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: ***Jurisdictional Decision and Related Issue Transfers***

Case Number: 25-4849 - Tacoma General Allenmore Hospital (Provider Number 50-0129)
FYE 12/31/2004

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced individual appeal in response to various transfer requests filed in February, 2026. The pertinent facts and the jurisdictional decision of the Board are set forth below.

Pertinent Facts:

On **January 28, 2025**, the Medicare Contractor ("MAC") issued a Notice of Reopening and a revised Notice of Program Reimbursement ("RNPR"). The Notice of Reopening indicates the RNPR was issued "[t]o implement the instructions contained in Change Request 13294 concerning the Treatment of Medicare Part C days for remands in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage in cost reporting periods prior to October 1, 2013, and that use a 2013 or prior SSI Ratio."

On **June 26, 2025**, Quality Reimbursement Services, Inc. ("QRS") filed an appeal on behalf of Tacoma General Allenmore Hospital ("Tacoma"/Prov. No. 50-0129) for its calendar year ("CY") 12/31/2004. The appeal included two issues which each referenced audit adjustment nos. 4, 5 and 7, and identified the same Amount in Controversy ($384,455) for both issues:[1]

1. DSH SSI Unduly Narrow Definition of SSI Entitlement ("Unduly Narrow"); and
2. Improper Rulemaking Related to DSH SSI Fraction DE Days ("Improper Rulemaking")

On **February 19, 2026**, QRS requested the transfer of **both** issues from the individual appeal to a single optional group, Case No. 26-1874G – the "QRS CY 2004 ***Improper Rulemaking - DSH SSI Fraction Dual Eligible Days*** Group."

[1] Tacoma also appealed the Part C issue which it directly added to a common issue related party ("CIRP") group, Case No. 25-4562GC – the "MultiCare Health CY 2004 Part C Days Retroactive Final Rule CIRP Group."

On **February 20, 2026**, QRS noted it had erred in requesting the transfer of the Unduly Narrow issue to the Improper Rulemaking group and requested that the issue be returned to the individual appeal so QRS could effectuate the proper transfer to an Unduly Narrow optional group, Case 26-1873G.[2]

Board's Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2015), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final contractor determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

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

Additionally, 42 C.F.R. § 405.1889 explains the effect of a cost report revision:

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

[2] After the transfer of both issues to groups, there would be no remaining issues and Case No. 25-4849 could be closed.

> considered in any appeal of the revised determination or decision.[3]

Further, this regulatory limitation is cross-referenced in 42 C.F.R. § 405.1835(a) as follows:

> (a) *Right to hearing on final contractor determination*. A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider 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. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[4]

The Board has determined that it does not have jurisdiction over Tacoma's Unduly Narrow and Improper Rulemaking issues that were appealed from the January 28, 2025 RNPR as neither issue was adjusted in the determination. The Provider referenced Audit Adjustment Nos. 4, 5 and 7 for both issues. According to the Provider's audit adjustment report, those adjustments all stem from a Part C days remand and were made to update the SSI percentage and DSH percentage based on the Part C final rule. There is no evidence from the Provider's generic "amount in controversy" calculations or any audit adjustment details to corroborate that the MAC adjusted something other than the Part C days as a result of the remand.

The regulations make clear that a Provider can only appeal from an RNPR the items that are specifically adjusted. In this case, Tacoma has appealed the Unduly Narrow and Improper

[3] 42 C.F.R. § 405.1889(a) and (b).
[4] (Bold emphasis added).

Ruling issues, neither of which were adjusted in the RNPR. Because the issues were not specifically adjusted in the RNPR, the Board ***dismisses both issues*** from Case No. 25-4849 and *denies the transfer* of these two issues to Case Nos. 26-1873G and 26-1874G, respectively.

As there are no other issues pending in the RNPR appeal for Tacoma, the Board hereby closes Case No. 25-4849 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:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

4/1/2026

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
Dean Wolfe, Noridian Healthcare Solutions (J-F)

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Via Electronic Delivery

Stephanie Webster, Esq.
Ropes & Gray, LLP
2099 Pennsylvania Avenue NW
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RE: ***Expedited Judicial Review Determination***
Case Numbers: 25-0396GC *et al.* (9 Cases – *See* **Appendix A**)

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed between **March 10 and 12, 2026** in the above-referenced appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Providers in these Common Issue Related Party ("CIRP") group appeals are all appealing from original and/or revised Notices of Program Reimbursement ("NPRs") which implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Providers' Fiscal Year Ends ("FYEs") in calendar years spanning 2005 to 2014.

The issue in these appeals is "the proper treatment in the Medicare disproportionate share hospital ("DSH") calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Allina II* litigation. The Providers contends that part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction for patients eligible for Medicaid."[2] The Providers are seeking to challenge the CMS policy adopted in the June 2023 Final Rule to be applied *retroactively* for periods prior to October 1, 2013.[3]

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

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] *E.g.,* Case No. 25-0396GC, Statement of Group Issue at 1 (Oct. 23, 2024).
[3] *Id.* at 2-3.

inpatient prospective payment system ("IPPS").[4] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[6] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] 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.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[11]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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

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[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[11] (Emphasis added.)
[12] 42 C.F.R. § 412.106(b)(2)-(3).

> 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.[13]

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.[14]

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

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

In the September 4, 1990 Federal Register, the Secretary[15] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[17]

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[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(4).
[15] of Health and Human Services.
[16] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[17] *Id.*

With the creation of Medicare Part C in 1997,[18] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C, and following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[19] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[20] The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[21]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.[22] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[23] In response to a comment regarding this change, the Secretary explained that:

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

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[18] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[19] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[20] *Id.*
[21] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[22] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[23] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).

> *at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[24]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[25] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[26] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[27]

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

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[28]

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[29] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[30] In vacating the final rule, it reasoned that this deprived the public of adequate

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

opportunity for notice and comment before the final rule was promulgated in 2004.[31] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[32] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.[33] A number of hospitals appealed this action.[34] In *Azar v. Allina Health Services* ("*Allina II*"),[35] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[36] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[37] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[38]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[39] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement

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[31] *Id.* at 2011.
[32] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[33] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[34] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo****(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board,* ***pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[35] 139 S.Ct. 1804 (2019).
[36] *Id.* at 1817.
[37] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[38] 139 S.Ct. at 1814.
[39] 85 Fed. Reg. 47723 (Aug. 6, 2020).

> (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[40]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[41] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[42]

Finally, the following excerpts from the June 9, 2023 Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule or subsequent publication of SSI ratios to be an appealable "final determination":

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports***. *In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[43]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court

[40] CMS Ruling 1739-R at 1-2.
[41] 88 Fed. Reg. 37772 (June 9, 2023).
[42] 88 Fed. Reg. at 37788 (emphasis in original).
[43] 88 Fed. Reg. at 37774-75 (emphasis added).

decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[44]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically."[45]

4. "*When the Secretary's treatment of Part C days in this final action is reflected* ***in NPRs and revised NPRs****, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation* ***by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[46]

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

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are "entitled to [Part A] benefits" within the context of 42 U.S.C.§ 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.[47] It ruled, however, that the June 9, 2023 Final Rule is both impermissibly retroactive[48] and arbitrary and capricious.[49] The court ordered the parties to submit briefs addressing whether vacatur is the appropriate remedy for the situation, which have since been filed.[50]

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[44] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[45] *Id.* at 37788 (emphasis added).
[46] *Id.* (emphasis added).
[47] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).
[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.

Providers' Position:

A. Providers' Appeal Requests

The Providers' appeal requests include a "Statement of Jurisdiction" asserting that the Providers have met the applicable statutory conditions for appeal because they are dissatisfied with their original and/or revised NPRs which apply the June 9, 2023 retroactive final rule related to Part C days. They cite language from that final rule which outlined Providers' ability to challenge this final rule once they were issued NPRs implementing the rule.[51]

The "Statement of Group Issue" included with the group appeal requests state that the issue concerns "the proper treatment in the Medicare [DSH] calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Allina II* litigation."[52] The Providers contend that the Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.[53]

The Providers characterized the relevant background facts as follows:

1. In the FY 2005 IPPS Final Rule, CMS first announced a policy change to count Part C days in the SSI fraction and to exclude those days from the numerator of the Medicaid fraction.

2. In *Allina I*, the D.C. Circuit vacated that policy change.

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking. The Supreme Court's decision "did not address the D.C. Circuit's alternate ruling that the readopted standard was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the standard could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[54]

4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.[55]

Based on the above, the Providers maintain that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule "is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, exceeds the

[51] *E.g.,* Case No. 25-0396GC, Appeal Request, Audit Adjustment/Statement of Jurisdiction at 1 (citations omitted).
[52] *E.g.*, Case No. 25-0396GC, Appeal Request, Statement of Group Issue at 1.
[53] *Id*.
[54] *Id.* (citing to 139 S. Ct. at 1816).
[55] *Id.*

agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[56]

B. Providers' Petitions for EJR

The Providers have requested EJR over the "post-*Allina* retroactive Part C policy issue" because they believe they have met the requirements for a hearing before the Board, but the Board lacks the authority to decide the substantive and procedural validity of CMS' final rule published in the Federal Register on June 9, 2023.[57] They seek a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.[58] The request states, again, that "[t]he Providers contend that the new, post-*Allina* retroactive part C days rule, applied in the [NPRs] appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[59] Since the Board is bound by this regulation,[60] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

The Medicare Contractor's representative, Federal Specialized Services, filed timely responses to all nine (9) Requests for EJR in these cases. Each response simply noted "that the MAC will not file a jurisdictional challenge. The MAC will not file a substantive claim challenge."[61]

Decision of the Board:

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

A. Jurisdiction

Providers generally have a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if:

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to

[56] *Id.* (citing 4 U.S.C. § 706(2)).
[57] *E.g.*, Case No. 25-0396GC, Provider's Petition for Expedited Judicial Review at 13 (Mar. 10, 2026).
[58] *Id.* at 16-17.
[59] *Id.* at 1-2.
[60] 42 C.F.R. § 405.1867.
[61] *E.g.*, Case No. 25-0396GC, Response to Provider's Request for Expedited Judicial Review at 1 (Mar. 16, 2026).

their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [62]

- The matter at issue involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $10,000 or more for an individual provider, or $50,000 or more for a group of providers.[63]

B. Inclusion of Final Determination with Appeal

42 C.F.R. § 405.1835(b)(3) requires that a provider's request for a Board hearing **must** include a copy of the final contractor or Secretary determination under appeal. Board Rule 6.1.1 specifically states that "[t]he Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b)[.]" Board Rule 7.1.1 reiterates that a copy of the final determination under appeal must be included as support for an appeal, and Board Rule 16.2 explains that the filing requirements found in these Rules are applicable to requests to join a group appeal from a final determination.

In Case 25-4793GC, HCA Houston Healthcare Medical Center (Provider Number 45-0659, FYE 12/31/2006) did not upload a copy of its RNPR with its request to be added to the group appeal. Instead, it uploaded a copy of West Boca Medical Center's (Prov. No. 10-0268, FYE 12/31/2006) RNPR to the appeal – a different participant in the group. Since it did not include a copy of the final determination under appeal, the Board hereby ***dismisses*** this Provider from the group.

C. Specific Adjustment Required for RNPR

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

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

Additionally, 42 C.F.R. § 405.1889[64] explains the effect of a cost report revision:

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[62] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[63] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.
[64] *See also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

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

As outlined above, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[65] Additionally, the June 9, 2023 Final Rule afforded appeal rights for NPRs and RNPRs which did not contain specific revisions to Part C days, but nevertheless implemented the Final Rule related to Part C Days (typically "no change" or $0 RNPRs).[66]

In Case 24-2544GC, Wellstar Atlanta Medical Center (Provider No. 11-0115, FYE 12/31/2012) is appealing from an RNPR dated July 2, 2025. The RNPR resulted in a payment due to the Provider in the amount of $44,983. The audit adjustments reference (1) clearing Level I edits related to Graduate Medical Education and Nursing and Allied Health Education, and (2) properly including the last settlement on the opened cost report. The appeal did not include a reopening request or an actual reopening notice issued by the Medicare Contractor as required by Board Rule 7.1.2.1 but simply attached two documents. The first is an Order of Administrator which remanded a number of court cases following the litigation in *Allina*. This Order, however, does not list specific providers or PRRB Cases, and there is nothing to indicate that this particular provider was part of this remand, or that the RNPR dated July 2, 2025, was issued as a result of this remand. It also attaches Change Request 13294, which instructs the Medicare Contractors to implement the June 9, 2023 Final Rule, but is not specific to this Provider or the RNPR from which it is appealing. In short, the record for this Provider does ***not*** have ***anything*** in the record to demonstrate that that the RNPR being appealed was issued to implement the new, retroactive Part C days rule, and the Board hereby ***dismisses*** this Provider from the group without prejudice. If the Provider has additional documentation that may establish that the RNPR was issued to implement the retroactive Part C final rule, then it has the ability to file a reinstatement request, pursuant to Board Rule 47.

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[65] 42 C.F.R. § 405.1889(b)(1).
[66] *See supra* notes 44-46 and accompanying text.

D. Remaining Providers

For remaining Providers in these nine (9) groups, the providers all appealed from original and/or revised NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. All the providers in the group appeals were directly added to their respective groups within 180 days of the issuance of their NPRs and/or RNPRs and the amount in controversy exceeds $50,000 in each case.

Except for the two Providers outlined above, the Board finds that the Providers in the Cases listed in **Appendix A** have all filed timely appeals from their original and/or revised NPRs concerning the same common issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these NPRs and/or RNPRs. The Board also finds that the amount in controversy in each CIRP group appeal exceeds $50,000 as required by 42 C.F.R. § 405.1837(a)(3). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) The Board finds that, ***except for*** HCA Houston Healthcare Medical Center (Prov. No. 45-0659, FYE 12/31/2006) in Case 25-4793GC and Wellstar Atlanta Medical Center (Provider No. 11-0115, FYE 12/31/2012) in Case 24-2544GC, it has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in the nine (9) Cases listed in **Appendix A**, and that the Providers in each appeal are entitled to a hearing before the Board;

2) Based upon the Providers' assertions regarding the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether the Part C Days policy issue, as adopted on a retroactive basis in the June 9, 2023 Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject years, ***except for*** HCA Houston Healthcare Medical Center (Prov. No. 45-0659, FYE 12/31/2006) in Case 25-4793GC and Wellstar Atlanta Medical Center (Provider No. 11-0115, FYE 12/31/2012) in Case 24-2544GC.

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 the nine (9) Cases listed in **Appendix A**, the Board hereby closes them and will remove them from its docket.

Board Members Participating:

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

FOR THE BOARD:

4/1/2026

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, Federal Specialized Services

Appendix A

25-0396GC	*Tenet Healthcare CY 2007 DSH Medicare Part C CR #13294 CIRP Group*
25-0032GC	*Tenet Healthcare CY 2009 DSH Medicare Part C Days CR #13294 CIRP Group*
25-0026GC	*Tenet Healthcare CY 2010 2010 DSH Medicare Part C Days #CR 13294 CIRP Group*
24-2544GC	*Tenet Healthcare CY 2012 DSH Medicare Part C Day CR #13294 CIRP Group*
24-2517GC	*Tenet Healthcare CY 2013 DSH Medicare Part C Days CR #13294 CIRP Group*
24-2527GC	*Tenet Healthcare CY 2014 DSH Medicare Part C Days CR #13294 CIRP Group*
25-4793GC	*Tenet Healthcare CYs 2005 - 2006 DSH Medicare Part C Days CR #13294 CIRP Group*
24-2556GC	*Tenet Healthcare CY 2011 DSH Medicare Part C Days CR #13294 CIRP Group*
24-2555GC	*Tenet Healthcare CY 2008 DSH Medicare Part C Days CR #13294 CIRP Group*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

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

RE: ***Jurisdictional Decision in Whole***
Baylor Scott & White Medical Center – College Station, Prov. No. 67-0088, FYE 05/31/2018
Case No. 20-0491

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 20-0491. Set forth below is the decision of the Board to dismiss the lone remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 20-0491*

On **June 12, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2018.

On **November 27, 2019**, the Board received the Provider's individual appeal request. The Individual Appeal Request contained five (11) issues:

1. DSH SSI Percentage (Provider Specific) [1]
2. SSI Percentage [2]
3. SSI Fr. Medicare Managed Care Pt. C Days [3]
4. SSI Fraction Dual Eligible Days [4]
5. DSH Payment – Medicaid Eligible Days
6. Medicaid Fr. Medicare Managed Care Pt. C D [5]
7. Medicaid Fraction Dual Eligible Days [6]
8. Uncompensated Care Distribution Pool [7]

[1] On March 10, 2026, this issue was withdrawn.
[2] On June 18, 2020, this issue was transferred to PRRB Case No. 20-1747GC.
[3] On June 18, 2020, this issue was transferred to PRRB Case No. 20-1748GC.
[4] On June 18, 2020, this issue was transferred to PRRB Case No. 20-1749GC.
[5] On June 18, 2020, this issue was transferred to PRRB Case No. 20-1750GC.
[6] On June 18, 2020, this issue was transferred to PRRB Case No. 20-1751GC.
[7] On January 5, 2026, this issue was withdrawn.

9. 2 Midnight Census IPPS Payment Reduction [8]
10. Standardized Payment [9]
11. American Taxpayer Relief Act (ATRA) [10, 11]

On **December 12, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

On **July 28, 2020**, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 5 set forth therein:

> Specifically, the Provider disagrees with the MAC's calculation 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…
>
> CMS acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:

[8] On January 5, 2026, this issue was withdrawn.
[9] On June 18, 2020, this issue was transferred to PRRB Case No. 20-1752GC.
[10] On June 12, 2020, via its Preliminary Position Paper filing, the Provider stated, "[w]e wish to withdraw the UCC Distribution Pool, 2 Midnight Census and the ATRA issues from this appeal." *Also see* Ex. C-4 (February 3, 2026).
[11] The Provider withdrew the issue in 2020. In the CMS OH CDMS system, the issue was noted as open. On March 20, 2026, in its request for postponement of the April 8, 2026 hearing date, the Provider states, "The Provider is also having difficulty finding a group to transfer the ATRA issue." The Board reviewed the request and issued a letter under separate cover on April 1, 2026, stating the Provider withdrew the issue in 2020. The Board updated OH CDMS accordingly.

> [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its 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]

On **October 22, 2020**, the Medicare Contractor filed its preliminary position paper.

On **May 9, 2023**, the Provider requested a change in representative to Quality Reimbursement Services, Inc. The Board acknowledged this change on

On **July 11, 2025**, the Board issued a Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

> Provider's Final Position Paper – *For each remaining 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 27 for more specific content requirements.[13]

On **January 5, 2026**, the Provider withdrew issues 8 and 9 from the appeal.

On **January 8, 2026**, the Provider timely filed its final position paper. The following is the Provider's ***complete*** position on Issue 5 set forth therein:

> Specifically, the Provider disagrees with the MAC's calculation 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

[12] Provider's Preliminary Position Paper at 7-8 (Jul. 28,2020). *Also see* Ex. C-6 (Feb. 3, 2026).
[13] (Emphasis added).

> 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…
>
> CMS 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 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 are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).

Based on the Listing of Medicaid Eligible days being sent under separate cover directly to the MAC, including Section 1115 waiver days (a redacted copy is attached), 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) and properly accounting for 1115 Waiver days as Medicaid Eligible days.[14]

On **January 22, 2026**, the Medicare Contractor timely filed its final position paper.

On **February 3, 2026**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 5.

On **March 10, 2026**, the Provider withdrew issue 1 from the appeal and also filed a response to the Medicare Contractor's jurisdictional challenge.

On **March 20, 2026**, the Provider indicated it indends to keep Issue 11 – ATRA, open, and has requested a postponement of the hearing date to allow for more time to find a group to transfer it to.

On March 24, 2026, the Board issued a letter on its own motion denying the postponement request and dismissing Issue 11 – ATRA, noting the Provider effectively abandoned the issue by not briefing it in its preliminary and final position papers, and noting in its final position paper that the issue was withdrawn.

B. Description of Issue 5 in the Appeal Request

In its Individual Appeal Request, the Provider summarizes its DSH Payment – Medicaid Eligible Days issue 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)(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.[15]

The Provider estimated the reimbursement impact of the issue at $77,819 based on an increase of 100 additional Medicaid days but failed to include a list of the additional days.[16]

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[14] Provider's Final Position Paper at 8-9 (Nov. 20, 2025).
[15] Issue Statement at 5 (December 12, 2019).
[16] *Id.*

MAC's Jurisdictional Challenge

Issue 5 – DSH Payment – Medicaid Eligible Days

The Medicare Contractor contends that this issue should be dismissed because the Provider failed to complete preliminary or final position papers including all supporting exhibits to document the merits of its argument in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25.

The Medicare Contractor notes that a Medicaid eligible days listing was never received with the Provider's preliminary position paper. The Medicare Contractor further notes that the Provider failed to submit either a redacted or unredacted listing of additional Medicaid eligible days with its final position paper.[17]

The Medicare Contractor contends 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 Rules 25.2.2, 25.3 and 27.2. The Provider has not submitted accurate and sufficient data to demonstrate that patients were eligible for Medicaid on the claimed patient hospital days or identified as to why the data is not yet available or when it will become available. [18]

Additionally, the Medicare Contractor argues this issue should be dismissed because the Provider is attempting to untimely and improperly add the issue of Section 1115 waiver days as a sub-issue via its final position paper filed on January 9, 2026. The Medicare Contractor issued the Provider's NPR on June 12, 2019. In accordance with 42 C.F.R. § 415.1835(e), the deadline for adding issues to the appeal was February 7, 2020. The issue was informally added through the Provider's final position paper, nearly six years after the filing deadline to add an issue.[19]

The Medicare Contactor contends that the Section 1115 Waiver Days issue is one component of the DSH issue that must be appealed as a separate issue. The Medicare Contractor notes that Board Rule 8 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.[20]

Finally, the Medicare Contractor argues this issue should be dismissed because the Provider failed to furnish documentation in support of its claim for additional Medicaid Eligible Days, the Provider made affirmative statements in its appeal request and preliminary and final position papers that the Medicare Contractor excluded days from the settled cost report, and that the Provider has effectively abandoned its claim for additional Medicaid Eligible Days given more than six years since the appeal was filed. [21]

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[17] Medicare Contractor's Jurisdictional Challenge at 12-15 (Feb. 3, 2026).
[18] *Id.*
[19] *Id.* at 15-17.
[20] *Id.* at 17-18.
[21] *Id.* at 19.

Provider's Response

Issue 5 – DSH Payment – Medicaid Eligible Days

Board Rule 44 discusses motions parties may file. Board Rule 44.1 notes: "All motions (including jurisdictional challenges) to the Board are to: (1) be made in writing, (2) set out the legal and factual basis supporting the motion, and (3) include supporting documentation. (See Rule 30.3 regarding requirements for requests to postpone a hearing.)"

The Medicare Contractor filed its Jurisdictional Challenge on February 3, 2026, after the final position paper deadlines. The Provider responded on March 10, 2026. Board Rule 44.3 specifies the time for filing a response: "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. Refer to Rule 30.3.1 regarding specific time limitations to respond to a motion to postpone a hearing and Rule 42.4 regarding specific time limitations to respond to an EJR request."

While the Provider's response was submitted more than 30 days following the filing of the MAC's jurisdictional challenge, as a one time courtesy, the Board will consider the Provider's response.

The Provider argues that the phrasing of its issue statement with respect to the Medicaid Eligible Days issue makes clear that the Provider appealed all Medicaid eligible days, including section 1115 waiver days:

> Section 1115 waiver days are part and parcel of Medicaid eligible days. And whereas the [Medicare Contractor] states that the Section 1115 Waiver Days issue is one component of the DSH issue, the regulations at 42 C.F.R. § 405.1835 contain requirements for appealing an "issue" and a time limit on adding an "issue" – not on clarifying "sub-issues" or "components" of an issue. Both a June 25, 2004 proposed rule (69 *Fed. Reg.* 35716) and a May 23, 2008 final rule (73 *Fed. Reg.* 30190) indicate that an "issue" is encapsulated by a specific cost report adjustment. They do not slice and dice an "issue" into component parts, including the specific reason why Medicaid eligible days were not counted in the numerator of the Medicaid Fraction of the Disproportionate Payment Percentage.[22]

The Provider goes on to contend that the version of Board Rule 8 (July 1, 2015), that it alleges was effective when the Provider filed its appeal, makes no mention of "section 115 waiver days" nor even "Medicaid eligible days." Thus, even if Rule 8's extension to "components of issues" were valid (and the Provider contends it is not), the Provider had no notice that it was required to specify section 1115 waiver days in its appeal request, and it would be a denial of due process for the PRRB to dismiss the section 1115 waiver days component of its appeal of Medicaid eligible days.[23]

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[22] Provider's Jurisdictional Response at 2 (Mar. 10, 2026).
[23] *Id.* at 3-4.

