PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

2026-D28

PROVIDER –
Franciscan Health Dyer

PROVIDER NUMBER – 15-0090

vs.

MEDICARE CONTRACTOR –
WPS Government Health Administrators

RECORD HEARING HELD –
January 22, 2025

FEDERAL FISCAL YEAR– 2021

CASE NUMBER – 21-1667

INDEX

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ISSUE STATEMENT:

Whether the Medicare Contractor erred in calculating Franciscan Health Dyer's ("Provider") hospital specific rate ("HSR") based upon the Provider's Fiscal Year ("FY") 1988 cost reporting period [utilizing the federal fiscal year ("FFY") 1987 base period], rather than its FY 1983 cost reporting period [utilizing the FFY 1982 base period].[1]

DECISION:

After considering Medicare law, the regulations and program instructions, the arguments presented and the evidence admitted, the Provider Reimbursement Review Board ("Board") remands the case to the Medicare Contractor to calculate the 1982 HSR by either:

> (1) re-creating the Target Amount Computation ("TAC") worksheet, in accordance with the Provider Reimbursement Manual ("PRM") 15-1, Section 2802.1, Exhibit C, utilizing the 1983 cost report and any necessary supporting documentation and data required to be provided by Franciscan Health Dyer; or
>
> (2) the Medicare Contractor may audit Franciscan Health Dyer's "recomputed TAC worksheet," utilizing any necessary supporting documentation and data required to be provided by Franciscan Health Dyer.

If both of these efforts should fail due to insufficient data, or if the 1982 calculated HSR is less than the 1987 calculated HSR, Franciscan Health Dyer's HSR will remain the 1987 calculated HSR, which has been shown to be higher than the 2002 calculation – as directed by 42 C.F.R. § 412.108(c)(2)(iii).

INTRODUCTION:

Franciscan Health Dyer is "a non-profit, short-term acute care hospital located in Dyer, Indiana."[2] Franciscan Health Dyer's designated Medicare contractor[3] is Wisconsin Physician Services ("WPS") Government Health Administrators ("Medicare Contractor").

In a letter dated March 1, 2021, the Medicare Contractor informed Franciscan Health Dyer that its Medicare Dependent Hospital ("MDH") status was approved effective December 31, 2020.[4] The same day, via e-mail correspondence, the Medicare Contractor requested information in order to calculate a hospital specific rate, stating:

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[1] Provider's Final Position Paper ("Provider's FPP") at FHDFPP0004 (Oct. 30, 2024).
[2] Stipulations in Support of Joint Request for Record Hearing ("Stip.") at ¶ 1 (Jan. 21, 2025).
[3] CMS's payment and audit functions under the Medicare program were historically contracted with organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The relevant law may refer to FIs and MACs interchangeably, and the Board will use the term "Medicare contractor" refers to both FIs and MACs, as appropriate and relevant.
[4] Exhibit ("Ex.") P-1 ("Medicare Dependent Hospital Initial Status Approval"). *See also* Provider's FPP at FHDFPP0005; Medicare Contractor's Final Position Paper ("Medicare Contractor's FPP") at 5 (Nov. 26, 2024).

> To do so, I need ***one*** of the following finalized cost reports:
>
> Ending on or after 9/30/87 and before 9/30/88
> Beginning 10/1/01 through 9/30/02
> Or, a TAC report relating to cost report ending on or after 9/30/82 and before 9/30/03[5]
>
> Unfortunately we were not the MAC at any of these times so don't have them. Please get to me as soon as possible.[6]

The Provider responded the same day stating they were providing the cost reports for 1982 and 2002 and advised they were still looking for the 1987 cost report.[7] On March 22, 2021, the Medicare Contractor provided the hospital specific rate calculation based on the 2002 cost report.[8] When the Provider inquired later that same day as to why the 1982 cost was not used (nor calculated), the Medicare Contractor replied that the 1982 cost report cannot be used as the TAC report would be required and explained:

