that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and provide arguments applying the material facts*** to the controlling authorities. This filing ***must include any exhibits*** the Provider will use to support its position and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.⁵

On **September 25, 2023**, CHS filed the Provider’s PPP.

On **November 27, 2023**, CHS requested a change of representation to Quality Reimbursement Services, Inc. (“QRS”), which the Board granted on the same day.

On **November 28, 2023**, QRS uploaded a “Supplement to Position Paper/Redacted Medicaid Eligible Days” listing.

On **December 18, 2023**, the MAC filed a Jurisdictional Challenge over the SSI Provider Specific issue (which was subsequently withdrawn) and the Medicaid Eligible Days issue.

On **January 15, 2024**, the MAC filed its PPP.

On **September 25, 2024**, QRS filed a (late) Response to the MAC’s Jurisdictional Challenge.

On **April 3, 2026**, the Board issued a Notice of Hearing scheduling the case for a **October 30, 2026** hearing.

On **July 31, 2026**, the Provider filed its final PP followed by the MAC’s final PP on **August 19, 2026**.

MAC’s Contentions- Issue #3 - DSH – Medicaid Eligible Days

In its Jurisdictional Challenge, the MAC argues the Board lacks jurisdiction over the Medicaid Eligible Days issue. The MAC contends that the Provider failed to include a list of additional

⁵ (Emphasis added.)

Medicaid eligible days they expect to be included with their appeal or their PPP (even though the Provider advised that it would send a listing of additional Medicaid eligible days under separate cover.)⁶ The MAC argues the Provider has abandoned this issue because it failed to sufficiently develop and set forth the relevant facts and arguments in its PPs and because it neglected to include all supporting documentation.⁷ In addition, the MAC contends the Provider is attempting to untimely add the issue of Section 1115 waiver days by including the issue in its PPP.⁸

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must be filed within thirty (30) days from the date the challenge was sent to the Board and the opposing party.⁹ The Provider's response to the Jurisdictional Challenge was filed beyond the 30-day deadline which elapsed on January 17, 2024 (*30 days after it was filed on December 18, 2023*).¹⁰ Therefore, the Board will make ". . . a jurisdictional determination with the information contained in the record."

Decision of the Board

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

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

A. DSH Payment – Medicaid Eligible Days

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

With regard to the filing of an individual appeal, Board Rule 7 - Support for Appealed Final Determination, Availability of Issue-Related Information and Basis for Dissatisfaction (Dec. 2023) 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

⁶ MAC's Jurisdictional Challenge at 2 and 10.

⁷ *Id.* at 11.

⁸ *Id.* at 2, 10 and 13-16.

⁹ Board Rule 44.4.3, v. 3.1 (Nov.1, 2021).

¹⁰ The Provider's Jurisdictional Response was filed on September 25, 2024.

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.¹¹

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

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

Rule 25 - Preliminary Position Papers¹²

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.

¹¹ (Bold emphasis added.)

¹² (Underline emphasis added to these excerpts and all other emphasis in original.)

25.1 Content of Position Paper Narrative

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

25.1.1 The Provider's Position Paper

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

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The February 1, 2023 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish *each Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

The hospital has the burden of furnishing data adequate to prove eligibility for *each* Medicaid patient *day claimed* under this paragraph, *and* of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.¹³

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carry[es] 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

¹³ (Emphasis added.)

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

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

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

On September 25, 2023, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.¹⁴ Significantly, the PPP 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 \$49,893 based on an estimated 100 days). The Provider's complete briefing of this issue in its PPP is as follows:

Calculation of Medicaid Eligible Days

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

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

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

¹⁴ Provider's PPP at 10.

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

Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).

Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2018 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.¹⁵

In its December 18, 2023 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid Eligible days issue 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 file a complete PPP in accordance with 42 CFR § 405.1853(b)(2) and Board Rule 25. Thus, the MAC 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 Board Rules.¹⁶ In addition, the MAC indicates the Provider is attempting to untimely add the issue of Section 1115 Waiver days by including the issue in its PPP.

The Board concurs with the MAC- 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

¹⁵ Provider's PPP at 8-9.