Finally, the Provider contends that prior to submission of the Provider's Final Position Paper, the Fifth Circuit ruled that the statute and CMS's own regulations require that CMS regard inpatient days attributable to an uncompensated care pool population as Medicaid eligible days, *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019). The Medicare Contractor is required by specific command of CMS to accept and audit the Provider's section 1115 waiver days in providers' Medicaid Fractions. Following a string of litigation defeats, including those in *Forrest General Hospital* and *Bethesda Health, Inc. v. Azar*, 980 F.3d 121 (D.C. Cir.2020), CMS issued Change Request 12669, Transmittal No. 11912 (March 16, 2023). The Provider asserts that under this Transmittal, the Medicare Contractor has the duty to accept the Provider's listing of section 1115 days and audit them. The Provider states that it submitted a redacted listing to the Medicare Contractor on March 10, 2026. [24]

Decision of the Board

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

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

A. DSH Payment – Medicaid Eligible Days

1. Section 1115 Waiver Days

The Board finds that the section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. The Provider failed to include section 1115 Waiver days as a cost issue in its appeal request and failed to timely and properly add this additional issue to the appeal. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the section 1115 Waiver days.

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

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

[24] *Id.* at 4-5.

> (ii) how and why the provider believes Medicare payment must be determined differently for each disputed item…[25]

Board Rule 7.2.1 (2018) 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.[26]

Board Rule 8 (2018) 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, but are not limited to:
>
> …
>
> - ***Section 1115 waiver days (program/waiver specific)***[27]

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.[28]
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 –
>
> . . .

[25] 42 C.F.R. § 405.1835(b).
[26] v. 2.0 (Aug. 2018).
[27] (Bold and italic emphasis added).
[28] *See* 73 Fed. Reg. 30190 (May 23, 2008).

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

In practice this means that new issues had to be added to 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.[29] Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program ***and*** not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction.[20] In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

Because the Provider did not raise the section 1115 Waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely

[29] 65 FR 47054, 47087 (Aug. 1, 2000).

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.

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 position paper filings. First, the Provider's preliminary position paper does not even mention § 1115 waiver days (much less even 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 (2018). 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* § 1115 waiver days sub-issue.

Finally, even in the Provider's final position paper, the Provider 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)(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 final position paper is perfunctory. 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 (2023) as applied via Board Rule 27.2.

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*.[30] 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 . . ."[31] 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."[32] 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.[33] Here, the Board makes the same finding based on similarly *overly generalized language*.

Based on the above, the Board finds that the appeal did not include the *alleged* § 1115 waiver

[30] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[31] *Id*. at *11.
[32] *Id.*
[33] *Id.*

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.[34] In the alternative, the Board finds that, even if it had been included as part of the appeal, the Board would find that the issue was not properly developed in the position paper process.

2. *Medicaid Eligible Days*

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

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

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

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

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[35]

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

Board Rule 25 (Aug. 2018) requires the Provider to file its complete, *fully* developed preliminary

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[34] If § 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 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).

[35] (Bold emphasis added.)

position paper with all available documentation and gives the following instruction on the content of position papers:

Rule 25 Preliminary Position Papers[36]

> **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…Therefore, the Board requires preliminary position papers to present the ***fully*** developed positions of the parties and expects that parties will be diligent in planning and conducting any required investigation, discovery, and analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

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

25.1.1 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, 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

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

> as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.
>
> **25.2.2 Unavailable and Omitted Documents**
>
> If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.
>
> **25.2.3 List of Exhibits**
>
> Parties must attach a list of the exhibits exchanged with the position paper.
>
> **25.3 Filing Requirements to the Board**
>
> Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.
>
> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on December 12, 2019 included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 5, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iv) places the burden of production on the provider, stating:

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

> day.[37]

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 28, 2020, the Provider filed its preliminary position paper in which no eligibility listing was submitted as an exhibit.[38] 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 $77,819 based on an estimated 100 days).

On January 8, 2026, the Provider filed its final position paper. The position paper stated, "[b]ased on the [l]isting of Medicaid Eligible days being sent under separate cover directly to the MAC, including Section 1115 waiver days (a redacted copy is attached), 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."[39] The Provider submitted a redacted Medicaid Eligible Days Listing to the Board. The Listing was 13 pages with 1,798 Medicaid eligible days. No explanation was provided as to why the listing of days was being submitted at this late date, ***more than seven years after the fiscal year at issue had closed***. NOTE—the 1,798 days included in this belated listing is exponentially larger than the original estimate of 100 days included with the appeal request. Regardless, this filing, importantly, ***was more than five years past the deadline for including it with the preliminary position paper*** since the position paper deadline was July 24, 2020.

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[37] (Emphasis added.)
[38] Provider's Preliminary Position Paper at 8.
[39] Provider's Final Position Paper at 10 and Exhibit P-1.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e*., the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[40] 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 submit a finalized listing of Medicaid eligible days, notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[41]

Based on the foregoing, the Board dismisses the lone remaining issue in this case – Issue 5. As no issues remain, the Board hereby closes Case No. 20-0491 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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[40] (Emphasis added.)

[41] *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.

Board Members Participating:

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

For the Board:

4/1/2026

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, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Fairview Health Services
Diane Del Santro, Gov. Reimb. Manager
1700 University Avenue West
St. Paul, MN 55104

RE: ***Board Determination: Failure to Timely Respond to Show Cause Order***

Case Number: 25-3697GC - Fairview Health CY 2020 Budget Neutrality CIRP Group
Case Number: 25-3680GC - Fairview Health CY 2021 Budget Neutrality CIRP Group

Dear Ms. Del Santro:

The Provider Reimbursement Review Board ("Board") has reviewed the subject common issue related party ("CIRP") group appeals which were deemed complete and for which a Show Cause Order was issued. A summary of the pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

On **March 11**, **2025**, Fairview Health Services ("Fairview") formed two CIRP groups for Fairview Health for the Budget Neutrality issue for calendar years ("CY") 2020 and 2021 as referenced above.

On **March 31, 2025**, the Board acknowledged each case in a Case Acknowledgement and Critical Due Dates notification ("ACDD"). The Board's ACDD notices gave the Group Representative a **March 11, 2026** deadline to file the "Group's Comments Regarding Full Formation – The comments ***must advise*** the Board whether the group is complete, ***and if not***, ***must specifically identify*** which providers within the related party chain organization have not yet received a final determination for the appealed year. See Board Rule 19."[1]

On **March 13, 2026**, after Fairview failed to file a timely response to the "Comments Regarding Full Formation" in both groups, the Board issued a Show Cause Order and notice deeming the Case Nos. 25-3697GC and 25-3680GC to be fully formed. The Board's Order required the Representative to submit its comments within 15 days (**i.e.**, by *March 28, 2026 which was extended to the next business day,* ***March 30, 2026***), showing cause as to why the cases should not be dismissed. Accordingly, Fairview was obligated to respond by the deadline. The Board's Order explicitly stated that "[f]ailure of the Group Representative to file a separate response in each case by this deadline, will result in the Board taking remedial action and the cases will be dismissed."

[1] (Bold and italics emphasis added.) The March 31, 2025 notifications also included the following dismissal warning: "The parties are responsible for pursuing the appeal in accordance with the Board's Rules. The parties must meet the following due dates regardless of any outstanding jurisdictional challenges, motions, or subpoena requests. If the Group misses any of its due dates, the Board will dismiss the appeal. If the Medicare Contractor fails to meet its deadlines, the Board will take actions described under 42 C.F.R. § 405.1868."

Board Determination:

Board Rule 4.4.2 states the following:

> ***All filings*** other than an appeal request or request to add issues (*e.g.*, position papers and other responsive documents) ***must be received by the Board no later than the date specified on the Board's notice*** or, if silent, the date specified in these Rules. ***If a party fails to file by the established due date***, ***the Board may take action as described in 42 C.F.R. § 405.1868***. For example, Rule 23.4 addresses the timely filing of preliminary position papers and specifies that the Board will dismiss the appeal if the representative for the provider(s) fails to file their preliminary position paper or PJSO by the established due date.[2]

Further, Board Rule 41.2 permits the Board to dismiss a case if it has a reasonable basis to believe that the issues have been fully settled or abandoned, or the group fails to comply with Board filing deadlines.[3]

After a review of the facts in this case, the Board finds dismissal of the groups to be appropriate based on Fairview's failure to respond to the Comments Regarding Full Formation **and its failure to respond** to the Board's Show Cause Order. Fairview has failed to meet its responsibilities per Board Rule 5.2, which require the representative to meet Board deadlines and respond timely to correspondence or requests from the Board. The Rule specifically notes that, "[f]ailure 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." In addition, Fairview failed to comply with Board 19.2, which requires that "at the one-year mark . . . , they must notify the Board if the group is complete and, if not, which providers have not yet received a final determination for the specified fiscal year and intend to join the group."

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

For the Board:

4/2/2026

X Kevin D. Smith, CPA

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

cc: Pam Van Arsdale, National Government Services (J-6)
Wilson C. Leong, Federal Specialized Services

[2] (Bold and italics emphasis added.)
[3] Board Rule 41.2 Own Motion – The Board may dismiss a case or an issue on its 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)[.]

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Perla Alvarado,CFO
Matrix Home Health Services
11351 James Watt, Suite C400
El Paso, TX 79936

Re: ***Dismissal for Failure to Meet Minimum Filing Requirements***

Matrix Home Health Services, Provider No. A9-1630, FFY 2025, Case No. 26-1971

Dear Ms. Alvarado:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced appeal request. After reviewing the pertinent facts outlined below, the Board has determined that the appeal request is fatally flawed as it was not filed in accordance with the regulations and Board Rules.

Pertinent Facts:

On **March 4, 2026**, Matrix Home Health Services ("Matrix"/the "Provider") filed an appeal with the Board to establish Case No. 26-1971. The appeal was filed from a determination entitled "Reconsideration Letter – Hospice Payment Reduction" ("QRP Determination") dated January 6, 2026.[1]

Matrix's appeal request did not, however, include:

- A suitable Letter of Representation (Board Rule 5.4)
- a comprehensive Issue Statement (42 C.F.R. § 405.1835(b) and Board Rules 6, 7 & 8) and
- proper calculation support.[2]

On **March 5, 2026**, the Board issued an Acknowledgement and Critical Due Dates ("ACDD") Notice in which it set a briefing schedule for the Parties to file preliminary position papers and requested the following corrected documentation: Representation Letter, Issue Statement and Calculation Support. The deadline for the corrected support required for the appeal was set for **March 20, 2026**.

On **March 23, 2026**, after the Provider did not file a response, the Board issued a Request for Information ("RFI") giving the Provider one final opportunity to correct its submissions. The final deadline for the corrected documentation was set for **April 2, 2026**.

To date, the Provider has not complied with either of the Board's requests.

[1] The Board notes the subject individual appeal was filed as a result of the dismissal of Case No. 26-1899G, the "Matrix HHS FFY 2025 Appealing our hospice payment reduction decision Group." The group, which was found to be deficient for a number of reasons, including having been filed in the wrong format, included the same Provider, Matrix.
[2] Board Rules Version 3.2 (Dec 15, 2023)

Rules/Regulations:

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

42 C.F.R. § 405.1835 establishes the right to a Board hearing and the required contents for an appeal request. Specifically, 42 C.F.R. § 405.1835(a)(2) requires that "[t]he amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more." Board Rules 5.4 and 6 through 8 further address individual appeal requirements related to Representative letters and Issue Support. Finally, Board Rule 6.1.1 indicates that the Board will dismiss appeal requests that do not meet the *minimum* filing requirements as identified in 42 C.F.R. § 405.1835(b).

Board Determination:

The Board has determined that the Provider's appeal request is fatally flawed as it was not filed in accordance with the regulations at 42 C.FR. § 405.1835 and with the Board Rules.

First, although the Provider's appeal request included a Representation letter, the letter did not include the necessary provider information. Pursuant to Board Rule 5.4, the Representation letter must reflect the provider's name, number, and fiscal year under appeal. The Representation letter filed with the appeal referenced a prior Group Name and Case Number 26-1899G, which was previously dismissed by the Board.

In addition, the appeal request is missing a comprehensive Issue Statement. The contents of a request for Board hearing, specifically the **Issue Statement**, are discussed in 42 C.F.R. 405.1835(b)(2) which indicates:

> For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final contractor or Secretary determination under appeal, including an account of all of the following:
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
>
> (iii) If the provider self-disallows a specific item (as specified in § 413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.[3]

[3] 42 C.F.R. § 405.1837(b)(2)

The Issue Statement included in the subject appeal is a two-sentence letter which simply indicates the Provider is requesting "a reconsideration of the 4% anticipated hospice payment reduction, as the HQRP standards were met with our HIS then later our HOPE assessments submitted in a timely manner." Although it lists various enclosures the Provider has included in support of its case, the letter does not go into any detail to explain why the Medicare payment is incorrect, why it must be determined differently or the basis for jurisdiction before the Board.[4]

Additionally, Matrix's appeal did not include proper calculation support. Board Rule 6.4 requires that a **calculation of the amount in controversy** must be submitted for each issue. The Board's RFI issued on March 23, 2026 emphasized that "[t]he reimbursement estimate must be expressed as a mathematical calculation estimating the financial impact of the payment reduction on your facility and the documentation to support that calculation. (See Board Rule 7.2.) Instead, the Calculation Support Document is a six-page listing of claims and payments titled "OCT THRU JAN. This document does not meet the criteria of required calculation support, as discussed in Board Rule 6.4. See 42 C.F.R. §§ 405.1835 and 405.1839.

Finally, the Board finds that the Provider was afforded two separate opportunities to cure the noted deficiencies. The Provider has failed to respond to both the Board's March 5, 2026 and March 23, 2026 Requests. Accordingly, the Board hereby dismisses Case No. 26-1971 since the appeal request is fatally flawed and does not meet the *minimum* filing requirements as outlined above and for failure to timely respond to the Board's Requests for Information. Based on the above, the Board closes this case and removes it from its docket.

Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 105.1877.

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

For the Board:

4/6/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)

[4] In fact, the issue statement submitted for Matrix's individual appeal is virtually identical as the one that was filed the earlier group, Case No. 26-1899G which was also found to be deficient.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Kenneth Williams, CEO/Physician
Alliance Healthcare System
1430 Highway 4 East, PO Box 6000
Holly Springs, MS 38635

Re: "Alliance Healthcare Sys FFY 2025 Appeal of denial for application as Medicare Dependent Hospital Group," PRRB Case No. 26-2078G

Dear Mr. Williams:

The Provider Reimbursement Review Board ("Board") is in receipt of the above-referenced optional *group* appeal request to which it assigned Case No. 26-2078G. The pertinent facts, the background regarding the case and the Board's determination are set forth below.

Pertinent Facts:

On **March 20, 2026**, **Alliance Healthcare System** ("**Alliance**"/**Prov. No. 25-0012**) filed a group appeal with the Board. The group was filed in the Office of Hearings Case & Document Management System ("OH CDMS") and includes a single participant, Alliance.

A review of the support filed with the appeal, although somewhat confusing, appears to reinforce that the appeal was filed on behalf of a ***single*** Provider appealing the CMS denial of the Hospital's request for Medicare Dependent Hospital ("MDH") status pursuant to 42 C.F.R. § 412.108.

In support of its appeal, Alliance uploaded the following documentation:

- *Final Determination Document* - A copy of a January 16, 2026 denial of the Provider's "Request for Medicare Dependent Hospital (MDH) Status ("MDH Denial"). The MDH Denial references a Provider Name of "**Progressive Health of Holly Springs**" ("**Holly Springs**"/**Prov. No. 25-0174)**;

- *Other Issue Support* -A document titled "Urban to Rural" which included a copy of the "Application for Reclassification of **Progressive Health of Holly Springs (25-0174**) Status from an Urban Hospital to Rural Hospital" dated July 10, 2025;

- *Other Issue Support* - A document titled "Timeline" which was a "Chronological Timeline of Hospital Operations, CMS Actions, and Enrollment Events for "**Progressive Health of Holly Springs/Alliance Healthcare Systems, Inc**." The timeline covers the period beginning with November 1999 when the hospital was a full-service acute care hospital under the Inpatient Prospective Payment System ("PPS") and ends with the January 16, 2026 CMS Denial of MDH Status;

- *Other Issue Support* - A document titled "Exhibit" which is the MDH Utilization Summary for **Holly Springs** for the 12-month PPS cost reporting periods preceding the hospital's Rural Emergency Hospital ("REH") conversion;

- *Other Issue Support* - A document titled "Issues" which includes a 2 page "Executive Summary" for **Holly Springs.** The summary includes a statement of the issue, undisputed findings, the basis for the denial, the procedural history, the legal argument and the relief requested;

- *Other Issue Support* - A document titled "Jurisdiction" which includes a 1-page summary describing how the provider, **Holly Springs**, meets the jurisdictional requirements (i.e., timeliness, amount in controversy, final determination, etc.);[1]

- *Other Issue Support* - A document titled "Cover Sheet" for the appeal of **Holly Springs** which summarizes the general appeal information (**i.e.**, Provider Name & No., MAC, Appeal Type, Regulations, FYE, and pertinent dates);[2]

- *Other Issue Support* - A document titled "PRRB Appeal letter" which is a 4-page narrative for **Holly Springs** which includes the background of the hospital and summarizes why it is appealing;[3]

- *Other Issue Support* - A document titled "Classification of hospital" which includes a copy of the CMS determination for **Alliance** processing the Medicare Tie in Notice approving the hospital's initial enrollment application as a REH and the deactivation of its hospital status effective March 15, 2023;

- *Calculation Support Document* - A document titled "Scan2026-03-20_132438" for **Holly Springs**, which explains the basis of the calculation and estimates the impact of the MDH payment;

- *Audit Adjustment Support* – A document titled "Scan2026-03-20_1320058" which includes an additional copy of the January 16, 2026 MDH Denial for **Holly Springs;** and

- *Representation Letter Document* – titled "representation letter" which includes a statement authorizing Kenneth Williams, MD as the authorized representative for the appeal for **Progressive Holly Springs,** dated March 20, 2026.

While substantial documentation has been submitted in support of the appeal, certain deficiencies in the filing have been identified, as outlined below.

[1] The document lists the Provider as Progressive Health of Holly Springs but lists the CCN as "Alliance Healthcare System Inc. #258528/Progressive Health of Holly Springs #250174."
[2] *Id*.
[3] *Id.*

Representation Letter

The March 20, 2026 document uploaded as the Representation letter was filed in the format of a memorandum, and although it included a subject line and a "Representation Statement, " it does not meet the requirements for a Representation letter.

Specifically, Board Rule 5.4 discusses the criteria for a **Representation Letter** and specifies that "the letter designating the case representative must be on the **provider's letterhead** and be signed by an authorizing official of the provider organization." The Rule goes on to say that ". . . the letter must reflect the provider's name, number and fiscal year under appeal." The letter must also contain the following contact information:

- Name,
- Organization,
- Address
- telephone number, and
- email address[4]

The memo filed in this case as the Representative letter was not filed on letterhead nor did it include the appropriate reference information for the Provider. Furthermore, the letter was also missing the authorized contact's address, telephone number and email address which are required by the Rules.

Appeal Format

Board Rule 12.2 discusses the general requirements for a group and explains that the group appeal format is used when there **are at least two providers** appealing ". . . a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers."[5] Correspondingly, Board Rule 12.6.2 instructs that "[O]ptional group appeals must have a minimum of two different providers, both at inception and at full formation of the group."

This appeal was filed in OH CDMS as an optional group appeal and currently includes only a single provider, Alliance (Prov. No. 25-0012).

Inconsistent Provider Information

As noted, Alliance filed the optional group appeal with Alliance listed as the sole participant. The determination support, however, refers to a different provider and provider number, Holly Springs (Prov. No. 25-0174). As evidenced supra, while some of the support documents refer only to Holly Springs, other support documents include references to both Alliance and Holly Springs, but there is no discussion explaining the inconsistencies.[6]

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 contractor's final determination, the amount in controversy is $10,000 or more (or $50,000

[4] Board Rules Version 3.2 (Dec. 15, 2023)
[5] Board Rules Version 3.2 (Dec. 15, 2023)
[6] Specifically, the final determination, utilization summary, executive summary and calculation support.

for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. Further, 42 C.F.R. § 405.1837 specifies that providers may appeal as a ***group*** if each satisfies the individual appeal requirements in 42 C.F.R. § 405.1835 (*except for the $10,000 individual appeal threshold*), the matter at issue **involves a single question of fact or interpretation of law, regulation or CMS Ruling**; and the aggregate amount in controversy for all providers will meet a $50,000 threshold. Consistent with this regulation, Board Rule 12.6 provides the *minimum* number of providers in a group (CIRP and optional) and specifies that mandatory and optional group appeals must have a *minimum of **two** different providers*. (Emphasis added).

Finally, 42 C.F.R. § 405.1835(b) specifies that, if a Provider's appeal request does not meet the requirements of paragraph (b)(3) of the same section, the Board may dismiss the appeal with prejudice or take any other remedial action it considers appropriate. In this case the Board finds that:

1) The appeal was filed in the wrong (*group)* format as it appears to pertain to a single Provider; and
2) The Provider failed to file a suitable letter of representation.

Accordingly, the Board finds that the appeal as filed does not meet the regulatory requirements for a group appeal and that dismissal is appropriate under § 405.1835(b) and Board Rules. Case No. 26-2078G is hereby dismissed 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 105.1877.

Based on the final determination date on the MDH Denial uploaded by Alliance, the Provider, Holly Springs, is still within its appeal period. Therefore, if Holly Springs elects to, it may refile an individual appeal in OH CDMS. Please see 42 CFR § 405.1835 and Board Rule 6, which both discuss individual appeal rights, and requirements.

In that regard, if Alliance (as a Provider) received a separate determination, depending on the date of issuance of that determination, it may also still be within the timeframe to file an individual appeal.[7] Alternatively, if Alliance is the parent organization or is acting solely as the authorized representative for Holly Springs, the new appeal should be filed using the identifying information for Holly Springs (**i.e.**, Provider Name, Provider No., etc.) and should include an explanation of the relationship between the two Parties.

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

For the Board:

4/6/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Esq., CPA, FSS
Paula Zarling, Novitas Solutions c/o GuideWell Source (J-H)

[7] Even it was the intent of Alliance to form the group and eventually add another provider (i.e., Holly Springs), the issue under appeal may not be suitable for group format given that the factual basis for the denial of MDH status may differ among Providers.

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

Stephanie A. Webster
Ropes & Gray, LLP
2099 Pennsylvania Ave NW
Washington, DC 20006

RE: ***Request for Reconsideration***
New York Gracie Square Hospital (Provider Number 33-4048)
FYE: 12/31/2015
Case Number: 18-0245

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the above referenced appeal in response to the Provider's motion for reinstatement ("Request for Reconsideration") submitted on July 17, 2025. The decision of the Board is set forth below.

Pertinent Facts:

On **November 11, 2017**, the Provider filed its appeal request.

On **July 2, 2018**, the Provider requested its first extension of the Preliminary Position Paper deadline by one year, pending the final resolution of *Clarian Health West, LLC. v. Burwell*, 206 F. Supp. 3d 393 (D.D.C. 2016). The Board granted the extension.

On **July 2, 2019**, the Provider requested another yearlong extension for the same reason as in 2018, and the Board granted the extension.

On **June 26, 2020**, the Provider requested another yearlong extension for the same reason as in 2018, and the Board granted the extension.

On **July 29, 2021**, the Board suspended Preliminary Position Paper deadlines under Alert 19 as a result of the COVID-19 pandemic.

On **December 21, 2022**, the Board issued a Critical Due Dates Notice setting the Provider's Preliminary Position Paper deadline to be May 23, 2023.

On **May 2, 2023**, the Provider requested a fourth one-year extension of the Preliminary Position Paper deadline pending the final resolution of *Clarian Health West, LLC v. Becerra,* Case No. 14-cv-339 (D.D.C.), and the Board granted the extension, setting the Provider's Preliminary Position Paper due date to be May 23, 2024.

On **May 8, 2023**, the Board issued a Notice of Hearing, setting the Final Position Paper deadline for the Provider to be December 13, 2023. The Board also granted the Provider's extension request in a separate letter on May 8, 2023.

On **May 9, 2023**, the Board issued an Acknowledgement and Critical Due Dates Notice, setting the Provider's Preliminary Position Paper deadline to be May 23, 2024. Additionally, on the same day, the Board issued a separate Notice of Hearing and Critical Due Dates – Rescheduled, moving back the Provider's Final Position Paper deadline to July 3, 2024.

On **May 25, 2023**, the Board issued another Notice of Hearing and Critical Due Dates, setting the Provider's final position paper deadline to be April 10, 2025.

On **May 1, 2024**, the Provider requested a fifth one-year extension of the Preliminary Position Paper deadline for the same reason as in 2018, 2019, 2020, and 2023, and the Board granted the extension.

On **May 2, 2024**, the Board issued a Critical Due Dates Notice setting the Provider's Preliminary Position Paper deadline to be May 23, 2025, after the deadline for the final position paper.

On **July 3, 2024**, the Board received a letter from the MAC asking if "an amended Notice of Hearing will be issued so that the preliminary position papers for the Provider and MAC will be completed prior to the final position papers."