> The reason for not using the 1982 cost report is that it is a pre-PPS cost report and has capital and medical education costs commingled in the cost line. If the base year is calculated on the cost report rather than the TAC report, it will be overstated by a potentially large amount. A[s] I said previously, the TAC report was created by MACs to compute the FY 1982 cost per discharge net of capital and medical education. ***It's possible that you may never have had this repor***t, ***but it's what we have to have to calculate based on 1982***.[9]

Subsequently, in December 2022, Franciscan Health Dyer submitted copies of its settled FY 1988 cost report (1987 base period) and the Medicare Contractor agreed to utilize the 1987 base period to calculate the Provider's HSR.[10] Franciscan Health Dyer agreed with the Medicare Contractor's calculations based on the 1987 base period but maintained that the 1982 base period should be utilized.[11]

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[5] The Board notes that the 2003 date appears to be incorrect, as a TAC report is only necessary for cost reports settled prior to the inception of the Inpatient Prospective Payment System ("IPPS") in 1983. Thus, the applicable date range would instead be ending on or after 9/30/82 and before 9/30/83. *See also* PRM 15-1, § 2802.1, Exhibit C, discussed *infra*.
[6] Ex. P-3 at FHDFPP0034 (Emphasis added).
[7] *Id*.
[8] Ex. P-2. *See also* Ex. P-3 at FHDFPP0034.
[9] Ex. P-3 at FHDFPP0033 (Bold and italics emphasis added).
[10] Stip. at ¶¶ 5, 6. *See also* Ex. P-21 at FHDFPP0167-0169; Provider's FPP at FHDFPP0006; Medicare Contractor's FPP at 6-7.
[11] Ex. P-21 at FHDFPP0170.

On September 2, 2021, the Provider timely appealed from the initial March 22, 2021 HSR determination, which utilized the 2002 cost report and met the jurisdictional requirements for a hearing.[12] The Board granted a record hearing on January 22, 2025. The Provider was represented by Daniel F. Miller, Esq. of Hall, Render, Killian, Heath & Lyman, P.C. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services ("FSS").

STATEMENT OF RELEVANT FACTS:

Franciscan Health Dyer received MDH status effective December 31, 2020.[13] In March 2021, the Medicare Contractor provided hospital-specific rate calculations based on the 2002 cost report.[14] In December 2022, the Medicare contractor provided hospital-specific rate calculations based on the 1987 cost report.[15] The calculation based on the 1987 base period was the higher of the two.[16] The Medicare Contractor has maintained throughout the process that:

> [I]t was unable to use the 1982 cost report and . . . in order to utilize the 1982 base period, it would need the TAC report. . . [T]he 1982 base period cost report is pre-PPS, and therefore, would have included capital and medical education costs commingled in the total cost line [which] would overstate the HSR by a potentially large amount.[17]

In October 2022, Franciscan Health Dyer sent its re-creation attempt of the TAC worksheet to the Medicare Contractor. The October 25, 2022 email stated, "we prepared a TAC calculation using the 1983 final settled cost report, following the instructions in PRM Chapter 28[,]" and attached both documents.[18] Ultimately, in November, 2022, the Medicare Contractor replied that after review, it was determined that the calculations could not be made without the TAC report.[19] Franciscan Health Dyer has argued that "Medicare program guidance does not require use of the TAC Worksheet for purposes of calculating the Provider's HSR using the FY 1983 cost report."[20]

Both Franciscan Health Dyer and the Medicare Contractor have undergone efforts to locate the TAC report. The Medicare Contractor has acknowledged that the TAC report was a Medicare Contractor tool and the possibility exists that Franciscan Health Dyer never had access to the

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[12] Note: The initial final determination document submitted was an e-mail from the Medicare Contractor with the attached documentation and was sent on March 22, 2021. Workpapers were later submitted with a date of March 9, 2021, and "approved" on March 18, 2021. In their communication to the Board, the Provider states the e-mail was received March 9, 2021. Based on either date, the appeal to the Board was timely.
[13] Ex. P-1.
[14] Provider's FPP at FHDFPP0006. *See also* Ex. C-1; Ex. P-2.
[15] *Id. See also* Ex. C-4; Ex. P-21.
[16] *Id.*
[17] Medicare Contractor's FPP at 5-6.
[18] Ex. P-20 at FHDFPP0136.
[19] *Id*. at FHDFPP0165.
[20] Provider's FPP at FHDFPP0013.