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.

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)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid Eligible days issue because the provider failed to identify any specific Medicaid Eligible days at issue (much less any supporting documentation for those days) in either its appeal request or its PPP.

Further, the Board rejects the Provider's attempt to "Supplement" the PPP by filing a Redacted Eligible Days listing on November 24, 2023 because:

1. The listing was filed past the deadline for the exhibits to be included with the PPP filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)) (*which was due on September 28, 2023*).
2. Given that the *material* facts (e.g., the days at issue) and all available exhibits were required to be part of the PPP, if the Board were to accept the November 24, 2023 listing of days (an auditable copy of which the MAC asserts it does not have), it would need to be either be a *refinement* of its PPP or a supplement of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the PPP, nor the subsequent listing, (*nor the redacted listing submitted as an exhibit to the final PP*), identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the redacted listings cannot be considered a refinement of the PPP since no specific days or listing were included with the PPP.¹⁷
3. Finally, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for *each* Medicaid patient day claimed"¹⁸ and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its PP 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 PPP filing (much less provider the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is \$0.

B. Section 1115 Waiver Days

The Board also concurs with the MAC, that the Section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. While the Provider appealed Medicaid Eligible days, this issue is separate and distinct from the Section 1115 Waiver days.

¹⁷ See, e.g., Board Rule 27.3 (Nov. 2021) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."

¹⁸ (Emphasis added.)

The appeal was filed with the Board in January of 2023 and the regulations required the following:

(b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing...must be submitted in writing to the Board, and the request must include...

(2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final...determination under appeal, including an account of...

(i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]

(ii) How and why the provider believes Medicare payment must be determined differently for each disputed item...¹⁹

Board Rule 7.2.1 (2021) elaborated on this regulatory requirement, instructing providers:

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

- An issue title and a concise issue statement describing:
 - the adjustment, including the adjustment number,
 - the controlling authority,
 - why the adjustment is incorrect,
 - how the payment should be determined differently,
 - the reimbursement effect, and
 - the basis for jurisdiction before the [Board].

Board Rule 8 (Nov.2021) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "...each contested component must be appealed as a separate issue and described as narrowly as possible...". The Rule goes on:

Several examples are identified below, but these are not exhaustive lists of categories or issues.

A. Disproportionate Share Hospital Payments

¹⁹ 42 C.F.R. § 405.1835(b).

Common examples include: . . . *Section 1115 waiver days (program/waiver specific)*. . .²⁰

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

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

(e) Adding issues to the hearing request. After filing a hearing request... a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –

. . .

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

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

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid Eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.²² Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying Section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a Section 1115 Waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

Specifically, § 412.106(b)(4) (2019) states in pertinent part:

(4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

²⁰ (Bold and italic emphasis added).

²¹ See 73 Fed. Reg. 30190 (May 23, 2008).

²² 65 FR 47054, 47087 (Aug. 1, 2000).

(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

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

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

Regardless, even if the Provider had included in its appeal request (*which it did not*), the Provider failed to properly develop the issue in its PPP filing as it does not identify the specific 1115 Waiver day program(s) at issue). In addition, the PPP does not discuss whether or not the Section 1115 Waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as “days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act” and the patients underlying those days are “deemed eligible for Medicaid” based on “the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered.” Rather, the PPP is perfunctory in that it only makes cursory conclusions. Again, the Provider failed to so develop its PPs, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Nov. 2021).

As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider “has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.” Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has 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.” The Provider’s briefing fails to establish the merits of its position on the *alleged*

Section 1115 Waiver days sub-issue.

The Board's finding that neither the appeal request nor the PPs 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, et al. v. Becerra*.²³ In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he 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 . . ."²⁴ The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."²⁵ The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.²⁶ Here, the Board makes the same finding based on similar *overly generalized language*.

* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible days (Issue #3) including Section 1115 Waiver days. As no issues remain, the Board hereby closes Case No. 23-0703 and removes it from the Board's docket.

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

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For the Board:

8/31/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

²³ No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).

²⁴ *Id.* at *11.

²⁵ *Id.*

²⁶ *Id.*