On July 8, 2024, the Board issued a Notice of Hearing and Critical Due Dates - Corrected, setting the deadline for the Provider's Final Position Paper to be April 10, 2026 and adjusting the MAC's Final Position Paper deadline accordingly.

On May 27, 2025, the Board dismissed the case after the Provider failed to submit its Preliminary Position Paper by May 23, 2025.

On July 17, 2025, the Provider filed a request for reconsideration and asked the Board to reinstate its appeal.

Board Decision:

The Board ***denies*** the motion for reinstatement for the reasons set forth below.

Failure to comply with the Board's deadline for submission of a required filing can be found at 42 C.F.R. § 405.1868:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this

> subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.
>
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—
>
> (1) Dismiss the appeal with prejudice;
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
> (3) Take any other remedial action it considers appropriate.

Board Rule 47.1 (Dec. 2023) governs motions to reinstate an issue:

> A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s) (*see* 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (*see* Rule 44 governing motions). ***The Board will not reinstate an issue(s)/case if the provider was at fault.*** If an issue(s)/case was remanded pursuant to a CMS ruling (*e.g.*, CMS Ruling 1498-R), the provider must address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board reinstates an issue(s) or case, the provider will have the same rights (no greater and no less) that it had in its initial appeal. These requirements also apply to Rule 47.2 below.[1]

More specifically, Board Rule 47.3 governs Dismissals for Failure to Comply with Board Procedures, stating:

> 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.[2]

---

[1] Emphasis added.
[2] Emphasis added.

The Board will not generally reinstate an appeal that was closed due to untimely filing based on administrative oversight except for good cause. The Provider did not provide any "good cause" to explain why the response to the Preliminary Position Paper deadline was missed. The Provider's explanation for the untimely filing was due to the Provider's counsel incorrectly assuming the Board had waived the requirement to file a Preliminary Position Paper.

When the Board received a letter from the Medicare Contractor inquiring if "an amended Notice of Hearing will be issued **so that the Preliminary Position Papers for the Provider and MAC will be completed prior** to the final position papers,"[3] the Board promptly adjusted the deadlines by issuing a Notice of Hearing and Critical Due Dates – Corrected. The Notice of Hearing and Critical Due Dates - Corrected set the ***Final*** Position Paper deadlines for both parties ***after*** the Preliminary Position Paper deadline and did not discuss or waive the requirement to file a Preliminary Position Paper.

The Provider counsel's error with regards to case tracking is clearly administrative oversight. Further, the deadline of May 23, 2025 for the Provider's Preliminary Position Paper was present in OH CDMS after the Board issued the May 2, 2024 Critical Due Dates Notice, and no action was taken to suggest the deadline was void. Board Rules 47.1 and 47.3 state the Board will not reinstate an issue if the Providers are at fault and administrative oversight is not "good cause" to reinstate. As such, the Board ***denies*** the request for reconsideration and Case No. 18-0245 remains closed.

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

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

FOR THE BOARD

4/6/2026

X Kevin D. Smith, CPA

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

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

[3] Request to Review Overlapping Due Dates at 1 (July 3, 2024).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Re: ***Denial of Good Cause for Late Filing and Dismissal of Issues from CIRP Groups***
As it relates to: Carolinas Medical Center-Northeast (Provider Number 34-0001)
Case Number: 25-4262 - FYE 12/31/2009
Case Number: 25-4263 - FYE 12/31/2010
Case Number: 25-4264 - FYE 12/31/2011

And, as a Participant in the following CIRP Groups
FYE 2009 **-** Case Numbers: 26-0569GC, 26-0570GC, 26-0571GC and 25-5139GC
FYE 2010 **-** Case Numbers: 14-2601GC**,** 26 -0574GC, 26-0575GC and 25-5179GC
FYE 2011 **-** Case Numbers: 14-4265GC**,** 26 -0577GC, 26-0579GC and 25-5178GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced individual appeals for Carolinas Medical Center – Northeast ("CMC-Northeast") and the related group cases to which the Provider transferred various issues. After reviewing the facts outlined below, the Board has determined that CMC-Northeast's individual appeal requests for calendar years ("CYs") 2009 through 2011 were untimely filed. Consequently, the subsequent transfers of issues to respective group appeals must also be denied. The Pertinent Facts, the Board's review and its determination are set forth below.

Pertinent Facts:

On **April 8, 2025,** Quality Reimbursement Services, Inc. ("QRS") filed separate individual appeals for CMC-Northeast (Prov. No. 34-0001) for the following fiscal year ends ("FYEs"):

Case No.	FYE	NPR Date	# of Days
25-4262	12/31/2009	8/28/2024	223[1]
25-4263	12/31/2010	8/30/2024	221
25-4264	12/31/2011	8/30/2024	221

[1] The filing deadline in Case No. 25-4262 fell on a Saturday so the filing deadline actually ended on the following business day, which would have been March 3, 2025.

Because the three individual appeals were being filed beyond the regulatory filing deadline, QRS simultaneously filed a Request for Good Cause Extension with its appeals. QRS' entire justification for good cause is set forth below:

> In January of 2025, QRS headquarters was subject to emergency evacuation orders due to the Eaton fire disaster. Additionally, the disaster resulted in employees having to flee their homes, with one key employee's home being destroyed by the conflagration.
>
> Due to the emergency conditions created by the fire disaster and its extensive impact on operations, manual operations recovery procedures caused several Board-issued deadlines to be missed, including the filing of the appeal. QRS apologizes for any inconvenience and respectfully requests that the Board accept this appeal as timely under the good cause provisions pursuant to 42 C.F.R. § 405.1836, and PRRB Rule 2.1.4. QRS believes that allowing the Provider to file an appeal under these provisions would be a reasonable remedy to these extraordinary circumstances.[2]

CMC-Northeast's individual appeals for CYs 2009 through 2011 each included the following issues:

- DSH Medicaid Eligible Days ("ME Days")
- DSH SSI Unduly Narrow Definition of SSI Entitlement ("Unduly Narrow")
- DSH SSI & MCD Fractions Medicare Managed Care Part C Days ("Part C Days")
- Improper Rulemaking- DSH SSI Fraction Dual Eligible Days (SSI Fr. DE Days")
- Improper Rulemaking- DSH Medicaid Fraction Dual Eligible Days (M'caid Fr. DE Days")

On **June 3, 2025**, QRS withdrew the ME Days issue from Case Nos. 25-4262 and 25-4264 and on **December 2, 2025**, it withdrew ME Days from Case No. 25-4263.

The remaining issues in the individual appeals were transferred by QRS to the following common issue related party ("CIRP") group appeals:

From Case No. 25-4262:

Issue	FYE	Transfer Date	To Group Case
Unduly Narrow	12/31/2009	12/1/2025	26-0569GC: Atrium Health Unduly Narrow Definition of SSI Entitlement CIRP Group
SSI Fr. DE Days	12/31/2009	12/1/2025	26-0570GC: Atrium Health Improper Rulemaking -SSI Fr. DE Days CIRP Group

[2] Appeal Filed Under Good Cause Extension at 1 (Apr. 8, 2025).

M'caid Fr. DE Days	12/31/2009	12/1/2025	26-0571GC: Atrium Health Improper Rulemaking-M'caid Fr. DE Days CIRP Group
Part C Days	12/31/2009	1/14/2026	25-5139GC: Advocate Health DSH Part C Days RNPR CIRP Group[3]

From Case No. 25-4263:

Issue	**FYE**	**Transfer Date**	**To Group Case**
Unduly Narrow	12/31/2010	4/25/2025	14-2601GC: Carolinas Healthcare System SSI Fraction Numerator/Baystate Errors/Sec 951 CIRP Group
SSI Fr. DE Days	12/31/2010	12/1/2025	26-0574GC: Atrium Health Improper Rulemaking - SSI Fr. DE Days CIRP Group
M'caid Fr. DE Days	12/31/2010	12/1/2025	26-0575GC: Atrium Health Improper Rulemaking-M'caid Fr. DE Days CIRP Group
Part C Days	12/31/2010	1/14/2026	25-5179GC: Advocate Health DSH Part C Days RNPR CIRP Group[4]

From Case No. 25-4264:

Issue	**FYE**	**Transfer Date**	**To Group Case**
Unduly Narrow	12/31/2011	4/25/2025	14-4265GC: Carolinas Healthcare System 2011 DSH/SSI Baystate Errors CIRP Group
SSI Fr. DE Days	12/31/2011	12/1/2025	26-0577GC: Atrium Health Improper Rulemaking -SSI Fr. DE Days CIRP Group
M'caid Fr. DE Days	12/31/2011	12/1/2025	26-0579GC: Atrium Health Improper Rulemaking-M'caid Fr. DE Days CIRP Group
Part C Days	12/31/2011	1/14/2026	25-5178GC: Advocate Health DSH Part C Days RNPR CIRP Group[5]

On **January 16, 2026**, prior to the Board rendering a determination on the Request for Good Cause Extension, Case Nos. 25-4262 and 25-4263 were closed as no issues remained in either case. On **February 23, 2026**, Case No. 25-4264 was also closed after all issues had been transferred and the case was withdrawn.

[3] With respect to varying parent organizations in the CIRPs to which the provider transferred (***i.e.***, Atrium Health vs. Advocate Health), based on an internet search, in December 2022, Advocate Health was formed by the merger of Advocate Aurora Health and Atrium Health.
[4] *Id.*
[5] *Id.*

Board Review:

The Provider's filing deadlines in the subject individual appeals expired 185 days after issuance of the NPRs. For all three cases the filing deadline fell on Monday, March 3, 2025.[6] Therefore, the Provider's appeals were filed **221 days after the expiration of the filing deadline**.

The Eaton fire, which was the basis of QRS' Request for Good Cause Extension, was fully contained more than a month before the filing deadlines in the individual appeals.[7]

42 C.F.R. § 405.1836(b) states:

> The Board may find good cause to extend the time limit **only if the provider demonstrates in writing it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control** (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180-day limit specified in § 405.1835(a)(3) or § 405.1835(c)(2).[8]

On April 21, 2025, the Board issued a determination regarding a request for Good Cause Extension in sixty-two cases where QRS filed a similar justification. In that determination, the Board indicated that:

> . . . while the requests for good cause extension refer generally to the California wildfires, the requests fail to provide any specific "relevant information and documents 'demonstrat[ing] . . . [the provider] could not be expected to file timely due to extraordinary circumstances beyond its control.'" There is a dearth of "relevant information" or "documents" accompanying the requests; in fact, there are no documents accompanying the requests, not even an official emergency declaration, news report, or map.[9]

The Board's determination went on to note that QRS' requests were devoid of detail regarding the operational challenges, in that they lacked specifics about how the QRS office was affected by the wildfires (e.g., building damage, power outages, access to the site). The Board also pointed out that QRS has various office locations in areas that were not impacted by the wildfire, so it was unclear why an employee in one of the other offices couldn't have filed the appeal or requested an

[6] As noted above, the filing deadline in Case No. 25-4262 actually fell on Saturday, March 1, 2025, but based on the Rules of Civil Procedure, the deadline was the next business day, which was Monday, March 3, 2025.
[7] Based on an internet search the Eaton fire started on January 7, 2025 and was fully contained on January 31, 2025.
[8] (Bold emphasis added).
[9] Board Determination in 25-3081GC et. al. at 7-8 (Apr. 21, 2025).

extension while the California-based employees were unavailable.[10] The Board also questioned why QRS "was able to complete some of its work and file some appeals timely, but was unable to file all appeals timely."[11]

Similarly, in Case Nos. 25-4262, 25-4263 and 25-4264, QRS indicated that the fire disaster had an "extensive impact on operations, [*and that*] manual operations recovery procedures caused several Board-issued deadlines to be missed, including the filing of the appeal."[12] However, QRS' Request for Good Cause Extension in the current appeals still lacked relevant documents or specific information related to how the fire impacted QRS' office(s) or why another office couldn't have assumed responsibility for assuring the timely filing of these appeals more than a month after the fire.

Board Determination:

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

With respect to Case Nos. 25-4262 through 25-4264, the Board finds that the rationale set forth in its April 21, 2025 Denial of Good Cause in Case Nos. 25-3081GC et. al., is applicable here.[13] Again, QRS relied on the "generic fire explanation" as the basis for its Request for Good Cause Extension and again, the Board finds this not to be an adequate justification. As in its prior determination, the Board bases its determination on the fact that QRS was able to accomplish its operations in numerous other cases during the time-period in question. In addition, QRS has seven other offices that are NOT located in the fire zone and QRS has provided no documentation of the actual disruption to its Arcadia office caused by the fire, or any explanation as to how operations in its other offices was disrupted.[14] Indeed, the three individual appeals are for CMC Northeast, which is located in Concord, North Carolina -NOT California. It is not clear how a fire near one of the eight QRS locations (six of which are in other states), could make its entire operation unable to continue working, nor is there sufficient explanation for such an argument.

Consequently, although Case Nos. 25-4262 and 25-4263 have been in a closed status as of January 16, 2026 and Case No. 25-4264 has been closed since February 23, 2026, the Board finds CMC-Northeast's individual appeals were untimely filed and denies QRS' Request for Good Cause Extension. The individual cases remain in a closed status, but now, in view of the

[10] *Id.* at 8.
[11] *Id.*
[12] Appeal Filed Under Good Cause Extension at 1. The Board notes that the filing of an appeal is a regulatory deadline, not a Board issued deadline.
[13] On March 24, 2026, the Board issued a similar determination denying the request for good cause extension in Case Nos. 25-4260 and 25-4261, as well as the respective transfers of issues from those cases to groups.
[14] QRS' website shows that, in addition to the location in Arcadia, California, it has offices in Colorado Springs, Colorado; Spokane, Washington; Los Angeles, California; Chicago, Illinois; Detroit, Michigan; Guttenberg, New Jersey and Birmingham, Alabama.

Good Cause Extension denial, the previous transfers of issues to the following groups are considered invalid and are hereby denied:

Unduly Narrow Definition of SSI

From	To	Group Name
25-4262	26-0569GC	Atrium Health CY 2009 DSH SSI Unduly Narrow Definition of SSI Entitlement CIRP Group
25-4263	14-2601GC	Carolinas Healthcare System 2010 DSH SSI Fraction Numerator/Baystate Errors/Sec 951 CIRP Group[15]
25-4264	14-4265GC	Carolinas Healthcare System 2011 DSH/SSI Baystate Errors CIRP Group[16]

Improper Rulemaking -SSI Fr. DE Days

From	To	Group Name
25-4262	26-0570GC	Atrium Health CY 2009 Improper Rulemaking - DSH SSI Fraction Dual Eligible Days CIRP Group
25-4263	26-0574GC	Atrium Health CY 2010 Improper Rulemaking - DSH SSI Fraction Dual Eligible Days CIRP Group
25-4264	26-0577GC	Atrium Health CY 2011 Improper Rulemaking - DSH SSI Fraction Dual Eligible Days CIRP Group

Improper Rulemaking -M'caid Fr. DE Days

From	To	Group Name
25-4262	26-0571GC	Atrium Health CY 2009 Improper Rulemaking - DSH Medicaid Fraction Dual Eligible Days CIRP Group
25-4263	26-0575GC	Atrium Health CY 2010 Improper Rulemaking - DSH Medicaid Fraction Dual Eligible Days CIRP Group
25-4264	26-0579GC	Atrium Health CY 2011 Improper Rulemaking - DSH Medicaid Fraction Dual Eligible Days CIRP Group

Part C Days

From	To	Group Name
25-4262	25-5139GC	Advocate Health CY 2009 DSH Part C Days RNPR CIRP Group
25-4263	25-5179GC	Advocate Health CY 2010 DSH Part C Days RNPR CIRP Group
25-4264	25-5178GC	Advocate Health CY 2011 DSH Part C Days RNPR CIRP Group

[15] As the transfer is being denied based on the untimeliness of the individual appeal from which the issue was transferred, there is no need to address the validity of the transfer of the Unduly Narrow issue to an SSI Percentage (Baystate) group.
[16] *Id*.

The Board notes that Hall, Render, Killian, Heath & Lyman, P.C. is the authorized group representative for the Advocate Health Part C Groups under Case Nos. 25-5139GC, 25-5179GC and 25-5178GC.

Accordingly, the Board dismisses the following seven group appeals as CMC-Northeast is the sole participant: Case Nos. 26-0569GC, 26-0570GC, 26-0571GC, 26-0574GC, 26-0575GC, 26-0577GC and 26-0579GC.

Although CMC-Northeast has also been dismissed from the following group appeals, these groups remain pending as there are other remaining participants: Case Nos. 14-2601GC, 14-4265GC, 25-5139GC, 25-5179GC and 25-5178GC.

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

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

For the Board:

4/6/2026

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
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Pamela Van Arsdale, National Government Services (MAC for 25-5178GC)
Heather Mogden, Hall, Render, Killian, Heath & Lyman, P.C.

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RE: ***Board Decision* – DSH Payment/SSI Percentage (Provider Specific) Issue**
United Hospital Center (Provider No. 51-0006)
FYE 12/31/2016
Case No. 24-0173

Dear Mr. Ravindran and Ms. Johnson,

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

Background:

A. *Procedural History for Case No. 24-0173*

On **May 19, 2023**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2016.

On **November 15, 2023**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained six (6) issues:

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

The Provider is commonly owned/controlled by West Virginia University Health System (hereinafter "WVU Medicine") and, thereby, is subject to the mandatory CIRP group regulation

[1] On June 28, 2024, this issue was transferred to PRRB Case No. 21-1434GC.
[2] This issue was withdrawn on September 9, 2024.
[3] On June 28, 2024, this issue was transferred to PRRB Case No. 21-1544GC.
[4] On June 28, 2024, this issue was transferred to PRRB Case No. 21-1546GC.
[5] On June 28, 2024, this issue was transferred to PRRB Case No. 21-1435GC.

at 42 C.F.R. § 405.1837(b)(1). For that reason, on **June 28, 2024**, the Provider transferred Issues 2, 4, 5 and 6 to WVU Medicine groups. As a result, there is one (1) remaining issue in this appeal: Issue 1 (DSH Payment/SSI Percentage (Provider Specific)).

On **November 16, 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. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

On **July 10, 2024**, the Provider timely filed its preliminary position paper.

On **September 19, 2024**, the Medicare Contractor timely filed its preliminary position paper.

On **October 29, 2024**, the Medicare Contractor filed a Substantive Claim Challenge[7] relative to Issue 1, requesting that the Board find that there is not an appropriate cost report claim for this issue per 42 C.F.R. § 413.24(j) and that this item is not reimbursable, regardless of whether the Board were to issue a favorable final hearing decision under 42 C.F.R. § 405.1871(a). Significantly, under Board Rule 44.5.1, the Provider had 30 days to respond to the Substantive Claim Challenge. However, the Provider ***failed*** to file any response.

On **October 30, 2024**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1. Under Board Rule 44.4.3, the Provider had 30 days to respond to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

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

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

---

[6] (Emphasis added).

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[8]

The group issue statement in Case No. 21-1434GC, WVU Medicine CY 2016 DSH SSI Percentage CIRP Group, to which the Provider transferred Issue 2 reads, in part:

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

[8] Issue Statement at 1 (Nov. 15, 2023).

6. Failure to adhere to required notice and comment rulemaking procedures.[9]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $70,356.

On July 10, 2024, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Issue #1: Provider Specific**
>
> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[10]

MAC's Contentions

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue for three reasons. First, the MAC argues that the SSI realignment portion of the issue has been abandoned by the Provider:

> This issue has been abandoned in the Provider's Preliminary position paper. The Provider makes no argument related to realignment or any reference to its fiscal year end vs. the federal

[9] Group Issue Statement, Case No. 21-1434GC.
[10] Provider's Preliminary Position Paper at 8-9 (Jul. 10, 2024).

> fiscal year end. The Provider's preliminary position paper argument is limited to the accuracy of the published SSI percentage . . . In accordance with Board Rule 25.3, "If the Provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn." The MAC contends that the Provider has failed to brief any position on realignment and therefore, has abandoned it.[11]

Failing that, the MAC argues the realignment sub-issue is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election and not a final MAC determination.
>
> . . .
>
> At the time of the appeal request, the MAC had not made a determination on the realignment of the SSI percentage to the hospital fiscal year end, as the requested SSI Realignment had not yet been finalized. As such, the Provider's appeal was premature. The Provider had not exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue. The MAC requests that the PRRB dismiss this subsidiary realignment issue consistent with its jurisdictional decisions.[12]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[13]

Finally, the MAC argues "the Provider did not file a **complete** preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3."[14] The MAC posits that the Provider "the Provider has not included any documentary evidence to support the basis for its estimate."[15]

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." The MAC filed its Jurisdictional Challenge on October 30, 2024. The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed.

---

[11] Jurisdictional Challenge at 5 (Oct. 30, 2024).
[12] *Id*. at 6.
[13] *Id*. at 4-5.
[14] *Id*. at 6.
[15] *Id*. at 8.

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/SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

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

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[16] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[17] The Provider argues 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."[18]

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

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

duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[19], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[20] Accordingly, Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, 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 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 21-1434GC.

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

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

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

[19] PRRB Rules v. 3.2 (Dec. 2023).
[20] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

> Once the documents become available, promptly forward them to the Board and the opposing party.[21]

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") 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.[22]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[23]

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 21-1434GC are the same issue.[24] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

Additionally, in its Preliminary Position Paper, the Provider states, "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 [sic] (Appellants' reply brief included as Exhibit P-3)." The Board finds that this incorporation by reference does not comply with the regulatory and Board rule requirements to fully develop the Provider's position in the Preliminary Position Paper. Particularly, 42 C.F.R. § 405.1853(b) provides in pertinent part:

---

[21] (Emphasis added).
[22] Last accessed August 14, 2024.
[23] Emphasis added.
[24] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a WVU Medicine CIRP group per 42 C.F.R. § 405.1837(b)(1).

> (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*.[25]

An incorporation of arguments by reference from a different case simply fails to do so. Accordingly, the Board dismisses that portion of the issue as well.

2. Second Aspect of Issue 1

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

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Moreover, without this written request, the Medicare Contractor 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 Medicare Contractor 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.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 21-1434GC and because the purported realignment portion of the issue is premature in absence of a properly submitted written realignment request subject to a final determination from which the Provider can appeal. As no issues remain pending, the Board hereby closes Case No. 24-0173 and removes it from the Board's docket.

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

[25] (Emphasis added).

Board Members Participating:

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

For the Board:

4/6/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: Determination re: Duplicative Filing
UC San Diego Health Hillcrest - Hillcrest Medical Center (05-0025)
Appealed Period: FYE 06/30/2009
PRRB Case Nos.: 26-1994 and 26-2133

Dear Ms. Bhatnagar and Mr. Connelly:

The above-captioned appeals were filed with the Provider Reimbursement Review Board ("Board") via the Office of Hearings Case and Document Management System ("OH CDMS"). After review of the facts outlined below, the Board has determined that the subject appeals are duplicative filings. The Board's review and determination is set forth below.

BACKGROUND:

Case No.: 26-1994:

On March 7, 2026, Powers, Pyles, Sutter & Verville, P.C. (hereafter, "Powers et al."), filed a request for an individual appeal on behalf of the above referenced Provider for its Fiscal Year End ("FYE") 06/30/2009. The appeal is based on a **Revised Notice of Program Reimbursement** ("NPR") dated October 2, 2025.

The appeal request identified a sole issue in dispute:

DGME Prior and penultimate year weighting (Hershey issue)

The Letter of Representation appointing Ronald Connelly of Powers et al. as the provider representative of record was dated March 3, 2026 and was signed by Leah Welsing, Director of Reimbursement.

The Board's Acknowledgement and Critical Due Dates notice ("ACDD") was issued to the Parties on March 9, 2026.

Case No.: 26-2133:

On March 30, 2026, Toyon Associates filed another individual appeal request involving the same Provider and FYE and based on the same **Revised Notice of Program Reimbursement (**"NPR"**)** dated October 2, 2025. This appeal request identified two (2) issues in dispute:

(IME) Payments-Understatement IME Payments Due-(FTE) Counts
(GME) Payments-Understatement GME Payments Due-(FTE) Counts

The Letter of Representation appointed Ms. Mridula Bhatnagar of Toyon Associates as the provider representative of record and is dated March 25, 2026. This letter of representation was also signed by Leah Welsing, Director of Reimbursement. The letter appointed Toyon Associates, Inc. as the representative for the individual appeal and any group appeals related to FYE 06/30/2009.

The Board's ACDD notice for this appeal was issued to the Parties on April 1, 2026.

Upon review, it is noted that CNs: 26-1994 and 26-2133 involve the same Provider, same FYE and are based on the same final determination dated October 2, 2025. Therefore, the appeal requests are duplicative filings.

Board's Determination:

Board Rule 4.6.1 **Same Issue from One Determination** states: A provider may not appeal and pursue the same issue from a single final determination in more than one appeal (individual or group).

Per the above rule, only **one** appeal per Provider per fiscal year end can be established.[1] Case numbers 26-1994 and 26-2133 are duplicate filings since they involve the same Provider, same FYE and are based on the same final determination dated October 2, 2025.