TAC report needed to calculate their HSR based on the 1982 base period.[21] The Medicare Contractor encouraged Franciscan Health Dyer to contact the prior Fiscal Intermediary ("FI") to inquire as to whether the TAC report could be located.[22] In September 2021, the Medicare Contractor also informed Franciscan Health Dyer that their file department "confirmed that we do not have any files related to [Franciscan Health Dyer] that are earlier than the 2000 FYE."[23]

Franciscan Health Dyer contacted the prior FI and was directed back to the current Medicare Contractor.[24] Subsequently, the Provider requested a renewed search of archived files by the Medicare Contractor.[25] The Medicare Contractor responded, stating that "our audit and reimbursement areas have exhausted their respective searches with no results, we do not plan to search any further."[26] This resulted in Franciscan Health Dyer sending a "Initial Request for Production of Documents Pursuant to PRRB Rule 26.2," dated April 14, 2022, requesting that the Medicare Contractor extend its search for the TAC report to include its hard copy files.[27] On May 6, 2022,[28] the Medicare Contractor replied, stating that their prior efforts had complied with PRRB discovery rules and that "[t]he Provider's current request has become unreasonable and unduly burdensome."[29] The Provider did not seek Board intervention in this discovery issue under 42 C.F.R. § 405.1853(e)(5).

STATEMENT OF RELEVANT LAW:

A. Regulations and Provider Reimbursement Manual

The parties stipulate that the regulation at 42 C.F.R. § 412.108 "governs the determination of a provider's MDH [HSR] based on a provider's historic reported inpatient operating costs, trended forward to adjust for inflation and other factors, based upon one of three [FFY] base periods: 1982, 1987, or 2002."[30] The version of that regulation effective October 1, 2018 states, in pertinent part:

> **§ 412.108 Special treatment: Medicare-dependent, small rural hospitals.**
>
> . . .
>
> (c) Payment methodology. A hospital that meets the criteria in paragraph (a) of this section is paid for its inpatient operating costs the sum of paragraphs (c)(1) and (c)(2) of this section.

[21] Ex. P-3 at FHDFPP0033.
[22] Ex. P-15 at FHDFPP0095.
[23] *Id*. at FHDFPP0093.
[24] Ex. P-17 at FHDFPP0116-118.
[25] *Id*. at FHDFPP0115-116.
[26] *Id*. at FHDFPP0112.
[27] *See* Ex. P-18.
[28] Ex. P-19 (Discovery Response) (May 6, 2022). Note: This letter was also contemporaneously filed in OH CDMS.
[29] *Id*. at FHDFPP0134.
[30] Stip. at ¶ 2.

> (1) The Federal payment rate applicable to the hospital, as determined under subpart D of this part, subject to the regional floor defined in § 412.70(c)(6).
>
> (2) The amount, if any, determined as follows:
>
> . . .
>
> (iii) For discharges occurring during cost reporting periods (or portions thereof) beginning on or after October 1, 2006, and before October 1, 2022, 75 percent of the amount that the Federal rate determined under paragraph (c)(1) of this section is exceeded by the highest of the following:
>
> (A) The hospital-specific rate as determined under § 412.73.
>
> (B) The hospital-specific rate as determined under § 412.75.
>
> (C) The hospital-specific rate as determined under § 412.79.

Respectively, the regulations at 42 C.F.R. §§ 412.73, 412.75, and 412.79 (as referenced above) govern the determination of the HSR for the FFY 1982, 1987, and 2002 base periods.