Board Rule 4.6 prohibits duplicate filings. The appeals are duplicative filings since they involve the same Provider, same FYE and are based on the same final determination. Therefore, the Board is consolidating case number 26-2133 into case number 26-1994 since case number 26-1994 was actively pending at the time case number 26-2133 was filed.

As a result of the consolidation, the Board hereby closes case number 26-2133 and removes it from its docket.

The Parties are to continue to adhere to the due dates set forth in the ACDD notice for case number 26-1994 which was issued on March 9, 2025.

Pursuant to Board Rule 5.1, which advises that there may be only one (1) case representative per appeal, the Board will continue to correspond with only Mr. Ronald Connelly of Powers et al., the appointed representative of the consolidated case, case number 26-1994. If the Provider wishes to change the representative of record in the surviving appeal, case number 26-1994, it must enter

[1] *See* Board Rules 4.6, 5.4, 7.1.1. *See also* 42 C.F.R. § 405.1835(a).

a formal request to the Board via OH CDMS. The Provider is reminded that the Board will not communicate with different representatives for different issue(s) within the same appeal. (See Board Rules 5, 5.4.)

The Board admonishes UC San Diego Health for filing multiple appeal requests and Letters of Representation for the same Provider, same FYE, and based on the same final determination. The Board reminds UC San Diego Health that it has a responsibility to oversee its designated agents that pursue the claims of UC San Diego Health and its providers for additional Medicare reimbursement before the Board. UC San Diego Health has a responsibility to ensure that it complies with the Board's Rules and filing requirements and does not pursue improper or duplicative claims/appeals.

Board Members:

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

FOR THE BOARD:

4/9/2026

X Nicole E. Musgrave

Nicole E. Musgrave, Esq.
Board Member
Signed by: Nicole Musgrave-burdette -A

Cc: Leah Welsing, Director of Reimbursement, UC San Diego Health
Wilson C. Leong, Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Boulevard
Suite 700
Los Angeles, CA 90064-1582

RE: ***Expedited Judicial Review Determination***
Case Number: 25-3627G - Blumberg Ribner CY 2003 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction Group

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petition for Expedited Judicial Review ("EJR") filed on **March 11, 2026** in the above-referenced group appeal. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Board received a request to establish an optional group on **March 10, 2025**. The Providers are appealing from original and/or revised Notices of Program Reimbursement ("NPRs/RNPRs") which they claim implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Providers' Fiscal Years Ended ("FYEs") in 2003.

The issue in this appeal is the proper treatment in the Medicare disproportionate share hospital ("DSH") adjustment calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days"). The Providers contend that part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction (for patients eligible for Medicaid).[2] The Providers are seeking to challenge the CMS policy adopted in the June 2023 Final Rule to be applied *retroactively* for periods prior to October 1, 2013.[3]

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

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] Statement of Issue at 1-2 (Mar. 10, 2025).
[3] *Id.* at 2-5.

inpatient prospective payment system ("IPPS").[4] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[6] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] 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.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[11]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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

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[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[11] (Emphasis added.)
[12] 42 C.F.R. § 412.106(b)(2)-(3).

> 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.[13]

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.[14]

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

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

In the September 4, 1990 Federal Register, the Secretary[15] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[17]

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[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(4).
[15] of Health and Human Services.
[16] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[17] *Id.*

With the creation of Medicare Part C in 1997,[18] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C, and following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[19] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[20] The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[21]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.[22] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[23] In response to a comment regarding this change, the Secretary explained that:

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

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[18] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[19] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[20] *Id.*
[21] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[22] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[23] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).

> *numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[24]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[25] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[26] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[27]

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

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[28]

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[29] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[30] In vacating the final rule, it reasoned that this deprived the public of adequate

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[24] *Id.* (emphasis added).
[25] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[26] *Id*. at 47411.
[27] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[28] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[29] 746 F. 3d 1102 (D.C. Cir. 2014).
[30] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's

opportunity for notice and comment before the final rule was promulgated in 2004.[31] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[32] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.[33] A number of hospitals appealed this action.[34] In *Azar v. Allina Health Services* ("*Allina II*"),[35] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[36] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[37] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[38]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[39] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions

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interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").

[31] *Id.* at 2011.

[32] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).

[33] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).

[34] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo****(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board, **pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).

[35] 139 S.Ct. 1804 (2019).

[36] *Id.* at 1817.

[37] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.

[38] 139 S.Ct. at 1814.

[39] 85 Fed. Reg. 47723 (Aug. 6, 2020).

> of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[40]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[41] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[42]

Finally, the following excerpts from the June 9, 2023 Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule or subsequent publication of SSI ratios to be an appealable "final determination":

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

[40] CMS Ruling 1739-R at 1-2.
[41] 88 Fed. Reg. 37772 (June 9, 2023).
[42] 88 Fed. Reg. at 37788 (emphasis in original).

*fractions for **each** applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[43]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[44]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions **contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised **NPRs** will provide hospitals with a **vehicle to appeal** the new final action* even if the Medicare fraction or DSH payment does not change numerically."[45]

4. "*When the Secretary's treatment of Part C days in this final action is reflected **in NPRs and revised NPRs**, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation **by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[46]

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

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are "entitled to [Part A] benefits" within the context of

[43] 88 Fed. Reg. at 37774-75 (emphasis added).
[44] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[45] *Id.* at 37788 (emphasis added).
[46] *Id.* (emphasis added).

42 U.S.C.§ 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.[47] It ruled, however, that the June 9, 2023 Final Rule is both impermissibly retroactive[48] and arbitrary and capricious.[49] The court ordered the parties to submit briefs on whether vacatur was the appropriate remedy for the situation, which have since been filed.[50]

Providers' Position:

A. Providers' Appeal Request

The Providers' appeal request argues that Medicare Part C days "should be reflected in the Medicaid percentage rather than the Medicare/SSI Fraction."[51] They seek to invalidate the Final Rule published on June 9, 2023 and the SSI Ratio published thereafter to implement the Final Rule.[52] The Providers argue that the Final Rule is contrary the statutory language of 42 U.S.C. § 1395ww(d)(5)(F)(vi) and that Secretary's interpretation of this statute deserves no deference following the Supreme Court's decision in *Loper Bright.*[53]

The Providers recount how, prior to 2004, CMS did not include Part C Days in the SSI Ratio, along with the subsequent rulemaking and litigation which can be outlined as follows:

1. In the FY 2005 IPPS Final Rule, CMS first announced a policy change to count Part C days in the SSI fraction and to exclude those days from the numerator of the Medicaid fraction.

2. In *Allina I*, the D.C. Circuit vacated that policy change.

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking.

4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.

Based on the above, the Providers maintain that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule is substantively and procedurally invalid and must be set aside because it is contrary to law, arbitrary and capricious, and *per se* unreasonable.[54]

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[47] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).
[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.
[51] Statement of Issue at 1.
[52] *Id.* at ¶ 3.
[53] *Id.* at ¶¶ 4-5 (citing *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024)).
[54] *Id.* at ¶¶ 6-18.

B. Providers' Petition for EJR

The Providers have requested EJR over the post-*Allina* retroactive Part C policy issue outlined above. They argue that they filed their appeals within 180 days of the issuance of their NPRs and/or RNPRs; that the amount in controversy exceeds $50,000; that they challenge the validity of the June 2023 Final Rule; and that the Board cannot grant this relief because it is bound by the policy.[55] They note that the June 2023 Final Rule affords appeal rights from RNPRs implementing the retroactive Part C Days policy even if a Provider's SSI Ratio does not change numerically.[56]

On **March 16, 2026**, the Medicare Contractor filed a PRRB Rule 22 Jurisdictional Review letter explaining it "believe[s] there are no jurisdictional impediments related to the providers in the Schedule of Providers or the corresponding indexed documents." On **March 18, 2026**, the Medicare Contractor's representative, Federal Specialized Services ("FSS"), filed a response to the Requests for EJR which simply advised that "the MAC will not file a jurisdictional challenge. The MAC will not file a substantive claim challenge."[57]

Decision of the Board:

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

A. Jurisdiction

A group of Providers generally have a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if:

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [58]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and

[55] Providers' Petition for Expedited Judicial Review at 1-4 (Mar. 11, 2026).
[56] *Id.* at 11.
[57] Response to Provider's Request for Expedited Judicial Review at 1 (Mar. 18, 2026).
[58] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).

- The amount in controversy is, in the aggregate, $50,000 or more.[59]

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

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

Additionally, 42 C.F.R. § 405.1889[60] explains the effect of a cost report revision:

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

As outlined above, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[61] Additionally, the June 9, 2023 Final Rule afforded appeal rights for NPRs and RNPRs which did not contain specific revisions to Part C days, but nevertheless implemented the Final Rule related to Part C Days (typically "no change" or $0 RNPRs).[62]

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[59] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.
[60] *See also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).
[61] 42 C.F.R. § 405.1889(b)(1).
[62] *See supra* notes 43-45 and accompanying text.

B. RNPRs Issued Pursuant to 1498-R and 1498-R3

1. Mercy Medical Center

Mercy Medical Center (Provider No. 33-0259) is appealing from an RNPR dated December 30, 2024 for its FYE December 31, 2003. The RNPR was issued "to implement the [PRRB] remand for the SSI Ratio and Dual Eligible Days" and calculated an overpayment of $31,572. The audit adjustments specify that the RNPR was issued "[t]o adjust the SSI ratio and the corresponding allowable DSH percentage in accordance with the PRRB remand of Case # 09-0929GC & 09-1523GC under the terms of CMS Rulings 1498-R and 1498-R3."

CMS Ruling 1498-R concerned the implementation of *Baystate*[63] and a revised data matching process for SSI fractions. The data matching process was revised to more accurately capture individuals who were "entitled to SSI." CMS later published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[64] Importantly, CMS Ruling 1498-R2 specified that "CMS Ruling 1498-R **does not** establish policy regarding the treatment of Medicare Part C days in the Medicare DSH methodology."[65] CMS Ruling 1498-R2 was revoked, however, via CMS Ruling 1498-R3 because *Empire Health*[66] "confirmed that the Medicare statute requires the calculation of Medicare fractions to be based on total days such that the choice permitted under CMS Ruling 1498-R2 of a calculation based on covered days is inconsistent with the Medicare statute[.]"[67]

The Providers in Case 09-1523GC (which was the original 1498-R remand for this FYE) have previously sought to reopen that case to bifurcate that case, arguing that their Dual Eligible Days issue was intended to encompass the Part C Days issue. The Board, however, rejected that request.[68]

The RNPR was issued to implement CMS Rulings 1498-R and 1498-R3, neither of which implement any change to the treatment of Part C Days. The Board has previously rejected this Provider's attempts to implicate the Part C Days issue in their appeals for this FY. Based on the foregoing, the Board hereby dismisses this Provider from the instant appeal.

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[63] *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008), *amended in part*, 587 F. Supp. 2d 37 (D.D.C. Nov. 07, 2008), *judgment entered*, 587 F. Supp. 2d 44 (D.D.C. Dec. 8, 2008), *dismissing appeal*, 2009 WL 604186 (D.C. Cir. 2009).
[64] CMS-1498-R2 at 2, 6.
[65] *Id.* at 8 (emphasis added).
[66] 142 S. Ct. 2354 (2022).
[67] CMS 1498-R3 at 2.
[68] Case No. 09-1523GC, Board Decision on Request to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days (Dec. 15, 2023).

2. Garnet Health Medical Center

Garnet Health Medical Center (Provider No. 33-0126) is appealing from an RNPR dated February 20, 2025 for its FYE December 31, 2003. The RNPR was issued "to implement the [PRRB] remand for the SSI Ratio and Dual Eligible Days" and calculated an overpayment of $29,796. The audit adjustments specify that the RNPR was issued "[t]o adjust the SSI ratio and the corresponding allowable DSH percentage in accordance with the PRRB remand of Case # 12-0322GC, 09-1924G under the terms of CMS Rulings 1498-R and 1498-R3."

Similar to Mercy Medical Center, the Board made a previous **specific** finding that the Part C Days issue was not included in the underlying remand for this Provider. It specifically found "that the issue statement for the group appeal can only be read to encompass the dual eligible Part A days issue. The group appeal issue language does not meet the specificity requirements as set forth in the regulation and Board rules to have appealed the dual eligible Part C days issue."[69]

The RNPR was issued to implement CMS Rulings 1498-R and 1498-R3, neither of which implement any change to the treatment of Part C Days. The Board has previously rejected this Provider's attempts to implicate the Part C Days issue in their appeals for this FY. Based on the foregoing, the Board hereby dismisses this Provider from the instant appeal.

3. Crouse Hospital

Crouse Hospital (Provider No. 33-0203) is appealing an RNPR dated February 27, 2025 for its FYE December 31, 2003. The RNPR was issued "to implement the [PRRB] remand for the SSI Ratio and Dual Eligible Days" and calculated an overpayment of $18,262. The audit adjustments specify that the RNPR was issued "[t]o adjust the SSI ratio and the corresponding allowable DSH percentage in accordance with the PRRB remand of Case # 08-1768G & 08-2013G under the terms of CMS Rulings 1498-R and 1498-R3."

Similar to Mercy Medical Center, the Board made a previous **specific** finding that the Part C Days issue was not included in the underlying remand for this Provider. It specifically found "it is clear that the group does not encompass Part C days[.]"[70]

The RNPR was issued to implement CMS Rulings 1498-R and 1498-R3, neither of which implement any change to the treatment of Part C Days. The Board has previously rejected this Provider's attempts to implicate the Part C Days issue in their appeals for this FY. Based on the foregoing, the Board hereby dismisses this Provider from the instant appeal.

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[69] Case No. 09-1924G, Board Decision on Request to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days at 6 (Dec. 20, 2023).
[70] Case No. 08-2013G, Board Decision on Request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal Regarding DSH Part C Days Issue at 3 (Sept. 30, 2024).

4. St. Joseph's Hospital Health Center

St. Joseph's Hospital Health Center (Provider No. 33-0140) is appealing an RNPR dated March 4, 2025 for its FYE December 31, 2003. The RNPR was issued "to implement the [PRRB] remand for the SSI Ratio" and calculated an overpayment of $17,256. The audit adjustments specify that the RNPR was issued "[t]o adjust the SSI ratio and the corresponding allowable DSH percentage in accordance with the PRRB Remand of Case #09-1981G under the terms of CMS Rulings 1498-R and 1498-R3."

The RNPR was issued to implement CMS Rulings 1498-R and 1498-R3, neither of which implement any change to the treatment of Part C Days. Based on the foregoing, the Board hereby dismisses this Provider from the instant appeal.

C. Remaining Providers

For the remaining Providers in this appeal, the providers all appealed from original and/or revised NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. All the providers in the group appeal were directly added to the groups within 180 days of the issuance of their NPRs and/or RNPRs (or filed a timely individual appeal and were transferred to this case) and the amount in controversy exceeds $50,000.

D. Board's Decision Regarding the EJR Requests

The Board finds that:

1) **Except for** the four (4) Providers outlined in Section B of the Decision of the Board section of this decision, it has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in this case and that the Providers are entitled to a hearing before the Board;

2) Based upon the Providers' assertions regarding the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether the Part C Days policy issue, as adopted on a retroactive basis in the June 9, 2023 Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject

years, **except for** the four (4) Providers outlined in Section B of the Decision of the Board section of this decision.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the case and removes it from its docket.

Board Members Participating:

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

FOR THE BOARD:

4/9/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedule of Providers

cc: Danelle Decker, National Government Services, Inc. (J-K)
Scott Berends, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Isaac Blumberg
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RE: ***Expedited Judicial Review Determination***
Case Number: 25-3631G - *Blumberg Ribner CY 2004 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction Group*

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petition for Expedited Judicial Review ("EJR") filed on **March 16, 2026** in the above-referenced group appeal. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Board received a request to establish an optional group on **March 10, 2025**. The Providers are appealing from original and/or revised Notices of Program Reimbursement ("NPRs/RNPRs") which they claim implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Providers' FYEs in 2004.

The issue in this appeal is the proper treatment in the Medicare disproportionate share hospital ("DSH") adjustment calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days"). The Providers contend that part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction (for patients eligible for Medicaid).[2] The Providers are seeking to challenge the CMS policy adopted in the June 2023 Final Rule to be applied *retroactively* for periods prior to October 1, 2013.[3]

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

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] Statement of Issue at 1-2 (Mar. 10, 2025).
[3] *Id.* at 2-5.

inpatient prospective payment system ("IPPS").[4] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[6] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] 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.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[11]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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

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[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[11] (Emphasis added.)
[12] 42 C.F.R. § 412.106(b)(2)-(3).

> 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.[13]

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.[14]

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

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

In the September 4, 1990 Federal Register, the Secretary[15] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[17]

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[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(4).
[15] of Health and Human Services.
[16] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[17] *Id.*

With the creation of Medicare Part C in 1997,[18] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C, and following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[19] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[20] The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[21]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.[22] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[23] In response to a comment regarding this change, the Secretary explained that:

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

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[18] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[19] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[20] *Id.*
[21] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[22] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[23] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).

> *numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[24]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[25] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[26] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[27]

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

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[28]

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[29] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[30] In vacating the final rule, it reasoned that this deprived the public of adequate

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[24] *Id.* (emphasis added).
[25] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[26] *Id*. at 47411.
[27] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[28] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[29] 746 F. 3d 1102 (D.C. Cir. 2014).
[30] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's

opportunity for notice and comment before the final rule was promulgated in 2004.[31] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[32] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.[33] A number of hospitals appealed this action.[34] In *Azar v. Allina Health Services* ("*Allina II*"),[35] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[36] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[37] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[38]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[39] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions

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interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").

[31] *Id.* at 2011.

[32] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).

[33] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).

[34] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo****(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board, **pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).

[35] 139 S.Ct. 1804 (2019).

[36] *Id.* at 1817.

[37] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.

[38] 139 S.Ct. at 1814.

[39] 85 Fed. Reg. 47723 (Aug. 6, 2020).

> of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[40]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[41] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[42]

Finally, the following excerpts from the June 9, 2023 Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule or subsequent publication of SSI ratios to be an appealable "final determination":

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

[40] CMS Ruling 1739-R at 1-2.
[41] 88 Fed. Reg. 37772 (June 9, 2023).
[42] 88 Fed. Reg. at 37788 (emphasis in original).

*fractions for **each** applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[43]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[44]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions **contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised **NPRs** will provide hospitals with a **vehicle to appeal** the new final action* even if the Medicare fraction or DSH payment does not change numerically."[45]

4. "*When the Secretary's treatment of Part C days in this final action is reflected **in NPRs and revised NPRs**, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation **by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[46]

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

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are "entitled to [Part A] benefits" within the context of

[43] 88 Fed. Reg. at 37774-75 (emphasis added).
[44] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[45] *Id.* at 37788 (emphasis added).
[46] *Id.* (emphasis added).

42 U.S.C.§ 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.[47] It ruled, however, that the June 9, 2023 Final Rule is both impermissibly retroactive[48] and arbitrary and capricious.[49] The court ordered the parties to submit briefs on whether vacatur was the appropriate remedy for the situation, which have since been filed.[50]

Providers' Position:

A. Providers' Appeal Request

The Providers' appeal request argues that Medicare Part C days "should be reflected in the Medicaid percentage rather than the Medicare/SSI Fraction."[51] They seek to invalidate the Final Rule published on June 9, 2023 and the SSI Ratio published thereafter to implement the Final Rule.[52] The Providers argue that the Final Rule is contrary the statutory language of 42 U.S.C. § 1395ww(d)(5)(F)(vi) and that Secretary's interpretation of this statute deserves no deference following the Supreme Court's decision in *Loper Bright.*[53]

The Providers recount how, prior to 2004, CMS did not include Part C Days in the SSI Ratio, along with the subsequent rulemaking and litigation which can be outlined as follows:

1. In the FY 2005 IPPS Final Rule, CMS first announced a policy change to count Part C days in the SSI fraction and to exclude those days from the numerator of the Medicaid fraction.

2. In *Allina I*, the D.C. Circuit vacated that policy change.

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking.

4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.

Based on the above, the Providers maintain that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule is substantively and procedurally invalid and must be set aside because it is contrary to law, arbitrary and capricious, and *per se* unreasonable.[54]

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[47] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).
[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.
[51] Statement of Issue at 1.
[52] *Id.* at ¶ 3.
[53] *Id.* at ¶¶ 4-5 (citing *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024)).
[54] *Id.* at ¶¶ 6-18.

B. Providers' Petition for EJR

The Providers have requested EJR over the post-*Allina* retroactive Part C policy issue outlined above. They argue that they filed their appeals within 180 days of the issuance of their NPRs and/or RNPRs; that the amount in controversy exceeds $50,000; that they challenge the validity of the June 2023 Final Rule; and that the Board cannot grant this relief because it is bound by the policy.[55] They note that the June 2023 Final Rule affords appeal rights from RNPRs implementing the retroactive Part C Days policy even if a Provider's SSI Ratio does not change numerically.[56]

On **March 18, 2026**, the Medicare Contractor's representative, Federal Specialized Services ("FSS"), filed a response to the Requests for EJR in simply advising that "the MAC will not file a jurisdictional challenge. The MAC will not file a substantive claim challenge."[57]

Decision of the Board:

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

A. Jurisdiction

A group of Providers generally have a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if:

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [58]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[59]

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[55] Providers' Petition for Expedited Judicial Review at 1-4 (Mar. 16, 2026).
[56] *Id.* at 11.
[57] Response to Provider's Request for Expedited Judicial Review at 1 (Mar. 18, 2026).
[58] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[59] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

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

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

Additionally, 42 C.F.R. § 405.1889[60] explains the effect of a cost report revision:

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

As outlined above, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[61] Additionally, the June 9, 2023 Final Rule afforded appeal rights for NPRs and RNPRs which did not contain specific revisions to Part C days, but nevertheless implemented the Final Rule related to Part C Days (typically "no change" or $0 RNPRs).[62]

B. RNPRs Issued Pursuant to 1498-R and 1498-R3

1. Bethesda North

Bethesda North (Provider No. 36-0179) is appealing from an RNPR dated October 22, 2024 for its FYE June 30, 2004. The RNPR was issued "to include the SSI ratio per the remand order of

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[60] *See also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).
[61] 42 C.F.R. § 405.1889(b)(1).
[62] *See supra* notes 43-45 and accompanying text.

PRRB Case # 11-0240G" and calculated an overpayment of $494. Case 11-0240G was remanded to the Medicare Contractor pursuant to CMS Ruling 1498-R on October 6, 2015. The audit adjustments specify that the RNPR was issued "[t]o update the SSI% in accordance with CMS 1498-R3."

CMS Ruling 1498-R concerned the implementation of *Baystate*[63] and a revised data matching process for SSI fractions. The data matching process was revised to more accurately capture individuals who were "entitled to SSI." CMS later published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[64] Importantly, CMS Ruling 1498-R2 specified that "CMS Ruling 1498-R **does not** establish policy regarding the treatment of Medicare Part C days in the Medicare DSH methodology."[65] CMS Ruling 1498-R2 was revoked, however, via CMS Ruling 1498-R3 because *Empire Health*[66] "confirmed that the Medicare statute requires the calculation of Medicare fractions to be based on total days such that the choice permitted under CMS Ruling 1498-R2 of a calculation based on covered days is inconsistent with the Medicare statute[.]"[67]

The RNPR was issued to implement CMS Rulings 1498-R and 1498-R3, neither of which implement any change to the treatment of Part C Days. The Board hereby dismisses this Provider from the instant appeal.

2. Niagara Falls Memorial Medical Center

Niagara Falls Memorial Medical Center (Provider No. 33-0065) is appealing from an RNPR dated March 6, 2025 for its FYE December 31, 2004. The RNPR was issued "to implement the [PRRB] remand for the SSI Ratio" and calculated an overpayment of $210,696. The audit adjustments specify that the RNPR was issued "[t]o adjust the SSI ratio and the corresponding allowable DSH percentage in accordance with the PRRB remand of Case # 08-1779G & 08-0693G under the terms of CMS Rulings 1498-R and 1498-R3."

In Case 08-0693G, the Board made a previous **specific** finding that the Part C Days issue was not included in the underlying remand for this Provider. It specifically found "it is clear that the group does not encompass the separate and distinct Part C days issue[.]"[68]

The RNPR was issued to implement CMS Rulings 1498-R and 1498-R3, neither of which

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[63] *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008), *amended in part*, 587 F. Supp. 2d 37 (D.D.C. Nov. 07, 2008), *judgment entered*, 587 F. Supp. 2d 44 (D.D.C. Dec. 8, 2008), *dismissing appeal*, 2009 WL 604186 (D.C. Cir. 2009).
[64] CMS-1498-R2 at 2, 6.
[65] *Id.* at 8 (emphasis added).
[66] 142 S. Ct. 2354 (2022).
[67] CMS 1498-R3 at 2.
[68] Case No. 08-0693G, Board Decision on Request to Rescind Remand and Bifurcate DSH Part C Days Issue at 3-4 (Sept. 30, 2024).

implement any change to the treatment of Part C Days. The Board has previously rejected this Provider's attempts to implicate the Part C Days issue in their appeals for this FY. The Board hereby dismisses this Provider from the instant appeal.