The regulation at 42 C.F.R. § 412.73 (effective Oct. 1, 2010) – governing the 1982 base period in contention in the instant appeal – states:

> **§ 412.73 Determination of the hospital-specific rate based on a Federal fiscal year 1982 base period.**
>
> (a) Costs on a per discharge basis. The intermediary will determine the hospital's estimated adjusted base-year operating cost per discharge by dividing the total adjusted operating costs by the number of discharges in the base period.
>
> (b) Case-mix adjustment. The intermediary will divide the adjusted base-year costs by the hospital's 1981 case-mix index. If the hospital's case-mix index is statistically unreliable (as determined by CMS), the hospital's base-year costs will be divided by the lower of the following:
>
> (1) The hospital's estimated case-mix index.
>
> (2) The average case-mix index for the appropriate classifications of all hospitals subject to cost limits established under § 413.30 of

> this chapter for cost reporting periods beginning on or after October 1, 1982 and before October 1, 1983.

Additionally, the regulation at 42 C.F.R. § 412.71 governs the determination of the base-year inpatient operating costs, stating:

> **§ 412.71 Determination of base-year inpatient operating costs.**
>
> . . .
>
> (b) Modifications to base-year costs. Prior to determining the hospital-specific rate, the intermediary will adjust the hospital's estimated base-year inpatient operating costs, as necessary, to include malpractice insurance costs in accordance with § 413.53(a)(1)(i) of this chapter, and exclude the following:
>
> (1) Medical education costs as described in § 413.85 of this chapter.
>
> (2) Capital-related costs as described in § 413.130 of this chapter.
>
> (3) Kidney acquisition costs incurred by hospitals with approved kidney transplant programs as described in § 412.100. Kidney acquisition costs in the base year are determined by multiplying the hospital's average kidney acquisition cost per kidney times the number of kidney transplants covered by Medicare Part A during the base period.
>
> (4) Higher costs that were incurred for purposes of increasing base-year costs.
>
> (5) One-time nonrecurring higher costs or revenue offsets that have the effect of distorting base-year costs as an appropriate basis for computing the hospital-specific rate.
>
> (6) Higher costs that result from changes in hospital accounting principles initiated in the base year.
>
> (7) The costs of qualified nonphysician anesthetists' services, as described in § 412.113(c).

As stated above, PRM 15-1, § 2802.1 includes as Exhibit C, "Instructions for Completion of Form HCFA-1007 Worksheet TAC – Target Amount Computation."[31] These instructions explain the use of the TAC worksheets for the 1982 base period:

> The TAC worksheets are ***for intermediary use only***. They are designed to serve two basic purposes. First, the worksheets provide for the computation of the "target amount" used to establish the hospital-specific portion of the prospective payment rate under section 1886(d) of the Social Security Act. This provision (enacted on March 1983 by Title VI of PL 98-21) is effective for cost reporting periods beginning on or after October 1, 1983. The provision provides that Medicare's payment for inpatient operating costs will be made prospectively on a per discharge basis. During a 3-year transition period, a portion of the prospective payment rate will be based on a target amount derived from historical cost experience in the hospital's base period (see section 2802A). Secondly, these worksheets provide for the computation of the "target amount" in accordance with the limitation on allowable rates of increase in hospital operating costs under section 1886(b) of the Social Security Act. This provision (enacted on September 3, 1982 by section 101(b) of PL 97-248) is effective for cost reporting periods beginning on or after October 1, 1982. The rate of increase ceiling limits the amount by which a hospital's inpatient operating costs per discharge may increase over its costs per discharge in the 12-month cost reporting period immediately preceding the effective date of the provision (the 12-month cost reporting period ending on or after September 30, 1982 and before September 30, 1983).[32]

Further, in Section 407 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA"), Congress anticipated potential issues with the availability of data required for determining the target amount:[33]