3. Crouse Hospital

Crouse Hospital (Provider No. 33-0203) is appealing an RNPR dated December 30, 2024 for its FYE December 31, 2004. The RNPR was issued "to implement the [PRRB] remand for the SSI Ratio Dual Eligible Days" and calculated an overpayment of $15,664. The audit adjustments specify that the RNPR was issued "[t]o adjust the SSI ratio and the corresponding allowable DSH percentage in accordance with the PRRB remand of Case # 08-1779GGC & 08-0693G under the terms of CMS Rulings 1498-R and 1498-R3."

In Case 08-0693G, the Board made a previous **specific** finding that the Part C Days issue was not included in the underlying remand for this Provider. It specifically found "it is clear that the group does not encompass the separate and distinct Part C days issue[.]"[69]

The RNPR was issued to implement CMS Rulings 1498-R and 1498-R3, neither of which implement any change to the treatment of Part C Days. The Board has previously rejected this Provider's attempts to implicate the Part C Days issue in their appeals for this FY. The Board hereby dismisses this Provider from the instant appeal.

4. Vassar Brothers Medical Center

Vassar Brothers Medical Center (Provider No. 33-0023) is appealing an RNPR dated February 25, 2025 for its FYE December 31, 2004. The RNPR was issued "to implement the [PRRB] remand for the SSI Ratio and Dual Eligibility" and calculated an underpayment of $42,552. The audit adjustments specify that the RNPR was issued "[t]o adjust the SSI ratio and the corresponding allowable DSH percentage in accordance with the PRRB Remand of Case #09-2031G & 09-1496G under the terms of CMS Rulings 1498-R and 1498-R3."

In Case 09-1496G, the Board made a previous **specific** finding that the Part C Days issue was not included in the underlying remand for this Provider. It specifically found "the alleged Part C Days issue was never part of the group appeal issue statement" and "that the issue statement for the group appeal can only be read to encompass the dual eligible Part A days issue."[70]

The RNPR was issued to implement CMS Rulings 1498-R and 1498-R3, neither of which implement any change to the treatment of Part C Days. The Board has previously rejected this Provider's attempts to implicate the Part C Days issue in their appeals for this FY. The Board hereby dismisses this Provider from the instant appeal.

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[69] *Id.*
[70] Case No. 09-1496G, Board Decision on Request to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue at 5-6 (Dec. 15, 2023).

5. St. Joseph's Hospital Health Center

St. Joseph's Hospital Health Center (Provider No. 33-0140) is appealing an RNPR dated March 5, 2025 for its FYE December 31, 2004. The RNPR was issued "to implement the [PRRB] remand for the SSI Ratio and Dual Eligible Days" and calculated an overpayment of $47,674. The audit adjustments specify that the RNPR was issued "[t]o adjust the SSI ratio and the corresponding allowable DSH percentage in accordance with the PRRB Remand of Case #09-2031G & 09-1496G under the terms of CMS Rulings 1498-R and 1498-R3."

In Case 09-1496G, the Board made a previous **specific** finding that the Part C Days issue was not included in the underlying remand for this Provider. It specifically found "the alleged Part C Days issue was never part of the group appeal issue statement" and "that the issue statement for the group appeal can only be read to encompass the dual eligible Part A days issue."[71]

The RNPR was issued to implement CMS Rulings 1498-R and 1498-R3, neither of which implement any change to the treatment of Part C Days. The Board has previously rejected this Provider's attempts to implicate the Part C Days issue in their appeals for this FY. The Board hereby dismisses this Provider from the instant appeal.

6. St. Joseph's Medical Center

St. Joseph's Medical Center (Provider No. 33-0006) is appealing an RNPR dated February 25, 2025 for its FYE December 31, 2004. The RNPR was issued "to implement the [PRRB] remand for the SSI Ratio and Dual Eligible Days" and calculated an underpayment of $52,436. The audit adjustments specify that the RNPR was issued "[t]o adjust the SSI ratio and the corresponding allowable DSH percentage in accordance with the PRRB Remand of Case #09-2031G, 09-1496G under the terms of CMS Rulings 1498-R and 1498-R3."

In Case 09-1496G, the Board made a previous **specific** finding that the Part C Days issue was not included in the underlying remand for this Provider. It specifically found "the alleged Part C Days issue was never part of the group appeal issue statement" and "that the issue statement for the group appeal can only be read to encompass the dual eligible Part A days issue."[72]

The RNPR was issued to implement CMS Rulings 1498-R and 1498-R3, neither of which implement any change to the treatment of Part C Days. The Board has previously rejected this Provider's attempts to implicate the Part C Days issue in their appeals for this FY. The Board hereby dismisses this Provider from the instant appeal.

7. Lenox Hill Hospital

Lenox Hill Hospital (Provider No. 33-0119) is appealing an RNPR dated February 4, 2025 for its FYE December 31, 2004. The RNPR was issued "to implement the [PRRB] remands for the SSI

[71] *Id.*
[72] *Id.*

Ratio and Dual Eligible Days" and calculated an underpayment of $245,012. The audit adjustments specify that the RNPR was issued "[t]o adjust the SSI ratio and the corresponding allowable DSH percentage in accordance with the PRRB Remand . . . under the terms of CMS Rulings 1498-R and 1498-R3."

The RNPR was issued to implement CMS Rulings 1498-R and 1498-R3, neither of which implement any change to the treatment of Part C Days. The Board hereby dismisses this Provider from the instant appeal.

8. Health Alliance Hospital Mary's Avenue Campus

Health Alliance Hospital Mary's Avenue Campus (Provider No. 33-0224) is appealing an RNPR dated January 30, 2025 for its FYE December 31, 2004. The RNPR was issued "to implement the [PRRB] remand for the SSI Ratio and Dual Eligible Days" and calculated an underpayment of $9,130. The audit adjustments specify that the RNPR was issued "[t]o adjust the SSI ratio and the corresponding allowable DSH percentage in accordance with the PRRB remand of Case # 08-1779GGC, 08-0693G under the terms of CMS Rulings 1498-R and 1498-R3."

In Case 08-0693G, the Board made a previous **specific** finding that the Part C Days issue was not included in the underlying remand for this Provider. It specifically found "it is clear that the group does not encompass the separate and distinct Part C days issue[.]"[73]

The RNPR was issued to implement CMS Rulings 1498-R and 1498-R3, neither of which implement any change to the treatment of Part C Days. The Board has previously rejected this Provider's attempts to implicate the Part C Days issue in their appeals for this FY. The Board hereby dismisses this Provider from the instant appeal.

C. Remaining Providers

For the remaining Providers in this appeal, the providers all appealed from original and/or revised NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. All the providers in the group appeal were directly added to the groups within 180 days of the issuance of their NPRs and/or RNPRs (or filed a timely individual appeal and were transferred to this case) and the amount in controversy exceeds $50,000.

D. Board's Decision Regarding the EJR Requests

The Board finds that:

1) **Except for** the eight (8) Providers outlined in Section B of the Decision of the Board section of this decision, it has jurisdiction over the Part C Days policy issue, as set forth

[73] Case No. 08-0693G, Board Decision on Request to Rescind Remand and Bifurcate DSH Part C Days Issue at 3-4.

in the June 9, 2023 Final Rule, for the subject years in this case and that the Providers are entitled to a hearing before the Board;

2) Based upon the Providers' assertions regarding the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether the Part C Days policy issue, as adopted on a retroactive basis in the June 9, 2023 Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject years, **except for** the eight (8) Providers outlined in Section B of the Decision of the Board section of this decision.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the appeal and removes it from its docket.

Board Members Participating:

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

FOR THE BOARD:

4/9/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedule of Providers

cc: Danelle Decker, National Government Services, Inc. (J-K)
Scott Berends, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Isaac Blumberg
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RE: ***Expedited Judicial Review Determination***
Case Number: 26-1929 - East Jefferson General Hospital (Provider Number 19-0146)
FYE: 12/31/2013

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's Petition for Expedited Judicial Review ("EJR") filed **March 11, 2026** in the above-referenced individual appeal. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

On **March 3, 2025**, the Board received an individual appeal request from East Jefferson General Hospital (Prov. No. 19-0146) appealing from a revised Notice of Program Reimbursement ("RNPR") dated September 6, 2024 concerning its fiscal year ending ("FYE") December 31, 2013. The Provider's RNPR implements the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule").[1]

The issue in this appeal is the proper treatment in the Medicare disproportionate share hospital ("DSH") adjustment calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days"). The Provider contends that part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction (for patients eligible for Medicaid).[2] The Provider is seeking to challenge the CMS policy adopted in the June 2023 Final Rule to be applied *retroactively* for periods prior to October 1, 2013.[3]

Statutory and Regulatory Background:

Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] Case No. 26-1929, Statement of Issue at 1-2 (Mar. 3, 2025).
[3] *Id*. at 2-5.

program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[4] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[6] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] 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.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[11]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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

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[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[11] (Emphasis added.)
[12] 42 C.F.R. § 412.106(b)(2)-(3).

> 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.[13]

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.[14]

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

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

In the September 4, 1990 Federal Register, the Secretary[15] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[17]

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[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(4).
[15] of Health and Human Services.
[16] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[17] *Id.*

With the creation of Medicare Part C in 1997,[18] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C, and following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[19] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[20] The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[21]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.[22] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[23] In response to a comment regarding this change, the Secretary explained that:

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

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[18] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[19] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[20] *Id.*
[21] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[22] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[23] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).

> *at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[24]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[25] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[26] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[27]

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

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[28]

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[29] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[30] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[31] However, the Secretary has not acquiesced to that decision.

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

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[32] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.[33] A number of hospitals appealed this action.[34] In *Azar v. Allina Health Services* ("*Allina II*"),[35] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[36] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[37] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[38]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[39] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

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

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[32] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[33] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[34] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo**(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board, **pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[35] 139 S.Ct. 1804 (2019).
[36] *Id.* at 1817.
[37] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[38] 139 S.Ct. at 1814.
[39] 85 Fed. Reg. 47723 (Aug. 6, 2020).

> 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[40]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[41] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[42]

Finally, the following excerpts from the June 9, 2023 Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule or subsequent publication of SSI ratios to be an appealable "final determination":

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports***. *In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[43]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the

[40] CMS Ruling 1739-R at 1-2.
[41] 88 Fed. Reg. 37772 (June 9, 2023).
[42] 88 Fed. Reg. at 37788 (emphasis in original).
[43] 88 Fed. Reg. at 37774-75 (emphasis added).

time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[44]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically."[45]

4. "*When the Secretary's treatment of Part C days in this final action is reflected* ***in NPRs and revised NPRs****, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation* ***by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[46]

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

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are "entitled to [Part A] benefits" within the context of 42 U.S.C.§ 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.[47] It ruled, however, that the June 9, 2023 Final Rule is both impermissibly retroactive[48] and arbitrary and capricious.[49] The court ordered the parties to submit briefs on whether vacatur is the appropriate remedy for the situation, which have since been filed.[50]

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[44] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[45] *Id.* at 37788 (emphasis added).
[46] *Id.* (emphasis added).
[47] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).
[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.

Providers' Position:

A. Provider's Appeal Request

The Provider's appeal request argues that Medicare Part C days "should be reflected in the Medicaid percentage rather than the Medicare/SSI Fraction."[51] They seek to invalidate the Final Rule published on June 9, 2023 and the SSI Ratio published thereafter to implement the Final Rule.[52] The Provider argues that the Final Rule is contrary the statutory language of 42 U.S.C. § 1395ww(d)(5)(F)(vi) and that Secretary's interpretation of this statute deserves no deference following the Supreme Court's decision in *Loper Bright.*[53]

The Provider recounts how, prior to 2004, CMS did not include Part C Days in the SSI Ratio, along with the subsequent rulemaking and litigation which can be outlined as follows:

1. In the FY 2005 IPPS Final Rule, CMS first announced a policy change to count Part C days in the SSI fraction and to exclude those days from the numerator of the Medicaid fraction.

2. In *Allina I*, the D.C. Circuit vacated that policy change.

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking.

4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.

Based on the above, the Providers maintain that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule is substantively and procedurally invalid and must be set aside because it is contrary to law, arbitrary and capricious, and *per se* unreasonable.[54]

B. Provider's Petition for EJR

The Provider requested EJR over the post-*Allina* retroactive Part C policy issue outlined above. They argue that they filed their appeals within 180 days of the issuance of their RNPRs; that the amount in controversy exceeds $10,000; that they challenge the validity of the June 2023 Final Rule; and that the Board cannot grant this relief because it is bound by the policy.[55] They note

[51] Case No. 26-1929, Statement of Issue at 1.
[52] *Id.* at ¶ 3.
[53] *Id.* at ¶¶ 4-5 (citing *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024)).
[54] *Id.* at ¶¶ 6-18.
[55] Case No. 26-1929, Provider's Petition for Expedited Judicial Review at 1-4 (Mar. 11, 2026).

that the June 2023 Final Rule affords appeal rights from RNPRs implementing the retroactive Part C Days policy even if a Provider's SSI Ratio does not change numerically.[56]

On **March 18, 2026**, the Medicare Contractor's representative, Federal Specialized Services ("FSS"), filed a response to the Requests for EJR simply advising that "the MAC will not file a jurisdictional challenge. The MAC will not file a substantive claim challenge."[57]

Decision of the Board:

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

A. Jurisdiction

An individual Provider generally has a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if

- It is dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing is filed within 180 days of the date of receipt of the final determination. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination;[58] and
- The amount in controversy is $10,000 or more.[59]

The Provider appealed from a revised NPR which implements the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. The Provider's appeal was filed within 180 days of the issuance of its RNPR and the amount in controversy exceeds $10,000.

The Board finds that the Provider has filed a timely appeal from its revised NPR concerning the issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these RNPRs. The Board also finds that the amount in controversy exceeds $10,000, as required by 42 C.F.R. § 405.1839(a)(1). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9th, 2023 Final Rule, invalid.

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[56] *Id.* at 11.
[57] Response to Provider's Request for Expedited Judicial Review at 1 (Mar. 18, 2026).
[58] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[59] 42 U.S.C. § 1395oo(a)(2); 42 C.F.R. §§ 405.1835 – 1840.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject year and that the Provider is entitled to a hearing before the Board;

2) Based upon the Provider's assertions regarding the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether the Part C Days policy issue, as adopted on a retroactive basis in the June 9, 2023 Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue in Case 26-1929.

The Provider has 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 Case 26-1929, the Board hereby closes it and removes it from its docket

Board Members Participating:

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

FOR THE BOARD:

4/9/2026

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)
Scott Berends, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Isaac Blumberg
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RE: ***Request for Reconsideration of Decision Not to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue Issued December 20, 2023***

Case Number: 07-0420G - Blumberg-Ribner 2000/2002 Dual Eligibles 2nd Group

Dear Mr. Blumberg,

The Provider Reimbursement Review Board ("Board") has reviewed the Request for Reconsideration of Decision Not to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue Issued December 20, 2023, submitted by Blumberg Ribner ("Group Representative") on behalf of the Group participants, on February 12, 2024. The decision of the Board Majority is set forth below.

Pertinent Facts:

On **November 6, 2006**, the Board received the group appeal request. The complete issue statement in the group appeal request reads:

> [DSH] Adjustment – The Provider contend that their respective DSH adjustments are understated due to the exclusion from the Medicaid proxy calculation of certain days relating to patients dually eligible for both Medicaid and Medicare. Further, the Providers assert that the HCFA Administrator's decision pertaining to said days in *Edgewater Medical Center v. Blue Cross and Blue Shield of Illinois* (June 19, 2000) is inconsistent with applicable Medicare Regulations.[1]

By letter dated **April 30, 2014**, ***the Board identified this case as subject to remand under CMS Ruling 1498-R*** and requested that, because the Board needed to first make a jurisdictional determination, ***the Group Representative submit a Schedule of Providers and associated jurisdictional documents***.

The Board received this documentation from the Group Representative on **August 11, 2014.**

[1] Initial Request for PRRB Group Appeal at 2 (Nov. 6, 2006).

On **December 2, 2015**, the Board issued a jurisdictional determination, and subsequently, remanded the remaining participants based on CMS Ruling 1498-R, and the appeal was closed.

On **May 16, 2016**, the Board received a letter from Blumberg Ribner requesting Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days issue. The Providers argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[2]

On **December 20, 2023**, the Board declined to exercise its discretion to reopen and reinstate Case No. 07-0420G and denied the request for reinstatement and rescission of remand in order to bifurcate a single participant from the group appeal regarding the Part C Days issue.

Provider Group's Position:

On **February 12, 2024**, the Group Representative submitted a request to reconsider the December 20, 2023 decision denying reinstatement and rescission of remand.

The Group Representative argues "[t]he Board's reasoning that the "instant appeal did not include Part C Days" is incorrect, contradictory to prior decisions of the Board expressly stating that identical appeals did include Part C Days. . ."[3] The Group Representative also argues that by denying the request while reinstating in other "nearly identical circumstances is arbitrary and capricious."[4] The Provider argued that the same material facts are present in the instant appeal as in Case No. 20-1976G,[5] a case granted reinstatement and bifurcation; specifically that "Part C Days were necessarily part of the appeal, but were not appropriate to have been identified as such at the time."[6]

The Group Representative also argues that the Board's reasoning of the abandonment of the Part C Days issue at the time of the December 2, 2015 remand is also being used arbitrarily and capriciously.[7] As evidence, the Group Representative points to Case Nos. 20-1976G,[8] 17-2284G,[9] and 07-1463.[10] The Group Representative argues that the Request for Reinstatement and Bifurcation acted as the notice to the Board of the need to separate the Part C Days issue, that this request was timely filed, and whether the Group Representative notified the Board prior to the remand or through the reinstatement request "is not germane."[11]

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[2] Request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal Regarding DSH Part C Days Issue Letter at 1 (May 16, 2016).
[3] Reconsideration Request Letter at 1 (Feb. 12, 2024). Note: While every first letter of each word was capitalized in the letter, this has been updated in this document and notated here for readability.
[4] *Id*. at 3.
[5] Bifurcated from Case No. 03-0419G.
[6] Reconsideration Request Letter at 2.
[7] *Id*. at 4.
[8] Bifurcated from Case No. 03-0419G.
[9] Bifurcated from Case No. 06-0092G.
[10] Reconsideration Request Letter at 4.
[11] *Id*.

The Group Representative has also included a corrected affidavit, as the Board noted in their prior denial that the affidavit included was not for the case at issue. The Group Representative has requested "relief as necessary to augment the Board's record with the corrected affidavit, which was inadvertently omitted at the time of the initial request for bifurcation and reinstatement."[12]

Finally, the Group Representative summarizes that at the time the appeal was submitted, there was no "litigation or other CMS issuances that made clear the separateness of the DSH Part C Day issues from DSH dual eligible days issue"[13], and that the Board has permitted the reinstatement and bifurcation of the Part C Days issue for other providers so to deny in the instant appeal is arbitrary and capricious.[14]

Board Majority's Analysis and Decision:

The Board Majority finds that there are important procedural differences between this appeal and the appeals that the Providers cite to that were reinstated and in which the Part C Days issue was bifurcated for the purposes of remand under CMS Ruling 1739-R. In the instant appeal, on April 30, 2014, the Board notified the Group Representative that the Board was identifying this case as subject to remand under CMS Ruling 1498-R, a ruling that does not pertain to the Part C Days issue. On August 11, 2014, the Group Representative submitted a Schedule of Providers necessary for a jurisdictional determination of all participants prior to a Board decision on the remand under CMS Ruling 1498-R. The case was remanded and closed on December 2, 2015. The Provider did not, at the time of the Board's request for the Schedule of Providers, or at the time it submitted that Schedule, identify that the group potentially contained more than one issue.

It was on May 16, 2016, nearly two (2) years after the Board had notified the Group Representative that the optional group case should be remanded under CMS Ruling 1498-R, that they requested bifurcation on the issues. Therefore, there is nothing arbitrary and capricious about the Board's denial of reinstatement and bifurcation.

Rules in place at the time of the Board's December 2, 2015 remand action required specificity as to issues and were referenced in the Board's denial of reinstatement. The denial letter referred to "minimum content for individual appeal requests (42 C.F.R. § 405.1835(b) (2009)," which reads, in part:

> (2) An explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of all of the following:

[12] *Id*. at 5.
[13] *Id*.
[14] *Id*. at 6.

> (i) Why the provider believes Medicare payment is incorrect *for each disputed item . . .*[15]
>
> (ii) How and why the provider believes Medicare payment must be determined differently *for each disputed item*.[16]

Board Rules have also long required that providers include identification of the issues in dispute with specificity:

> Your hearing request must include an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for contending the findings and conclusions are incorrect . . . You must clearly and specifically identify your position in regard to the issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not definite the issue as "DSH". You must precisely identify the component of the DSH issue that is in dispute.[17]

While the Group Representative has argued this rule was not in place at the time of the appeal request,[18] the Board Majority finds that it is relevant to the decision at hand and that the Group Representative is incorrect because that rule was in place at the time of the Board's April 30, 2014 letter notifying of potential remand action subject to CMS Ruling 1498-R and the Board's December 2, 2015 remand action.

Additionally, the instant appeal is a group appeal and therefore, providers may only appeal a single issue under 42 C.F.R. § 405.1837 (2008):

> (a) Right to Board hearing as part of a group appeal; criteria. A provider (but no other individual, entity, or party) has a right to a Board hearing, as part of a group appeal with other providers, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination for the period only if—
>
> . . .

[15] (Emphasis added).
[16] 42 C.F.R § 405.1835(b)(1)-(2) (emphasis added.)
[17] Provider Reimbursement Review Board, Part I, B, II. (March 1, 2002).
[18] Reconsideration Request Letter at 2.

> (2) ***The matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group*** . . .[19]

According to their own timeline of events, the Group Representative has essentially argued that the issue statement at the time of the appeal included both Dual Eligible Days and Part C Days. Later, the Group Representative was put on alert by the Board of the remand of its group issue under 1498-R in 2014, which pertains only to the Dual Eligible Days issue. Finally, after the Board remanded the case under 1498-R in late 2015, the Group Representative requested reinstatement in May 2016 and bifurcation of the Part C Days issue because the Part C Days issue was a part of the appeal all along. The Board Majority emphasizes that the issue-specificity requirements were in place when the Providers were filing various requests in this group, and the regulation requiring a group to have only one issue has been in place since the group appeal was filed. Therefore, the Board Majority ***denies*** the Provider's request for reconsideration.

Board Members Participating:

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

For the Board:

4/13/2026

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
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)

[19] (Emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Boulevard, Suite 700
Los Angeles, CA 90064-1582

RE: ***Request for Reconsideration of Decision Not to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue Issued December 15, 2023***

Blumberg Ribner Independent Hosps Pre-10/1/2004 Dual Eligible Days Group II
Case Number: 09-1496G

Dear Mr. Blumberg,

The Provider Reimbursement Review Board ("Board") has reviewed the Request for Reconsideration of Decision Not to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue Issued December 15, 2023 submitted by Blumberg Ribner ("Group Representative") on behalf of the Group participants submitted on February 12, 2024. The decision of the Board Majority is set forth below.

Pertinent Facts:

On **July 22, 2008**, the Board received the group appeal request. The entire description for the Medicare/Medicaid Dual Eligible Patient Days issue reads:

> Dual Eligible Days Issue – Dual Eligible Days are patient days associated with those patients who were not included in the SSI denominator by CMS' design as they were not directly billed to Medicare and did not flow through the MEDPAR system via Fee For Service Medicare Part-A. Moreover, these days were disallowed from the Medicaid numerator as well. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with the undisputed indigent population. As the days represent patient who were Medicaid Eligible but not Medicare Entitled, the Provider contends that these days should be included in the Medicaid fraction.
>
> Dual Eligible Days were excluded from the Medicaid fraction for a variety of reasons. By way of example, certain Dual Eligible Days are days associated with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL.) v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held

> The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. *See Jersey Shore Medical Center v. Blue Cross and Blue Shield of New Jersey*, PRRB Case No. 99-D4, Medicare and Medicaid Guide (CCH) ¶80,083, October 30, 1998, *vacated and remanded*, HCFA Administrator, January 4, 1999, Medicare and Medicaid Guide (CCH) ¶80,153 ("*Jersey*").
>
> Thus, in accordance with the Board's holding in the Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days".

By letter dated **June 24, 2010**, Blumberg Ribner identified this case as subject to remand under CMS Ruling 1498-R, and as a result, notified the Board it would not submit its Preliminary Position Paper by the July 1, 2010 filing deadline and requested standard remand under 1498-R.

On **November 13, 2015**, the Board, on its own motion, bifurcated the period from 10/1/2004-12/31/2004 and established a new group appeal for that period (16-0206G), which was not subject to 1498-R Remand. The period prior to 10/1/2004 remained in the appeal.

On **December 30, 2015**, the Board remanded the group appeal of DSH dual eligible days based on CMS Ruling 1498-R, and the appeal was closed.