> (iii) In no case shall a hospital be denied treatment as a sole community hospital ***or payment*** (***on the basis of a target rate as such as a hospital)*** because data are unavailable for any cost reporting period due to changes in ownership, ***changes in fiscal intermediaries***, or other extraordinary circumstances, ***so long as***

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[31] *See* Ex. P-30 at FHDFPP0845-0909 (where Ex. C is labeled "Rev. 291," indicating that it was added pursuant to "Medicare Provider Reimbursement Manual (CMS Pub. 15-1), Transmittal No. 291, 05-83." In May 1983, CMS issued Transmittal 291 to revise PRM 15-1, adding new sections 2801 and 2082, which mandated the calculation of target amounts.).

[32] *Id*. at FHDFPP0845 (bold and italics emphasis added).

[33] PL 108-173, 117 Stat 2066, 2270 (Dec. 8, 2003); *see also* Ex. P-15 at FHDFPP0095 (in which the Medicare Contractor cites the MMA).

data for at least one applicable base cost reporting period is available.[34]

B. Burden of Proof and Standard of Review

A Board decision must include findings of fact and conclusions of law that "the provider carried its 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."[35] Additionally, "[a] decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole."[36] In *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938), the U.S. Supreme Court held, "[s]ubstantial evidence is more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion."[37] Accordingly, in an appeal before the Board, a provider must prove by a preponderance of substantial, relevant evidence that it is entitled to the relief sought. And, while the provider has the burden of proof, the Medicare contractor must "[e]nsure that the evidence it considered in making its determination . . . is included in the record."[38] Further the "Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS."[39]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

Without question or dispute, Franciscan Health Dyer is entitled to the highest of the HSRs calculated based upon FFY base periods 1982, 1987, or 2002.[40] To date, the calculations for base periods of 1987 and 2002 have been provided by the Medicare Contractor, and the 1987 base period includes the higher HSR of the two.[41] Therefore, the Provider's Hospital Specific Rate based upon the Provider's Fiscal Year 1988 cost report [utilizing the FFY 1987 base period] must be used unless the HSR based upon FFY base period 1982 can be calculated and it produces a higher HSR.

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[34] 42 U.S.C. § 1395ww(b)(3)(I)(iii) (2004) (emphasis added). Although this statutory provision is specific to sole community hospitals, the same rationale should apply to Medicare dependent hospitals as it relates to the target amount computation. Cf. 42 U.S.C. § 1395ww(d)(5)(G)(iv) (2004) (which defines a "medicare dependent, small rural hospital") and 42 C.F.R. §§ 412.92 and 412.108, which respectively set forth the "special treatment" classification criteria for sole community hospitals and Medicare-dependent, small rural hospitals.
[35] 42 C.F.R. § 405.1871(a)(3).
[36] 42 U.S.C. § 1395oo(d). This statutory provision also confirms that: "[t]he Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination." *See also* 42 C.F.R. § 405.1869(a).
[37] *See also Pomona Valley Hosp. Med. Ctr. v. Becerra*, 82 F.4th 1252, 1258-59 (D.C. Cir. 2023).
[38] 42 C.F.R. § 405.1853(a)(3).
[39] 42 C.F.R. § 405.1867.
[40] *See* 42 C.F.R. § 412.108(c)(2)(iii). *See also* Stip. at ¶ 2; Medicare Contractor's FPP at 9; Provider's FPP at 3.
[41] *See* Stip. at ¶¶ 3, 6-7. *See also* Exs. P-2, P-21.