On **June 2, 2016**, the Board received a letter from Blumberg Ribner requesting Recission of Remand and Bifurcation of Group Appeal regarding DSH Part C Days issue. The Providers argue that the references to dual eligible patient days were "intended to refer to persons eligible for Part A and Part C."[1]

On **December 15, 2023**, the Board declined to exercise its discretion to reopen and reinstate PRRB Case No. 09-1496G and denied the request for reinstatement and rescission of remand in order to bifurcate a single participant from the group appeal regarding the Part C Days issue.

Provider Group's Position:

On **February 12, 2024**, the Group Representative requested that the Board reconsider its December 15, 2023 decision denying reinstatement and rescission of remand.

The Group Representative argues "[t]he Board's reasoning that the "instant appeal did not include Part C Days" is incorrect, contradictory to prior decisions of the Board expressly stating that identical appeals did include Part C Days. . ."[2] The Group Representative also argues that by denying the request while reinstating in other "nearly identical circumstances is arbitrary and

[1] Bifurcation Request Letter at 1 (May 27, 2016).
[2] Reconsideration Request Letter at 1 (Feb. 9, 2024). Note: While every first letter of each word was capitalized in the letter, this has been updated in this document and notated here for readability.

capricious."[3] The Provider argued that the same material facts are present in the instant appeal as in Case No. 20-1976G,[4] a case granted reinstatement and bifurcation; specifically that Part C Days were "necessarily part of the appeal, but were not appropriate to have been identified as such at the time."[5]

They also argue that the Board's reasoning of the abandonment of the Part C Days issue at the time of the December 30, 2015 remand is also being used arbitrarily and capriciously.[6] As evidence, the Group Representative points to Case Nos. 20-1976G,[7] 17-2284G,[8] and 07-1463.[9] The Group Representative argues that the Request for Reinstatement and Bifurcation acted as the notice to the Board of the need to separate the Part C Days issue, that this request was timely filed, and whether the Group Representative notified the Board prior to the remand or through the reinstatement request "is not germane."[10]

The Group Representative has also included a corrected affidavit, as the Board noted in their prior denial that the affidavit included was not for the case at issue. The Group Representative has requested "relief as necessary to augment the Board's record with the corrected affidavit, which was inadvertently omitted at the time of the initial request for bifurcation and reinstatement."[11]

Finally, the Group Representative summarizes that at the time the appeal was submitted, there was no "litigation or other CMS issuances that made clear the separateness of the DSH Part C Day issues from DSH dual eligible days issue"[12], and that the Board has permitted the reinstatement and bifurcation of the Part C Days issue for other providers so to deny in the instant appeal is arbitrary and capricious.[13]

Board Majority's Analysis and Decision:

The Board Majority finds that there are important procedural differences between this appeal and the appeals that the Providers cite to that were reinstated and in which the Part C Days issue was bifurcated for the purposes of remand under CMS Ruling 1739-R. In the instant appeal, on June 24, 2010, the Group Representative wrote to the Board identifying this case as subject to remand under CMS Ruling 1498-R, a ruling that does not pertain to the Part C Days issue. On November 13, 2015, the Board notified the Group Representative that the periods of the instant appeal that were not subject to 1498-R Remand were being bifurcated into a new case. The case

[3] *Id*.
[4] Bifurcated from Case No. 03-0419G.
[5] Reconsideration Request Letter at 2.
[6] *Id*. at 3.
[7] Bifurcated from Case No. 03-0419G.
[8] Bifurcated from Case No. 06-0092G.
[9] Reconsideration Request Letter at 4.
[10] *Id*.
[11] *Id*. at 5.
[12] *Id*.
[13] *Id*. at 6.

was remanded and closed on December 30, 2015. Finally, on June 2, 2016, the Group Representative requested to reinstate the case in order to bifurcate the Part C Days issue.

This bifurcation request was submitted nearly six (6) years after the Group Representative had notified the Board that the optional group case should be remanded under CMS Ruling 1498-R. Further, the June 24, 2010 letter requesting remand of the group appeal distinguishes the instant appeal from the cases cited by the Group Representative in their Request for Reconsideration. No such request appears in the other case files, and therefore, the Provider's request for remand was the catalyst to determine the issue as solely related to CMS Ruling 1739-R and therefore appropriate for remand and closure. Thus, there is nothing arbitrary and capricious about the Board's denial of reinstatement and bifurcation.

Rules in place at the time of both June 24, 2010 letter and the Board's December 30, 2015 remand action required specificity as to issues and were referenced in the Board's denial of reinstatement:

> As pointed out in the rescission and bifurcation request, regulations and Board rules require specificity with regards to each item under appeal. 42 C.F.R. § 405.1835(b)(2) (2009) reads, in part:
>
> > (2) An explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of the following:
> >
> > (i) Why the provider believes Medicare payment is incorrect *for each disputed item* . . .[14]
> >
> > (ii) How and why the provider believes Medicare payment must be determined differently *for each disputed item*.[15]
>
> Board Rules have also long required that providers include identification of the issues in dispute with specificity:
>
> > Your hearing request must include an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for contending the findings and conclusions are incorrect . . . You must clearly and specifically identify your position in regard to the issues in dispute. For instance, if you are appealing an aspect of the

[14] (Emphasis added).
[15] 42 C.F.R § 405.1835(b)(1)-(2) (emphasis added.)

> disproportionate share (DSH) adjustment factor or calculation, do not definite the issue as "DSH". You must precisely identify the component of the DSH issue that is in dispute.[16]

While the Group Representative has argued this rule was not in place at the time of the appeal request,[17] the Board Majority finds that it is relevant to the decision at hand and that the Group Representative is incorrect because that rule was in place at the time of the Group Representative's June 24, 2010 letter requesting remand and the Board's December 30, 2015 remand action.

Additionally, the instant appeal is a group appeal and therefore, providers may only appeal a single issue under 42 C.F.R. § 405.1837 (2008):

> (a) Right to Board hearing as part of a group appeal; criteria. A provider (but no other individual, entity, or party) has a right to a Board hearing, as part of a group appeal with other providers, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination for the period only if—
>
> . . .
>
> (2) ***The matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group*** . . .[18]

According to their own timeline of events, the Group Representative has essentially argued that the issue statement at the time of the appeal (2008) included both Dual Eligible Days and Part C Days. Later, the Group Representative requested remand of its group issue under 1498-R in 2010, which pertains only to the Dual Eligible Days issue. Finally, after the Board remanded the case under 1498-R in late 2015, the Group Representative requested reinstatement in May 2016 and bifurcation of the Part C Days issue because the Part C Days issue was a part of the appeal all along. The Board Majority emphasizes that the issue-specificity requirements were in place when the Providers were filing various requests in this group, and the regulation requiring a group to have only one issue has been in place since the group appeal was filed. Therefore, the Board Majority ***denies*** the Provider's request for reconsideration.

---

[16] Provider Reimbursement Review Board, Part I, B, II. (March 1, 2002).
[17] Reconsideration Request Letter at 2.
[18] (Emphasis added).

Board Members Participating:

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

For the Board:

4/13/2026

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
Danelle Decker, National Government Services, Inc. (J-K)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Isaac Blumberg
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RE: ***Expedited Judicial Review Determination***
Case Number: 26-0160 - UT Health East Texas Athens Hospital (Provider Number 45-0389)
FYE: 04/30/2013

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petition for Expedited Judicial Review ("EJR") filed **March 16, 2026** in the above-referenced individual appeal. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

On **October 20, 2025**, the Board received an individual appeal request from UT Health East Texas Athens Hospital (Prov. No. 45-0389) appealing from a revised Notice of Program Reimbursement ("RNPR"), dated April 23, 2025, concerning its Fisal Year Ending ("FYE") April 30, 2013. The Provider's RNPR implements the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule").[1]

The issue in this appeal is the proper treatment in the Medicare disproportionate share hospital ("DSH") adjustment calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days"). The Provider contends that part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction (for patients eligible for Medicaid).[2] The Provider is seeking to challenge the CMS policy adopted in the June 2023 Final Rule to be applied *retroactively* for periods prior to October 1, 2013.[3]

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] Statement of Issue (CMS 1739R Challenge issue) at 1 (Oct. 20, 2025).
[3] *Id.* at 2-5.

program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[4] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[6] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] 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.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[11]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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

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[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[11] (Emphasis added.)
[12] 42 C.F.R. § 412.106(b)(2)-(3).

> 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.[13]

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.[14]

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

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

In the September 4, 1990 Federal Register, the Secretary[15] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[17]

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[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(4).
[15] of Health and Human Services.
[16] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[17] *Id.*

With the creation of Medicare Part C in 1997,[18] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C, and following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[19] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[20] The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[21]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.[22] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[23] In response to a comment regarding this change, the Secretary explained that:

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

[18] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[19] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[20] *Id.*
[21] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[22] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[23] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).

> *at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[24]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[25] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[26] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[27]

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

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002 but did not address whether it could be applied to later years or whether the interpretation was reasonable.[28]

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[29] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[30] In vacating the final rule, it reasoned that this deprived the public of adequate

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

opportunity for notice and comment before the final rule was promulgated in 2004.[31] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[32] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.[33] A number of hospitals appealed this action.[34] In *Azar v. Allina Health Services* ("*Allina II*"),[35] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[36] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[37] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[38]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[39] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement

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[31] *Id.* at 2011.
[32] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[33] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[34] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo****(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board, **pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[35] 139 S.Ct. 1804 (2019).
[36] *Id.* at 1817.
[37] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[38] 139 S.Ct. at 1814.
[39] 85 Fed. Reg. 47723 (Aug. 6, 2020).

> (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[40]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[41] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[42]

Finally, the following excerpts from the June 9, 2023 Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule or subsequent publication of SSI ratios to be an appealable "final determination":

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports***. *In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[43]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court

[40] CMS Ruling 1739-R at 1-2.
[41] 88 Fed. Reg. 37772 (June 9, 2023).
[42] 88 Fed. Reg. at 37788 (emphasis in original).
[43] 88 Fed. Reg. at 37774-75 (emphasis added).

decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[44]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically."[45]

4. "*When the Secretary's treatment of Part C days in this final action is reflected* ***in NPRs and revised NPRs****, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation* ***by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[46]

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

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are "entitled to [Part A] benefits" within the context of 42 U.S.C.§ 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.[47] It ruled, however, that the June 9, 2023 Final Rule is both impermissibly retroactive[48] and arbitrary and capricious.[49] The court ordered the parties to submit briefs on whether vacatur is the appropriate remedy for the situation, which have since been filed.[50]

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[44] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[45] *Id.* at 37788 (emphasis added).
[46] *Id.* (emphasis added).
[47] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).
[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.

Provider's Position:

A. Provider's Appeal Request

The Provider's appeal request argues that Medicare Part C days "should be reflected in the Medicaid percentage rather than the Medicare/SSI Fraction."[51] It seeks to invalidate the Final Rule published on June 9, 2023 and the SSI Ratio published thereafter to implement the Final Rule.[52] The Provider argues that the Final Rule is contrary to the statutory language of 42 U.S.C. § 1395ww(d)(5)(F)(vi) and that Secretary's interpretation of this statute deserves no deference following the Supreme Court's decision in *Loper Bright.*[53]

The Provider recounts how, prior to 2004, CMS did not include Part C Days in the SSI Ratio, along with the subsequent rulemaking and litigation which can be outlined as follows:

1. In the FY 2005 IPPS Final Rule, CMS first announced a policy change to count Part C days in the SSI fraction and to exclude those days from the numerator of the Medicaid fraction.

2. In *Allina I*, the D.C. Circuit vacated that policy change.

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking.

4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.

Based on the above, the Provider maintains that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule is substantively and procedurally invalid and must be set aside because it is contrary to law, arbitrary and capricious, and *per se* unreasonable.[54]

B. Provider's Petition for EJR

The Provider has requested EJR over the post-*Allina* retroactive Part C policy issue outlined above. It argues that it filed its appeal within 180 days of the issuance of its RNPR; that the amount in controversy exceeds $10,000; that it challenges the validity of the June 2023 Final Rule; and that the Board cannot grant this relief because it is bound by the policy.[55] It notes that the June 2023 Final Rule affords appeal rights from RNPRs implementing the retroactive Part C Days policy even if a Provider's SSI Ratio does not change numerically.[56]

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[51] Statement of Issue (CMS 1739F Challenge issue) at 1.
[52] *Id.* at ¶ 3.
[53] *Id.* at ¶¶ 4-5 (citing *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024)).
[54] *Id.* at ¶¶ 6-18.
[55] Provider's Petition for Expedited Judicial Review at 1-4 (Mar. 16, 2026).
[56] *Id.* at 11.

On **March 18, 2026**, the Medicare Contractor's representative, Federal Specialized Services ("FSS"), filed a response to the Request for EJR simply advising that "the MAC will not fie a jurisdictional challenge. The MAC will not file a substantive claim challenge."[57]

Decision of the Board:

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

A. Jurisdiction

An individual Provider generally has a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if

- It is dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing is filed within 180 days of the date of receipt of the final determination. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination;[58] and
- The amount in controversy is $10,000 or more.[59]

This Provider appealed from a revised NPR which implements the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. The Provider's appeal was filed within 180 days of the issuance of the RNPR and the amount in controversy exceeds $10,000.

The individual appeal contains two separate "issues" – one a specific challenge over whether Part C Days should be in the Medicaid or Medicare Fraction, and a second which seeks attorney's fees and interest for the years of delay in tendering the Provider's DSH reimbursement. The second, separate "unreasonable delay" issue specifically states:

> **The issue in this Appeal is UNREASONABLE DELAY: whether DSH reimbursement for Providers' year in this appeal has been unreasonably delayed, should be made without further delay under the long-standing rulings of the *Northeast Decision, Allina I* and *Allina***

[57] Response to Provider's Request for Expedited Judicial Review at 1 (Mar. 18, 2026).
[58] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[59] 42 U.S.C. § 1395oo(a)(2); 42 C.F.R. §§ 405.1835 – 1840.

> ***II*, and should include payment of attorney fees and interest for all the years of delay, as provided in 42 U.S.C. § 1395oo(f)(2).**[60]

The Part C Days issue statement has an entire section dedicated to the same arguments,[61] with a heading which reads:

> **Unreasonable Delay: Administration of these claims, as required by *Allina I, Northeast Hospital, and Allina II*, has been long and unreasonably delayed since 2010**

This issue also seeks Provider's DSH payment and "payment of attorney fees and interest for all the years of delay, as provided in 42 U.S.C. § 1395oo(f)(2)."[62]

Since this argument for attorney's fees and interest is encompassed within the Part C Days issue, and the Board is granting EJR over that issue in its entirety, the "separate" Unreasonable Delay issue is hereby ***dismissed*** from the case as duplicative.

Similarly, though it is not specifically identified as such within the appeal request or listed issues, the Board notes that the Part C Days issue also encompasses a *third*, multi-faceted issue: "SSI Data Problems Abound in the Calculation of the Medicare Fraction (SSI Ratio)."[63] In reality, the arguments made on this topic encompass several distinct issues. Indeed, arguments are made about the interpretation of "entitled to SSI benefits," an issue which was finally settled by *Advocate Christ* (which specifically rejected the Providers' arguments),[64] and the use of only three SSI status codes in determining SSI entitlement.[65] There are also arguments made that CMS is in violation of MMA § 951,[66] which mandates that CMS must give hospitals the information necessary to compute the number of patient days used in computing their DPPs.[67] These arguments were raised within the issue statement for the Part C Days challenge but are distinct and unrelated to that issue. They concern completely different legal authorities and their potential impact on a Provider's DSH payment is distinct and unrelated to the treatment of Part C Days.

Board Rule 8 requires that multiple components of issues be "described as narrowly as possible." To the extent that the Provider wished to include legal challenges related to *Advocate Christ*, MMA § 951, or any other SSI DSH issue in the appeal, they should have been raised, briefed, and argued as separate issues. Additionally, the Board notes that the Revised NPR being appealed made no change to the Provider's SSI percentage and was issued solely to implement the retroactive Part C Days rule. Since no adjustment was made related to the SSI percentage

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[60] Statement of Issue (Unreasonable Delay) at 1.
[61] Statement of Issue (CMS 1739R Challenge issue) at ¶¶ 19-24.
[62] *Id.* at ¶ 19.
[63] *Id.* at ¶¶ 25-35.
[64] *Advocate Christ Med. Ctr. v. Kennedy*, 145 S.Ct 1262, 1274 (2025).
[65] Statement of Issue (CMS 1739R Challenge issue) at ¶ 26.
[66] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173, § 951, 117 Stat. 2066, 2427 (2003).
[67] Statement of Issue (CMS 1739R Challenge issue) at ¶ 29.

that would implicate any issues related to SSI Data Matching, *Advocate Christ*, or MMA § 951, the Board lacks jurisdiction over these portions of the Part C Days issue statement[68] and hereby dismisses them from the appeal.

The Board finds that the Provider in Case 26-0160 has filed a timely appeal from its revised NPR concerning the issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from this RNPR. The Board also finds that the amount in controversy exceeds $10,000 as required by 42 C.F.R. § 405.1839(a)(1). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject year in Case 26-0160 and that the Provider is entitled to a hearing before the Board;

2) The "Unreasonable Delay" issue in this appeal is duplicative of the arguments raised in the Part C Days issue and the second, separate issue in the appeal is hereby dismissed;

3) The SSI Data Problems arguments raised in the Part C Days Appeal[69] are beyond the scope of the Board's jurisdiction from the RNPR being appealed and are hereby dismissed from the appeal;

4) Based upon the Provider's assertions regarding the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, there are no findings of fact for resolution by the Board;

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 question of whether the Part C Days policy issue, as adopted on a retroactive basis in the June 9, 2023 Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, properly 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 year.

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[68] 42 C.F.R. § 405.1889(b).
[69] Statement of Issue (CMS 1739R Challenge issue) at ¶¶ 25-35.

The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since the Board is dismissing the second Unreasonable Delay issue in this appeal and no other issues will remain in the case, the Board hereby closes the case and removes it from its docket.

Board Members Participating:

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

FOR THE BOARD:

4/13/2026

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)
Scott Berends, Federal Specialized Services

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RE: ***Board Decision in Whole – Dismissal of DSH Payment/SSI Percentage (Provider Specific)***
IU Health LaPorte Hospital (Provider No. 15-0006)
FYE 12/31/2018
Case No. 23-0279

Dear Mr. Ravindran and Mr. Lamprecht,

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

Background:

A. *Procedural History for Case No. 23-0279*

On **June 10, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2018.

On **November 21, 2022**, the Board received the Provider's individual appeal request. The Appeal Request was filed by Community Health Systems, Inc. ("CHS") and included five (5) issues:

1. DSH Pymt/SSI % (Provider Specific)
2. DSH/SSI - Unduly Narrow Definition of SSI Entitlement
3. DSH Pymt - Medicaid Eligible Days
4. Medicare Managed Care Part C – SSI & Medicaid Fractions
5. Dual Eligible Days – SSI & Medicaid Fractions

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 **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 (*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.[1]

On **March 24, 2023**, a Critical Due Dates notification was issued assigning new PPP deadlines.

On **June 9, 2023,** CHS transferred Issues 2, 4 and 5 to CIRP groups. As a result, there were two (2) remaining issues in this appeal: DSH Pymt/SSI % (Provider Specific) and DSH Pymt - Medicaid Eligible Days. *The Medicaid Eligible Days issue was subsequently withdrawn on June 10, 2024.*

On **July 5, 2023**, CHS filed the Provider's PPP.

On **August 24, 2023**, the Medicare Contractor ("MAC") filed a Jurisdictional Challenge over the DSH Pymt/SSI % (Provider Specific) (*and DSH Pymt - Medicaid Eligible Days issues- which again, was withdrawn.)*

On **August 31, 2023** CHS requested that Quality Reimbursement Services, Inc. ("QRS") be appointed the representative which the Board acknowledged the following day.

On **October 16, 2023,** the MAC filed its PPP.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 21-1206GC

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

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

[1] (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.[2]

The group issue statement in Case No. 21-1206GC, CHS CY 2018 DSH SSI Percentage CIRP Group, to which the Provider transferred Issue 2 reads, in part:

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

[2] Issue Statement at 1 (Nov. 21, 2022).

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.

COVERED DAYS VS. TOTAL DAYS

The statutory language defines the Medicare/SSI fraction as consisting solely of days for patients who were "entitled to benefits under part A" of Medicare. The numerator includes only those Part A days for patients who are also entitled to SSI benefits. The denominator of the Medicare/SSI fraction includes all Part A days. As set forth in the statutory language above, the numerator of the Medicaid fraction consists of days of patients who were both eligible for medical assistance under Title XIX, or Medicaid, and not entitled to benefits under Part A of Title XVII, or Medicare. The denominator for the Medicaid fraction is the hospital's total patient days for the period.

CMS considers an individual to be "entitled to benefits under Part A" regardless of whether the days were "covered" or paid by Medicare. This means that now Part C days, Exhausted Benefit days, and Medicare Secondary Payer ("MSP") days are included in the denominator of the Medicare/SSI fraction even when there is no payment by Medicare, which is a departure from the treatment of these days as excluded from the Medicare/SSI fraction prior to the 2004 rule.

The Provider(s) contend(s) that if CMS includes unpaid Medicare Part A days in the denominator of the Medicare/SSI fraction, then unpaid SSI eligible patient days must be included in the numerator of the Medicare/SSI fraction, utilizing SSI payment codes that reflect the individuals' eligibility for SSI – even if the individuals did not receive SSI payments, as a matter of statutory consistency.[3]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $33,360.

[3] Group Appeal Issue Statement in Case No. 21-1206GC.

On July 5, 2023, the Provider filed its PPP in Case No. 23-0279. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Issue #1: Provider Specific**
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[4]

MAC's Contentions

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

In its jurisdictional challenge, the MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (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 the SSI Systemic Errors issue under appeal in Group Case 21-1206GC

The MAC also contends that the component related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[5] Finally, the MAC asserts that the Provider

[4] Provider's Preliminary Position Paper at 8-9 (Jul. 5, 2023).
[5] MAC's Jurisdictional Challenge at 2 (Aug. 24, 2023).

did not file a complete preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3.[6]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[7] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

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

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

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider's disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 21-1206GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[8] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance

[6] MAC's Jurisdictional Challenge at 9 (Aug. 24, 2023).
[7] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[8] Issue Statement at 1.

with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[9] 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."[10]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 21-1206GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 21-1206GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[11], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[12] Accordingly, Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, 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 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 21-1206GC.

To this end, the Board also reviewed the Provider's PPP to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 21-1206GC but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's PPP failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its PPP and include *all* exhibits.

---

[9] *Id.*
[10] *Id.*
[11] PRRB Rules v. 3.1 (Nov. 2021).
[12] 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).

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[13]

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") 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.[14]

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the issue under appeal in the Group Case 21-1206GC are the same issue.[15] Because

[13] (Emphasis added).
[14] Last modified March 17, 2026.
[15] 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 CHS CIRP group per 42 C.F.R. § 405.1837(b)(1).

the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

Additionally, in its PPP, the Provider states, "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 [sic] (Appellants' reply brief included as Exhibit P-3)." The Board finds that this incorporation by reference does not comply with the regulatory and Board rule requirements to *fully* develop the Provider's position in the PPP. Particularly, 42 C.F.R. § 405.1853 provides 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*.[16]

An incorporation of arguments by reference from a different case simply fails to do so. Accordingly, the Board dismisses that portion of the issue as well.

2. Second Aspect of Issue 1

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

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Moreover, without this written request, the Medicare Contractor 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 Medicare Contractor 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.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 21-1206GC and because the purported realignment portion of the issue is premature in absence of a properly submitted written realignment request subject to a final determination from which the Provider can appeal.

[16] (Emphasis added).

As no issues remain pending, the Board hereby closes Case No. 23-0279 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

4/16/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: 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: ***Notice of Dismissal***
Starke Hospital (Prov. No. 15-0102), FYE 12/31/2019
Case No. 23-1666

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-1666. Set forth below is the decision of the Board to dismiss the last remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") SSI Provider Specific issue.

Background:

A. *Procedural History for Case No. 23-1666*

On **March 23, 2023**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2019. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **September 11, 2023**, CHS filed the Provider's individual appeal request which included four (4) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH Payment-Medicaid Days
3. Medicare Managed Care Part C Days (SSI & Mcaid Fractions)
4. Dual Eligible Days (SSI Fraction)[1]
5. Dual Eligible Days (Medicaid Fraction)

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).

On **September 12, 2023**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary

[1] The Dual Eligible Days issue was initially filed as one issue which included both the SSI & Medicaid Fractions.

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.[2]

On **April 4, 2024**, CHS requested the bifurcation of its SSI/Medicaid Fraction Dual Eligible Days issue.

On **April 10, 2024,** the Board granted the bifurcation of the Dual Eligible Days issue, but noted that Starke Hospital had already directly added the SSI fraction aspect of the Dual Eligible Days issue to a CIRP group under Case No. 22-1006GC. Therefore, the Board dismissed the SSI Fraction Dual Eligible Days portion of the issue as it was a prohibited duplicate of the issue in Case No. 22-1006GC.

On **April 11, 2024**, CHS transferred the Part C Days issue to Case No. 23-0078GC.

On **May 2, 2024**, CHS withdrew the DSH Payment-Medicaid Eligible Days issue.

On **May 6, 2024**, CHS transferred the Medicaid Fraction Dual Eligible Days issue to Case No. 23-0079GC.

On **May 7, 2024**, the Provider timely filed its PPP.

On **July 10, 2024**, the MAC timely filed its PPP.

On **August 5, 2024**, the Medicare Contractor ("MAC") filed a jurisdictional challenge, requesting the dismissal of Issue 1. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **August 12, 2024**, the Representative for Case No. 23-1666 was changed to Quality Reimbursement Services, Inc. ("QRS").

[2] (Emphasis added.)

B. Description of Issue 1 in the Individual Appeal Request

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

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

The Board notes that the parent organization, CHS, has a pending CIRP group appeal for the SSI Percentage issue under Case No. 22-1031GC. Starke Hospital is ***not*** *a participant in the group.*

The amount in controversy listed on the calculation support for the SSI Provider Specific Issue #1 in the Provider's individual appeal request is $2,542.

In the Provider's May 7, 2024 PPP in Case No. 23-1666, the following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this

[3] Issue Statement at 1 (Sept. 11, 2023).

> review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-2).[4]

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

The MAC argues that the Board lacks jurisdiction over the SSI Percentage (Provider Specific) issue, which has two components: 1) SSI data accuracy and 2) SSI realignment.

With respect to SSI realignment, the MAC contends that this issue has been abandoned. The Provider failed to file a complete PPP with a fully developed narrative of the SSI realignment issue, including all exhibits in accordance with 42 C.F.R. 405.1853(b)(2) and Board Rule 25. As a result, it should be considered withdrawn in accordance with Board Rules 25.3.

Alternatively, the MAC asserts that the Board does not have jurisdiction over an SSI realignment. There was no final determination over the SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies. This issue should be dismissed.[5]

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.[6] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed (on ***September 4, 2024***). Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

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.

[4] Provider's PPP at 7-8 (May 7, 2024).
[5] MAC's Jurisdictional Challenge at 2 (Aug. 5, 2024)
[6] Board Rule 44.4.3, v. 2.0 (Nov. 2021).

As set forth below, the Board hereby dismisses the Provider's last remaining issue in the appeal.

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 the SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[7] 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)."[8] 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."[9]

The Board reviewed the Provider's PPP which refers to systemic *Baystate* data matching issues. 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 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;

[7] Issue Statement at 1.
[8] *Id.*
[9] *Id.*

> 3. *State the efforts* made to obtain the documents; and
> 4. *Explain when* the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[10]

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 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.[11]

Accordingly, *based on the record before it*, the Board dismisses this aspect of the SSI Provider Specific issue from the instant appeal.

[10] (Italics and underline emphasis added.)
[11] Last modified March 17, 2026.

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. In this case, there is nothing in the record to indicate the MAC has made a final determination. Therefore, the Board finds that the Provider has not exhausted all available remedies for this issue. In addition, this component was not briefed in the Provider's PPP and thus is considered to have been abandoned.

****

Based on the foregoing, the Board is dismissing the last issue in this case: the SSI Percentage (Provider Specific) - Issue 1. As no issues remain, the Board hereby closes Case No. 23-1666 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:

4/16/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Byron Lamprecht, WPS Government Health Administrators (J-8)
Wilson C. Leong, Esq., Federal Specialized Services

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Via Electronic Delivery

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Boulevard, Suite 700
Los Angeles, CA 90064-1582

RE: ***Request for Reconsideration of Decision Not to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue Issued December 15, 2023***

NYU Healthcare System 2000-9/30/2004 Dual Eligible Days CIRP Group
Case Number: 09-0926GC

Dear Mr. Blumberg,

The Provider Reimbursement Review Board ("Board") has reviewed the Request for Reconsideration of Decision Not to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue Issued December 15, 2023 submitted by Blumberg Ribner ("Group Representative") on behalf of the Group participants submitted on February 12, 2024. The decision of the Board Majority is set forth below.

Pertinent Facts:

On **February 19, 2009**, the Board received the group appeal request. The complete issue statement in the group appeal request reads:

> Dual Eligible Days – Dual Eligible Days are patient days associated with those patients who were not included in the SSI denominator by CMS' design as they were not directly billed to Medicare and did not flow through the MEDPAR system via Fee For Service Medicare Part-A. Moreover, these days were disallowed from the Medicaid numerator as well. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with the undisputed indigent population. As the days represent patient who were Medicaid Eligible but not Medicare Entitled, the Provider contends that these days should be included in the Medicaid fraction.
>
> Dual Eligible Days were excluded from the Medicaid fraction for a variety of reasons. By way of example, certain Dual Eligible Days are days associated with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL.) v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held

> The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. *See Jersey Shore Medical Center v. Blue Cross and Blue Shield of New Jersey*, PRRB Case No. 99-D4, Medicare and Medicaid Guide (CCH) ¶80,083, October 30, 1998, *vacated and remanded*, HCFA Administrator, January 4, 1999, Medicare and Medicaid Guide (CCH) ¶80,153 ("*Jersey*").
>
> Thus, in accordance with the Board's holding in the Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days".[1]

By letter dated **August 30, 2012**, the Board identified this case as subject to remand under CMS Ruling 1498-R and requested that the Group Representative make necessary adjustments to comply with Board Rules on group issues arising from a single common issue.

On **October 16, 2012**, the Group Representative replied with an inquiry as to whether a certain participant could remain in the instant appeal while complying with Board Rules.

On **December 31, 2012**, the Board advised the Group Representative that the Board had established a new CIRP group, Case No. 13-0143GC and added that participant to it, because the participant did not have an FYE that resulted in it being governed by CMS Ruling 1498-R.

By letter dated **June 19, 2015**, the Board again identified this case as subject to remand under CMS Ruling 1498-R and requested that the Group Representative send a Schedule of Providers and associated jurisdictional documentation so that a jurisdictional determination could be made prior to remand action.

On **July 16, 2015**, the Group Representative sent a Schedule of Providers and associated jurisdictional documents.

On **September 17, 2015**, the Board issued a jurisdictional determination, and subsequently, remanded the remaining participants based on CMS Ruling 1498-R and closed the appeal.

On **May 6, 2016**, the Board received a letter from Blumberg Ribner requesting Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days issue. The Providers argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[2]

---

[1] Group Issue Statement (Feb. 19, 2009).
[2] Request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal Regarding DSH Part C Days Issue Letter at 1 (May 6, 2016).

On **December 15, 2023**, the Board declined to exercise its discretion to reopen and reinstate Case No. 09-0926GC and denied the request for reinstatement and rescission of remand in order to bifurcate a single participant from the group appeal regarding the Part C Days issue.

Provider Group's Position:

On **February 12, 2024**, the Group Representative submitted a request to reconsider the December 15, 2023 decision denying reinstatement and rescission of remand.

The Group Representative argues "[t]he Board's reasoning that the "instant appeal did not include Part C Days" is incorrect, contradictory to prior decisions of the Board expressly stating that identical appeals did include Part C Days. . ."[3] The Group Representative also argues that by denying the request while reinstating in other "nearly identical circumstances is arbitrary and capricious."[4] The Provider argued that the same material facts are present in the instant appeal as in Case No. 20-1976G,[5] a case granted reinstatement and bifurcation; specifically that Part C Days were "necessarily part of the appeal, but were not appropriate to have been identified as such at the time."[6]

The Group Representative also argues that the Board's reasoning of the abandonment of the Part C Days issue at the time of the July 8, 2015 remand is also being used arbitrarily and capriciously.[7] As evidence, the Group Representative points to Case Nos. 20-1976G,[8] 17-2284G,[9] and 07-1463.[10] The Group Representative argues that the Request for Reinstatement and Bifurcation acted as the notice to the Board of the need to separate the Part C Days issue, that this request was timely filed, and whether the Group Representative notified the Board prior to the remand or through the reinstatement request "is not germane."[11]

The Group Representative has also included a corrected affidavit, as the Board noted in their prior denial that the affidavit included was not for the case at issue. The Group Representative has requested "relief as necessary to augment the Board's record with the corrected affidavit, which was inadvertently omitted at the time of the initial request for bifurcation and reinstatement."[12]

Finally, the Group Representative summarizes that at the time the appeal was submitted, there was no "litigation or other CMS issuances that made clear the separateness of the DSH Part C

[3] Reconsideration Request Letter at 1 (Feb. 12, 2024). Note: While every first letter of each word was capitalized in the letter, this has been updated in this document and notated here for readability.
[4] *Id*. at 3.
[5] Bifurcated from Case No. 03-0419G.
[6] Reconsideration Request Letter at 2.
[7] *Id*. at 3-4.
[8] Bifurcated from Case No. 03-0419G.
[9] Bifurcated from Case No. 06-0092G.
[10] Reconsideration Request Letter at 4.
[11] *Id*.
[12] *Id*. at 5.

Day issues from DSH dual eligible days issue"[13], and that the Board has permitted the reinstatement and bifurcation of the Part C Days issue for other providers so to deny in the instant appeal is arbitrary and capricious.[14]

Board Majority's Analysis and Decision:

The Board Majority finds that there are important procedural differences between this appeal and the appeals that the Providers cite to that were reinstated and in which the Part C Days issue was bifurcated for the purposes of remand under CMS Ruling 1739-R. In the instant appeal, on August 30, 2012 (and again on June 19, 2015), the Board notified the Group Representative that the Board was identifying this case as subject to remand under CMS Ruling 1498-R, a ruling that does not pertain to the Part C Days issue. Indeed, the August 30, 2012 letter indicated that "the matter at issue must involve a single common issue of fact or interpretation of law."[15] The Group Representative made no representations at that time that the issue addressed Part C days. On July 16, 2015, the Group Representative submitted a Schedule of Providers necessary for a jurisdictional determination of all participants prior to a Board decision on the remand under CMS Ruling 1498-R. The case was remanded on September 17, 2015, and the case was closed. Finally, on May 6, 2016, the Group Representative requested to reinstate the case in order to bifurcate the Part C Days issue.

This request was submitted more than three years after the Board had notified the Group Representative that the CIRP group case should be remanded under CMS Ruling 1498-R. Therefore, there is nothing arbitrary and capricious about the Board's denial of reinstatement and bifurcation.

Rules in place at the time of the Board's September 17, 2015 remand action required specificity as to issues and were referenced in the Board's denial of reinstatement:

> As pointed out in the rescission and bifurcation request, regulations and Board rules require specificity with regards to each item under appeal. 42 C.F.R. § 405.1835(b)(2) (2009) reads, in part:
>
> > (2) An explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of the following:
> >
> > (i) Why the provider believes Medicare payment is incorrect *for each disputed item* . . .[16]

[13] *Id*.
[14] *Id*. at 6.
[15] (Underline emphasis in original.)
[16] (Emphasis added).

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

Board Rules have also long required that providers include identification of the issues in dispute with specificity:

> Your hearing request must include an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for contending the findings and conclusions are incorrect . . . You must clearly and specifically identify your position in regard to the issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not definite the issue as "DSH". You must precisely identify the component of the DSH issue that is in dispute.[18]

While the Group Representative has argued this rule was not in place at the time of the appeal request,[19] the Board Majority finds that it is relevant to the decision at hand and that the Group Representative is incorrect because that rule was in place at the time of the Board's August 30, 2012 letter notifying of potential remand action subject to CMS Ruling 1498-R and the Board's September 17, 2015 remand action.

Additionally, the instant appeal is a group appeal and therefore, providers may only appeal a single issue under 42 C.F.R. § 405.1837 (2008):

> (a) Right to Board hearing as part of a group appeal; criteria. A provider (but no other individual, entity, or party) has a right to a Board hearing, as part of a group appeal with other providers, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination for the period only if—
>
> . . .
>
> (2) ***The matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group*** . . .[20]

[17] 42 C.F.R § 405.1835(b)(1)-(2) (emphasis added.)
[18] Provider Reimbursement Review Board, Part I, B, II. (March 1, 2002).
[19] Reconsideration Request Letter at 2.
[20] (Emphasis added).

According to their own timeline of events, the Group Representative has essentially argued that the issue statement at the time of the appeal included both Dual Eligible Days and Part C Days. Later, the Group Representative was put on alert by the Board of the remand of its group issue under 1498-R in 2012 (and again in June of 2015), which pertained only to the Dual Eligible Days issue. Finally, after the Board remanded the case under 1498-R in September 2015, the Group Representative requested reinstatement in May 2016 and bifurcation of the Part C Days issue because the Part C Days issue was a part of the appeal all along. The Board Majority emphasizes that the issue-specificity requirements were in place when the Providers were filing various documents in this group, including their response to the Board's notification of the potential 1498-R remand, and the regulation requiring a group to have only one issue has been in place since the group appeal was filed. Therefore, the Board Majority ***denies*** the Provider's request for reconsideration.

Board Members Participating:

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

For the Board:

4/16/2026

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
Danelle Decker, National Government Services, Inc. (J-K)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Boulevard, Suite 700
Los Angeles, CA 90064-1582

RE: ***Request for Reconsideration of Decision Not to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue Issued December 15, 2023 - Corrected***

Blumberg Ribner Independent Hosps Pre-10/1/2004 Dual Eligible Days Group II
Case Number: 09-1496G

Dear Mr. Blumberg,

This decision is being re-issued to correct an error in the version that was issued on April 13, 2026.[1]

The Provider Reimbursement Review Board ("Board") has reviewed the Request for Reconsideration of Decision Not to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue Issued December 15, 2023 submitted by Blumberg Ribner ("Group Representative") on behalf of the Group participants submitted on February 12, 2024. The decision of the Board Majority is set forth below.

Pertinent Facts:

On **July 22, 2008**, the Board received the group appeal request. The entire description for the Medicare/Medicaid Dual Eligible Patient Days issue reads:

> Dual Eligible Days Issue – Dual Eligible Days are patient days associated with those patients who were not included in the SSI denominator by CMS' design as they were not directly billed to Medicare and did not flow through the MEDPAR system via Fee For Service Medicare Part-A. Moreover, these days were disallowed from the Medicaid numerator as well. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with the undisputed indigent population. As the days represent patient who were Medicaid Eligible but not Medicare Entitled, the Provider contends that these days should be included in the Medicaid fraction.
>
> Dual Eligible Days were excluded from the Medicaid fraction for a variety of reasons. By way of example, certain Dual Eligible Days are days associated

[1] *See* n. 15 and accompanying text.

> with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL.) v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held
>
> > The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. *See Jersey Shore Medical Center v. Blue Cross and Blue Shield of New Jersey*, PRRB Case No. 99-D4, Medicare and Medicaid Guide (CCH) ¶80,083, October 30, 1998, *vacated and remanded*, HCFA Administrator, January 4, 1999, Medicare and Medicaid Guide (CCH) ¶80,153 ("*Jersey*").
>
> Thus, in accordance with the Board's holding in the Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days".

By letter dated **June 24, 2010**, Blumberg Ribner identified this case as subject to remand under CMS Ruling 1498-R, and as a result, notified the Board it would not submit its Preliminary Position Paper by the July 1, 2010 filing deadline and requested standard remand under 1498-R.

On **November 13, 2015**, the Board, on its own motion, bifurcated the period from 10/1/2004-12/31/2004 and established a new group appeal for that period (16-0206G), which was not subject to 1498-R Remand. The period prior to 10/1/2004 remained in the appeal.

On **December 30, 2015**, the Board remanded the group appeal of DSH dual eligible days based on CMS Ruling 1498-R, and the appeal was closed.

On **June 2, 2016**, the Board received a letter from Blumberg Ribner requesting Recission of Remand and Bifurcation of Group Appeal regarding DSH Part C Days issue. The Providers argue that the references to dual eligible patient days were "intended to refer to persons eligible for Part A and Part C."[2]

On **December 15, 2023**, the Board declined to exercise its discretion to reopen and reinstate PRRB Case No. 09-1496G and denied the request for reinstatement and rescission of remand in order to bifurcate a single participant from the group appeal regarding the Part C Days issue.

Provider Group's Position:

On **February 12, 2024**, the Group Representative requested that the Board reconsider its December 15, 2023 decision denying reinstatement and rescission of remand.

[2] Bifurcation Request Letter at 1 (May 27, 2016).

The Group Representative argues "[t]he Board's reasoning that the "instant appeal did not include Part C Days" is incorrect, contradictory to prior decisions of the Board expressly stating that identical appeals did include Part C Days. . ."[3] The Group Representative also argues that by denying the request while reinstating in other "nearly identical circumstances is arbitrary and capricious."[4] The Provider argued that the same material facts are present in the instant appeal as in Case No. 20-1976G,[5] a case granted reinstatement and bifurcation; specifically that Part C Days were "necessarily part of the appeal, but were not appropriate to have been identified as such at the time."[6]

They also argue that the Board's reasoning of the abandonment of the Part C Days issue at the time of the December 30, 2015 remand is also being used arbitrarily and capriciously.[7] As evidence, the Group Representative points to Case Nos. 20-1976G,[8] 17-2284G,[9] and 07-1463.[10] The Group Representative argues that the Request for Reinstatement and Bifurcation acted as the notice to the Board of the need to separate the Part C Days issue, that this request was timely filed, and whether the Group Representative notified the Board prior to the remand or through the reinstatement request "is not germane."[11]

The Group Representative has also included a corrected affidavit, as the Board noted in their prior denial that the affidavit included was not for the case at issue. The Group Representative has requested "relief as necessary to augment the Board's record with the corrected affidavit, which was inadvertently omitted at the time of the initial request for bifurcation and reinstatement."[12]

Finally, the Group Representative summarizes that at the time the appeal was submitted, there was no "litigation or other CMS issuances that made clear the separateness of the DSH Part C Day issues from DSH dual eligible days issue"[13], and that the Board has permitted the reinstatement and bifurcation of the Part C Days issue for other providers so to deny in the instant appeal is arbitrary and capricious.[14]

---

[3] Reconsideration Request Letter at 1 (Feb. 9, 2024). Note: While every first letter of each word was capitalized in the letter, this has been updated in this document and notated here for readability.
[4] *Id*.
[5] Bifurcated from Case No. 03-0419G.
[6] Reconsideration Request Letter at 2.
[7] *Id*. at 3.
[8] Bifurcated from Case No. 03-0419G.
[9] Bifurcated from Case No. 06-0092G.
[10] Reconsideration Request Letter at 4.
[11] *Id*.
[12] *Id*. at 5.
[13] *Id*.
[14] *Id*. at 6.

Board Majority's Analysis and Decision:

The Board Majority finds that there are important procedural differences between this appeal and the appeals that the Providers cite to that were reinstated and in which the Part C Days issue was bifurcated for the purposes of remand under CMS Ruling 1739-R. In the instant appeal, on June 24, 2010, the Group Representative wrote to the Board identifying this case as subject to remand under CMS Ruling 1498-R, a ruling that does not pertain to the Part C Days issue. On November 13, 2015, the Board notified the Group Representative that the periods of the instant appeal that were not subject to 1498-R Remand were being bifurcated into a new case. The case was remanded and closed on December 30, 2015. Finally, on June 2, 2016, the Group Representative requested to reinstate the case in order to bifurcate the Part C Days issue.

This bifurcation request was submitted nearly six (6) years after the Group Representative had notified the Board that the optional group case should be remanded under CMS Ruling 1498-R. Further, the June 24, 2010 letter requesting remand of the group appeal distinguishes the instant appeal from the cases cited by the Group Representative in their Request for Reconsideration. No such request appears in the other case files, and therefore, the Provider's request for remand was the catalyst to determine the issue as solely related to CMS Ruling 1498-R[15] and therefore appropriate for remand and closure. Thus, there is nothing arbitrary and capricious about the Board's denial of reinstatement and bifurcation.

Rules in place at the time of both June 24, 2010 letter and the Board's December 30, 2015 remand action required specificity as to issues and were referenced in the Board's denial of reinstatement:

> As pointed out in the rescission and bifurcation request, regulations and Board rules require specificity with regards to each item under appeal. 42 C.F.R. § 405.1835(b)(2) (2009) reads, in part:
>
> > (2) An explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of the following:
> >
> > (i) Why the provider believes Medicare payment is incorrect *for each disputed item . . .*[16]
> >
> > (ii) How and why the provider believes Medicare payment must be determined differently *for each disputed item*.[17]

[15] The previous version of this decision erroneously referenced CMS Ruling 1739-R. This corrected version is being updated to correctly reflect the reference to CMS Ruling 1498-R.
[16] (Emphasis added).
[17] 42 C.F.R § 405.1835(b)(1)-(2) (emphasis added.)

> Board Rules have also long required that providers include identification of the issues in dispute with specificity:
>
> > Your hearing request must include an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for contending the findings and conclusions are incorrect . . . You must clearly and specifically identify your position in regard to the issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not definite the issue as "DSH". You must precisely identify the component of the DSH issue that is in dispute.[18]

While the Group Representative has argued this rule was not in place at the time of the appeal request,[19] the Board Majority finds that it is relevant to the decision at hand and that the Group Representative is incorrect because that rule was in place at the time of the Group Representative's June 24, 2010 letter requesting remand and the Board's December 30, 2015 remand action.

Additionally, the instant appeal is a group appeal and therefore, providers may only appeal a single issue under 42 C.F.R. § 405.1837 (2008):

> (a) Right to Board hearing as part of a group appeal; criteria. A provider (but no other individual, entity, or party) has a right to a Board hearing, as part of a group appeal with other providers, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination for the period only if—
>
> . . .
>
> (2) ***The matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group*** . . .[20]

According to their own timeline of events, the Group Representative has essentially argued that the issue statement at the time of the appeal (2008) included both Dual Eligible Days and Part C Days. Later, the Group Representative requested remand of its group issue under 1498-R in 2010, which pertains only to the Dual Eligible Days issue. Finally, after the Board remanded the

[18] Provider Reimbursement Review Board, Part I, B, II. (March 1, 2002).
[19] Reconsideration Request Letter at 2.
[20] (Emphasis added).

case under 1498-R in late 2015, the Group Representative requested reinstatement in May 2016 and bifurcation of the Part C Days issue because the Part C Days issue was a part of the appeal all along. The Board Majority emphasizes that the issue-specificity requirements were in place when the Providers were filing various requests in this group, and the regulation requiring a group to have only one issue has been in place since the group appeal was filed. Therefore, the Board Majority ***denies*** the Provider's request for reconsideration.

Board Members Participating:

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

For the Board:

4/16/2026

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
Danelle Decker, National Government Services, Inc. (J-K)

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11400 W. Olympic Boulevard, Suite 700
Los Angeles, CA 90064-1582

RE: ***Request for Reconsideration of Decision Not to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue Issued December 15, 2023***

Catholic Health Services of Long Island 1998-2004 Dual Eligible Days Group
Case Number: 09-1523GC

Dear Mr. Blumberg,

The Provider Reimbursement Review Board ("Board") has reviewed the Request for Reconsideration of Decision Not to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue Issued December 15, 2023 submitted by Blumberg Ribner ("Group Representative") on behalf of the Group participants on February 12, 2024. The decision of the Board Majority is set forth below.

Pertinent Facts:

On **April 15, 2009**, the Board received the group appeal request. The complete issue statement in the group appeal request reads:

> Dual Eligible Days – Dual Eligible Days are patient days associated with those patients who were not included in the SSI denominator by CMS' design as they were not directly billed to Medicare and did not flow through the MEDPAR system via Fee For Service Medicare Part-A. Moreover, these days were disallowed from the Medicaid numerator as well. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with the undisputed indigent population. As the days represent patient who were Medicaid Eligible but not Medicare Entitled, the Provider contends that these days should be included in the Medicaid fraction.
>
> Dual Eligible Days were excluded from the Medicaid fraction for a variety of reasons. By way of example, certain Dual Eligible Days are days associated with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL.) v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held

> The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. *See Jersey Shore Medical Center v. Blue Cross and Blue Shield of New Jersey*, PRRB Case No. 99-D4, Medicare and Medicaid Guide (CCH) ¶80,083, October 30, 1998, *vacated and remanded*, HCFA Administrator, January 4, 1999, Medicare and Medicaid Guide (CCH) ¶80,153 ("*Jersey*").
>
> Thus, in accordance with the Board's holding in the Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days".[1]

By letter dated **May 6, 2015**, the Board identified this case as subject to remand under CMS Ruling 1498-R and requested that because the Board needed to first make a jurisdictional determination that the Group Representative submit a Schedule of Providers and associated jurisdictional documents.

The Board received this documentation from the Group Representative on **June 2, 2015.**

On **July 8, 2015**, the Board issued a jurisdictional determination, and subsequently, remanded the remaining participants based on CMS Ruling 1498-R. The appeal remained open for two participants appealing for the period between 10/1/2004 through 12/31/2004.

On **December 18, 2015**, Blumberg Ribner ("Group Representative") requested to withdraw the group appeal and the appeal was closed.

On **May 12, 2016**, the Board received a letter from Blumberg Ribner requesting Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days issue. The Providers argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[2]

On **December 15, 2023**, the Board declined to exercise its discretion to reopen and reinstate Case No. 09-1523GC and denied the request for reinstatement and rescission of remand.