Franciscan Health Dyer believes that the FFY 1982 base period "yields the highest HSR."[42] This is based upon the Provider's calculated HSR using its 1983 cost reporting period, as the Medicare Contractor has not made a calculation for that year.[43] In order to determine the highest of the HSRs, all three FFY base periods must be determined, if the underlying data is available.[44] While the Board acknowledges that the TAC report *is* required in order to exclude costs that are normally already excluded in the 1987 and 2002 base periods, the Board finds that ***it is the function of the TAC report that is required***, rather than the original document from 1983. Thus, the Board finds that although it would be ideal to have the original TAC report, it is unavailable, and the Board agrees with Franciscan Health Dyer that the TAC worksheet could or should be recreated using the PRM 15-1, section 2801.1, Ex. C, and the 1983 cost report. However, the Board also notes that, if certain data/documentation is required to recreate the TAC report, Franciscan Health Dyer ***must*** produce that data/documentation. Indeed, PRM 15-1, § 2801.1, Ex. C explicitly states that the TAC worksheets are "for intermediary use only."[45] These instructions further state that one purpose of the TAC worksheet is to "provide for the computation of the 'target amount' used to establish the hospital-specific portion of the prospective payment rate."[46] If the purpose of the worksheet is designed for the calculation, and it is specifically for intermediary use, then it follows that if the original one cannot be found, the intermediary could then calculate a new one in the same fashion as the original.

In the alternative, should certain underlying documentation be "unavailable" or unobtainable, the Board orders that the Medicare Contractor audit Franciscan Health Dyer's recreation of the TAC worksheet that they have provided at Exhibit P-22. Again, if any documentation is required for that task, the Board orders that Franciscan Health Dyer provide that to the Medicare Contractor.

If, ***and only if***, both of these required actions are not possible due to missing documentation, or in the event that the HSR based upon the 1982 base period is calculated and produces a lower payment, Franciscan Health Dyer must accept the higher of the two remaining calculations, that is, the calculation based on the 1987 base period. In this respect, the Board notes that MMA Section 407 only specifies that a hospital shall not be denied "***payment (on the basis of a target rate as such as a hospital)*** because data are unavailable for any cost reporting period ***due to . . . changes in fiscal intermediaries . . . so long as data for at least one applicable base cost reporting period is available***.[47] Accordingly, if the 1982 base period cannot be calculated due to missing documentation, then there would still be at least two (2) applicable base cost reporting periods available, and, as discussed *supra*, the 1987 HSR would be applied.

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[42] Provider's FPP at FHDFPP0011.
[43] *Id.* at FHDFPP0010.
[44] *See supra* n. 32.
[45] Ex. P-30 at FHDFPP0845.
[46] *Id*.
[47] 42 U.S.C. § 1395ww(b)(3)(I)(iii) (2004) (emphasis added). Although this statutory provision is specific to sole community hospitals, the same rationale should apply to Medicare dependent hospitals as it relates to the target amount computation. Cf. 42 U.S.C. § 1395ww(d)(5)(G)(iv) (2004) (which defines a "medicare dependent, small rural hospital") and 42 C.F.R. §§ 412.92 and 412.108, which respectively set forth the "special treatment" classification criteria for sole community hospitals and Medicare-dependent, small rural hospitals.

DECISION:

After considering Medicare law, the regulations and program instructions, the arguments presented and the evidence admitted, the Provider Reimbursement Review Board ("Board") remands the case to the Medicare Contractor to calculate the 1982 HSR by either:

> (1) recreating the TAC worksheet, in accordance with the PRM 15-1, section 2802.1, Exhibit C, utilizing the 1983 cost report and any necessary supporting documentation and data required to be provided by Franciscan Health Dyer; or
>
> (2) the Medicare Contractor may audit Franciscan Health Dyer's "recomputed TAC worksheet," utilizing any necessary supporting documentation and data required to be provided by Franciscan Health Dyer.

If both of these efforts should fail due to insufficient data or if the 1982 calculated HSR is less than the 1987 calculated HSR, then Franciscan Health Dyer's HSR will remain the 1987 calculated HSR, which has been shown to be higher than the 2002 calculation – in accordance with 42 C.F.R. § 412.108(c)(iii).

BOARD MEMBERS PARTICIPATING:

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FOR THE BOARD:

9/9/2026

X Kevin D. Smith, CPA

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