Provider Group's Position:

On **February 12, 2024**, the Group Representative submitted a request to reconsider the December 15, 2023 decision denying reinstatement and rescission of remand.

The Group Representative argues "[t]he Board's reasoning that the "instant appeal did not include Part C Days" is incorrect, contradictory to prior decisions of the Board expressly stating

[1] Group Issue Statement (Apr. 15, 2009).
[2] Request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal Regarding DSH Part C Days Issue Letter at 1 (May 16, 2016).

that identical appeals did include Part C Days."[3] The Group Representative also argues that by denying the request while reinstating in other "nearly identical circumstances is arbitrary and capricious."[4] The Provider argued that the same material facts are present in the instant appeal as in Case No. 20-1976G,[5] a case granted reinstatement and bifurcation; specifically that Part C Days were "necessarily part of the appeal, but were not appropriate to have been identified as such at the time."[6]

The Group Representative also argues that the Board's reasoning of the abandonment of the Part C Days issue at the time of the July 8, 2015 remand is also being used arbitrarily and capriciously.[7] As evidence, the Group Representative points to Case Nos. 20-1976G,[8] 17-2284G,[9] and 07-1463.[10] The Group Representative argues that the Request for Reinstatement and Bifurcation acted as the notice to the Board of the need to separate the Part C Days issue, that this request was timely filed, and whether the Group Representative notified the Board prior to the remand or through the reinstatement request "is not germane."[11]

The Group Representative has also included a corrected affidavit, as the Board noted in their prior denial that the affidavit included was not for the case at issue. The Group Representative has requested "relief as necessary to augment the Board's record with the corrected affidavit, which was inadvertently omitted at the time of the initial request for bifurcation and reinstatement."[12]

Finally, the Group Representative summarizes that at the time the appeal was submitted, there was no "litigation or other CMS issuances that made clear the separateness of the DSH Part C Day issues from DSH dual eligible days issue"[13], and that the Board has permitted the reinstatement and bifurcation of the Part C Days issue for other providers so to deny in the instant appeal is arbitrary and capricious.[14]

Board Majority's Analysis and Decision:

The Board Majority finds that there are important procedural differences between this appeal and the appeals that the Providers cite to that were reinstated and the Part C Days issue was bifurcated for the purposes of remand under CMS Ruling 1739-R. In the instant appeal, on May

[3] Reconsideration Request Letter at 1 (Feb. 12, 2024). Note: While every first letter of each word was capitalized in the letter, this has been updated in this document and notated here for readability.
[4] *Id*. at 3.
[5] Bifurcated from Case No. 03-0419G.
[6] Reconsideration Request Letter at 2.
[7] *Id*. at 4.
[8] Bifurcated from Case No. 03-0419G.
[9] Bifurcated from Case No. 06-0092G.
[10] Reconsideration Request Letter at 3.
[11] *Id*. at 4.
[12] *Id*. at 5.
[13] *Id*.
[14] *Id*. at 6.

6, 2015, the Board notified the Group Representative that the Board was identifying this case as subject to remand under CMS Ruling 1498-R, a ruling that does not pertain to the Part C Days issue. On June 2, 2015, the Group Representative submitted a Schedule of Providers necessary for a jurisdictional determination of all participants prior to a Board decision on the remand under CMS Ruling 1498-R. The case was remanded on July 8, 2015. However, the case remained open until the Group Representative ***voluntarily withdrew*** the appeal on December 18, 2015, and the case was closed. Finally, on May 12, 2016, the Group Representative requested to reinstate the case in order to bifurcate the Part C Days issue.

This request was submitted more than a year after the Board had notified the Group Representative that the CIRP group case should be remanded under CMS Ruling 1498-R. Therefore, there is nothing arbitrary and capricious about the Board's denial of reinstatement and bifurcation.

Board Instructions in place at the time the Providers filed their individual appeals (between March 1, 2002 and August 21, 2009) required specificity as to issues and were referenced in the Board's denial of reinstatement:

> Your hearing request must include an identification and statement of the issue(S) you are disputing. You must identify the specific issues, findings of fact and conclusions of law . . . **You must precisely identify the component of the DSH issue that is in dispute**.[15]

While the Group Representative has argued this rule was not in place at the time of the appeal request,[16] the Board Majority finds that it is relevant to the decision at hand and that the Group Representative is incorrect because that rule was in place at the time of the Providers' individual appeals (2002-2009), as well as the Board's May 6, 2015 letter notifying of potential remand action subject to CMS Ruling 1498-R and the Board's July 8, 2015 remand action.

Additionally, the instant appeal is a group appeal and therefore, providers may only appeal a single issue under 42 C.F.R. § 405.1837 (2008):

> (a) Right to Board hearing as part of a group appeal; criteria. A provider (but no other individual, entity, or party) has a right to a Board hearing, as part of a group appeal with other providers, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination for the period only if—
>
> . . .

[15] Provider Reimbursement Review Board, Part I, B, II. (March 1, 2002) (Bold emphasis added).
[16] Reconsideration Request Letter at 2.

> (2) ***The matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group*** . . .[17]

According to their own timeline of events, the Group Representative has essentially argued that the issue statement at the time of the appeal included both Dual Eligible Days and Part C Days. Later, the Group Representative was put on alert by the Board of the remand of its group issue under 1498-R in 2015, which pertains only to the Dual Eligible Days issue. Finally, after the Board remanded the case under 1498-R in mid-2015, and the Group Representative voluntarily withdrew the remaining case entirely in late-2015, the Group Representative requested reinstatement in May 2016 and bifurcation of the Part C Days issue because the Part C Days issue was a part of the appeal all along. The Board Majority emphasizes that the Board Instructions from 2002 were applicable to this appeal and did require the type of specificity to distinguish between these issues. Therefore, the Board Majority ***denies*** the Provider's request for reconsideration.

Board Members Participating:

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

For the Board:

4/16/2026

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
Danelle Decker, National Government Services, Inc. (J-K)

[17] (Emphasis added).

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Los Angeles, CA 90064-1582

RE: ***Request for Reconsideration of Decision Not to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue Issued December 15, 2023***

Blumberg Ribner Independent Hospitals 2002 Dual Eligible Days 2nd Group
Case Number: 09-1915G

Dear Mr. Blumberg,

The Provider Reimbursement Review Board ("Board") has reviewed the Request for Reconsideration of Decision Not to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue Issued December 15, 2023 submitted by Blumberg Ribner ("Group Representative") on behalf of the Group participants submitted on February 12, 2024. The decision of the Board Majority is set forth below.

Pertinent Facts:

On **June 19, 2009**, the Board received the group appeal request. The complete issue statement in the group appeal request reads:

> Dual Eligible Days Issue – Dual Eligible Days are patient days associated with those patients who were not included in the SSI denominator by CMS' design as they were not directly billed to Medicare and did not flow through the MEDPAR system via Fee For Service Medicare Part-A. Moreover, these days were disallowed from the Medicaid numerator as well. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with the undisputed indigent population. As the days represent patient who were Medicaid Eligible but not Medicare Entitled, the Provider contends that these days should be included in the Medicaid fraction.
>
> Dual Eligible Days were excluded from the Medicaid fraction for a variety of reasons. By way of example, certain Dual Eligible Days are days associated with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL.) v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held

> The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. *See Jersey Shore Medical Center v. Blue Cross and Blue Shield of New Jersey*, PRRB Case No. 99-D4, Medicare and Medicaid Guide (CCH) ¶80,083, October 30, 1998, *vacated and remanded*, HCFA Administrator, January 4, 1999, Medicare and Medicaid Guide (CCH) ¶80,153 ("*Jersey*").

Thus, in accordance with the Board's holding in the Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days".[1]

On **August 31, 2010**, Blumberg Ribner submitted a letter to the Board indicating that it would not be submitting a Preliminary Position Paper because the appeal issue is subject to remand. They stated:

> In accordance with the PRRB's recently issued Alert 7, Blumberg Ribner (BRI) hereby identifies the subject of the group appeal, dual eligible days, as governed by CMS – 1498-R. Accordingly, BRI will not be submitting a Preliminary Position Paper (PPP) by the September 1, 2010 deadline. Should the Board determine that a PPP is necessary, please notify us as soon as possible. BRI hereby requests that the group appeal be remanded under the Standard Procedure. Finally, we reserve the right to challenge both the CMS Ruling and any remand order at the appropriate time.[2]

On **September 1, 2011**, the Board received a Schedule of Providers and jurisdictional documentation from the Group Representative**.**

On **July 2, 2014**, the Board issued a jurisdictional determination, and subsequently, remanded the remaining participants based on CMS Ruling 1498-R, and the appeal was closed.

On **May 23, 2016**, the Board received a letter from Blumberg Ribner requesting Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days issue. The Providers argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[3]

On **December 15, 2023**, the Board declined to exercise its discretion to reopen and reinstate PRRB Case No. 09-1915G and denied the request for reinstatement and rescission of remand in order to bifurcate a single participant from the group appeal regarding the Part C Days issue.

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[1] Group Issue Statement (Jun. 19, 2009).
[2] Remand Request (Aug. 31, 2010).
[3] Request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal Regarding DSH Part C Days Issue Letter at 1 (May 23, 2016).

Provider Group's Position:

On **February 12, 2024**, the Group Representative submitted a request to reconsider the December 15, 2023 decision denying reinstatement and rescission of remand.

The Group Representative argues "[t]he Board's reasoning that the "instant appeal did not include Part C Days" is incorrect, contradictory to prior decisions of the Board expressly stating that identical appeals did include Part C Days. . ."[4] The Group Representative also argues that by denying the request while reinstating in other "nearly identical circumstances is arbitrary and capricious."[5] The Provider argued that the same material facts are present in the instant appeal as in PRRB Case No. 20-1976G,[6] a case granted reinstatement and bifurcation; specifically that Part C Days were "necessarily part of the appeal, but were not appropriate to have been identified as such at the time."[7]

The Group Representative also argues that the Board's reasoning of the abandonment of the Part C Days issue at the time of the July 2, 2014 remand is also being used arbitrarily and capriciously.[8] As evidence, the Group Representative points to Case Nos. 20-1976G,[9] 17-2284G,[10] and 07-1463.[11] The Group Representative argues that the Request for Reinstatement and Bifurcation acted as the notice to the Board of the need to separate the Part C Days issue, that this request was timely filed, and whether the Group Representative notified the Board prior to the remand or through the reinstatement request "is not germane."[12]

The Group Representative has also included a corrected affidavit, as the Board noted in their prior denial that the affidavit included was not for the case at issue. The Group Representative has requested "relief as necessary to augment the Board's record with the corrected affidavit, which was inadvertently omitted at the time of the initial request for bifurcation and reinstatement."[13]

Finally, the Group Representative summarizes that at the time the appeal was submitted, there was no "litigation or other CMS issuances that made clear the separateness of the DSH Part C Day issues from DSH dual eligible days issue,"[14] and that the Board has permitted the

[4] Reconsideration Request Letter at 1 (Feb. 12, 2024). Note: While every first letter of each word was capitalized in the letter, this has been updated in this document and notated here for readability.
[5] *Id*. at 3.
[6] Bifurcated from Case No. 03-0419G.
[7] Reconsideration Request Letter at 2.
[8] *Id*. at 3-4.
[9] Bifurcated from Case No. 03-0419G.
[10] Bifurcated from Case No. 06-0092G.
[11] Reconsideration Request Letter at 4.
[12] *Id*.
[13] *Id*. at 5.
[14] *Id*.

reinstatement and bifurcation of the Part C Days issue for other providers so to deny in the instant appeal is arbitrary and capricious.[15]

Board Majority's Analysis and Decision:

The Board Majority finds that there are important procedural differences between this appeal and the appeals that the Providers cite to that were reinstated and in which the Part C Days issue was bifurcated for the purposes of remand under CMS Ruling 1739-R. In the instant appeal, on August 31, 2010, the Group Representative wrote to the Board identifying this case as subject to remand under CMS Ruling 1498-R, a ruling that does not pertain to the Part C Days issue. The case was remanded and closed on July 2, 2014. Finally, on May 23, 2016, the Group Representative requested to reinstate the case in order to bifurcate the Part C Days issue.

The bifurcation request was submitted nearly six (6) years after the Group Representative had notified the Board that the optional group case should be remanded under CMS Ruling 1498-R. Further, the August 31, 2010 letter requesting remand of the group appeal distinguishes the instant appeal from the cases cited by the Group Representative in their Request for Reconsideration. No such request appears in the other case files, and therefore, the Provider's request for remand was the catalyst to determine the issue as solely related to CMS Ruling 1498-R and therefore appropriate for remand and closure. Therefore, there is nothing arbitrary and capricious about the Board's denial of reinstatement and bifurcation.

Rules in place at the time of both the August 31, 2010 letter and the Board's July 2, 2014 remand action required specificity as to issues and were referenced in the Board's denial of reinstatement:

> As pointed out in the rescission and bifurcation request, regulations and Board rules require specificity with regards to each item under appeal. 42 C.F.R. § 405.1835(b)(2) (2009) reads, in part:
>
> > (2) An explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of the following:
> >
> > (i) Why the provider believes Medicare payment is incorrect *for each disputed item* . . .[16]
> >
> > (ii) How and why the provider believes Medicare payment must be determined differently *for each disputed item*.[17]

[15] *Id*. at 6.
[16] (Emphasis added).
[17] 42 C.F.R § 405.1835(b)(1)-(2) (emphasis added.)

> Board Rules have also long required that providers include identification of the issues in dispute with specificity:
>
> > Your hearing request must include an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for contending the findings and conclusions are incorrect . . . You must clearly and specifically identify your position in regard to the issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not definite the issue as "DSH". You must precisely identify the component of the DSH issue that is in dispute.[18]

While the Group Representative has argued this rule was not in place at the time of the appeal request,[19] the Board Majority finds that it is relevant to the decision at hand and that the Group Representative is incorrect because that rule was in place at the time of the Group Representative's August 31, 2010 letter requesting remand and the Board's July 2, 2014 remand action.

Additionally, the instant appeal is a group appeal and therefore, providers may only appeal a single issue under 42 C.F.R. § 405.1837 (2008):

> (a) Right to Board hearing as part of a group appeal; criteria. A provider (but no other individual, entity, or party) has a right to a Board hearing, as part of a group appeal with other providers, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination for the period only if—
>
> . . .
>
> (2) ***The matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group*** . . .[20]

According to their own timeline of events, the Group Representative has essentially argued that the issue statement at the time of the appeal included both Dual Eligible Days and Part C Days. Later, the Group Representative requested remand of its group issue under 1498-R in 2010, which pertains only to the Dual Eligible Days issue. Finally, after the Board remanded the case

[18] Provider Reimbursement Review Board, Part I, B, II. (March 1, 2002).
[19] Reconsideration Request Letter at 2.
[20] (Emphasis added).

under 1498-R in mid-2014, the Group Representative requested reinstatement in May 2016 and bifurcation of the Part C Days issue because the Part C Days issue was a part of the appeal all along. The Board Majority emphasizes that the issue-specificity requirements were in place when the Providers were filing various documents in this group, including the notice that they would not be filing a PPP because the group was subject to remand, and the regulation requiring a group to have only one issue has been in place since the group appeal was filed. Therefore, the Board Majority ***denies*** the Provider's request for reconsideration

Board Members Participating:

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

For the Board:

4/16/2026

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
Danelle Decker, National Government Services, Inc. (J-K)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Boulevard, Suite 700
Los Angeles, CA 90064-1582

RE: ***Request for Reconsideration of Decision Not to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue Issued December 20, 2023***

Blumberg Ribner Independent Hosps 2003 Dual Eligible Days – 2nd Group
Case Number: 09-1924G

Dear Mr. Blumberg,

The Provider Reimbursement Review Board ("Board") has reviewed the Request for Reconsideration of Decision Not to Reinstate & Bifurcate Group Appeal Regarding DSH Part C Days Issue Issued December 20, 2023 submitted by Blumberg Ribner ("Group Representative") on behalf of the Group participants submitted on February 12, 2024. The decision of the Board Majority is set forth below.

Pertinent Facts:

On **June 23, 2009**, the Board received the group appeal request. The complete issue statement in the group appeal request reads:

> Dual Eligible Days Issue – Dual Eligible Days are patient days associated with those patients who were not included in the SSI denominator by CMS' design as they were not directly billed to Medicare and did not flow through the MEDPAR system via Fee For Service Medicare Part-A. Moreover, these days were disallowed from the Medicaid numerator as well. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with the undisputed indigent population. As the days represent patient who were Medicaid Eligible but not Medicare Entitled, the Provider contends that these days should be included in the Medicaid fraction.
>
> Dual Eligible Days were excluded from the Medicaid fraction for a variety of reasons. By way of example, certain Dual Eligible Days are days associated with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL.) v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held

> The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. *See Jersey Shore Medical Center v. Blue Cross and Blue Shield of New Jersey*, PRRB Case No. 99-D4, Medicare and Medicaid Guide (CCH) ¶80,083, October 30, 1998, *vacated and remanded*, HCFA Administrator, January 4, 1999, Medicare and Medicaid Guide (CCH) ¶80,153 ("*Jersey*").

Thus, in accordance with the Board's holding in the Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days".[1]

On **August 31, 2010**, Blumberg Ribner submitted a letter to the Board indicating that it would not be submitting a Preliminary Position Paper because the appeal issue is subject to remand. They stated:

> In accordance with the PRRB's recently issued Alert 7, Blumberg Ribner (BRI) hereby identifies the subject of the group appeal, dual eligible days, as governed by CMS – 1498-R. Accordingly, BRI will not be submitting a Preliminary Position Paper (PPP) by the September 1, 2010 deadline. Should the Board determine that a PPP is necessary, please notify us as soon as possible. BRI hereby requests that the group appeal be remanded under the Standard Procedure. Finally, we reserve the right to challenge both the CMS Ruling and any remand order at the appropriate time.[2]

The Board also received a Schedule of Providers and jurisdictional documentation from the Group Representative**.**

On **February 25, 2014**, the Board issued a jurisdictional determination, and subsequently, remanded the remaining participants based on CMS Ruling 1498-R, and the appeal was closed.

On **May 12, 2016**, the Board received a letter from Blumberg Ribner requesting Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days issue. The Providers argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[3]

On **December 20, 2023**, the Board declined to exercise its discretion to reopen and reinstate PRRB Case No. 09-1924G and denied the request for reinstatement and rescission of remand in order to bifurcate a single participant from the group appeal regarding the Part C Days issue.

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[1] Group Issue Statement (Jun. 23, 2009).
[2] Remand Request (Aug. 31, 2010).
[3] Request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal Regarding DSH Part C Days Issue Letter at 1 (May 12, 2016).

Provider Group's Position:

On **February 12, 2024**, the Group Representative submitted a request to reconsider the December 20, 2023 decision denying reinstatement and rescission of remand.

The Group Representative argues "[t]he Board's reasoning that the "instant appeal did not include Part C Days" is incorrect, contradictory to prior decisions of the Board expressly stating that identical appeals did include Part C Days. . ."[4] The Group Representative also argues that by denying the request while reinstating in other "nearly identical circumstances is arbitrary and capricious."[5] The Provider argued that the same material facts are present in the instant appeal as in PRRB Case No. 20-1976G,[6] a case granted reinstatement and bifurcation; specifically that Part C Days were "necessarily part of the appeal, but were not appropriate to have been identified as such at the time."[7]

The Group Representative also argues that the Board's reasoning of the abandonment of the Part C Days issue at the time of the February 25, 2014 remand is also being used arbitrarily and capriciously.[8] As evidence, the Group Representative points to Case Nos. 20-1976G,[9] 17-2284G,[10] and 07-1463.[11] The Group Representative argues that the Request for Reinstatement and Bifurcation acted as the notice to the Board of the need to separate the Part C Days issue, that this request was timely filed, and whether the Group Representative notified the Board prior to the remand or through the reinstatement request "is not germane."[12]

Finally, the Group Representative summarizes that at the time the appeal was submitted, there was no "litigation or other CMS issuances that made clear the separateness of the DSH Part C Day issues from DSH dual eligible days issue,"[13] and that the Board has permitted the reinstatement and bifurcation of the Part C Days issue for other providers so to deny in the instant appeal is arbitrary and capricious.[14]

Board Majority's Analysis and Decision:

The Board Majority finds that there are important procedural differences between this appeal and the appeals that the Providers cite to that were reinstated and in which the Part C Days issue was bifurcated for the purposes of remand under CMS Ruling 1739-R. In the instant appeal, on

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[4] Reconsideration Request Letter at 1 (Feb. 12, 2024). Note: While every first letter of each word was capitalized in the letter, this has been updated in this document and notated here for readability.
[5] *Id*. at 3.
[6] Bifurcated from Case No. 03-0419G.
[7] Reconsideration Request Letter at 2.
[8] *Id*. at 3-4.
[9] Bifurcated from Case No. 03-0419G.
[10] Bifurcated from Case No. 06-0092G.
[11] Reconsideration Request Letter at 4.
[12] *Id*.
[13] *Id*. at 4.
[14] *Id*. at 5.

August 31, 2010, the Group Representative wrote to the Board specifically identifying this case as subject to remand under CMS Ruling 1498-R, a ruling that does not pertain to the Part C Days issue. The Group Representative made no mention of any other issues pending in the appeal at that time. The case was remanded and closed on February 25, 2014. Finally, on May 12, 2016, the Group Representative requested to reinstate the case in order to bifurcate the Part C Days issue.

This reinstatement/bifurcation request came nearly six (6) years after the Group Representative had notified the Board that the optional group case should be remanded under CMS Ruling 1498-R. Further, the August 31, 2010 letter requesting remand of the group appeal distinguishes the instant appeal from the cases cited by the Group Representative in their Request for Reconsideration. No such request appears in the other case files, and therefore, the Provider's request for remand was the catalyst to determine the issue as solely related to CMS Ruling 1498-R and therefore appropriate for remand and closure. Therefore, there is nothing arbitrary and capricious about the Board's denial of reinstatement and bifurcation.

Rules in place at the time of both the August 31, 2010 letter and the Board's February 25, 2014 remand action required specificity as to issues and were referenced in the Board's denial of reinstatement:

> As pointed out in the rescission and bifurcation request, regulations and Board rules require specificity with regards to each item under appeal. 42 C.F.R. § 405.1835(b)(2) (2009) reads, in part:
>
> > (2) An explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of the following:
> >
> > (i) Why the provider believes Medicare payment is incorrect *for each disputed item* . . .[15]
> >
> > (ii) How and why the provider believes Medicare payment must be determined differently *for each disputed item*.[16]
>
> Board Rules have also long required that providers include identification of the issues in dispute with specificity:
>
> > Your hearing request must include an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you

[15] (Emphasis added).
[16] 42 C.F.R § 405.1835(b)(1)-(2) (emphasis added.)

> must specify the basis for contending the findings and conclusions are incorrect . . . You must clearly and specifically identify your position in regard to the issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not definite the issue as "DSH". You must precisely identify the component of the DSH issue that is in dispute.[17]

While the Group Representative has argued this rule was not in place at the time of the appeal request,[18] the Board Majority finds that it is relevant to the decision at hand and that the Group Representative is incorrect because that rule was in place at the time of the Group Representative's August 31, 2010 letter requesting remand and the Board's February 25, 2014 remand action.

Additionally, the instant appeal is a group appeal and therefore, providers may only appeal a single issue under 42 C.F.R. § 405.1837 (2008):

> (a) Right to Board hearing as part of a group appeal; criteria. A provider (but no other individual, entity, or party) has a right to a Board hearing, as part of a group appeal with other providers, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination for the period only if—
>
> . . .
>
> (2) ***The matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group*** . . .[19]

According to their own timeline of events, the Group Representative has essentially argued that the issue statement at the time of the appeal included both Dual Eligible Days and Part C Days. Later, the Group Representative requested remand of its group issue under 1498-R in 2010, which pertains only to the Dual Eligible Days issue. Finally, after the Board remanded the case under 1498-R in early 2014, the Group Representative requested reinstatement in May 2016 and bifurcation of the Part C Days issue because the Part C Days issue was a part of the appeal all along. The Board Majority emphasizes that the issue-specificity requirements were in place when the Providers specifically notified the Board that the ***issue*** in this group appeal was subject to CMS Ruling 1498-R remand. Furthermore, the regulation requiring a group to have only one issue has been in place since the group appeal was filed. Therefore, the Board Majority ***denies*** the Provider's request for reconsideration.

---

[17] Provider Reimbursement Review Board, Part I, B, II. (March 1, 2002).
[18] Reconsideration Request Letter at 2.
[19] (Emphasis added).

Board Members Participating:

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

For the Board:

4/16/2026

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
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)

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: ***Notice of Dismissal***
Houston Methodist Willowbrook Hospital (Prov. No. 45-0844), FYE 12/31/2017
Case No. 23-0738

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0738. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Payment SSI (Provider Specific) issue.

Background:

On **August 9, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2017. The Provider is commonly owned by Houston Methodist Hospital System ("Houston Methodist").

On **February 1, 2023**, Houston Methodist filed the Provider's individual appeal request which included seven (7) issues:

1. DSH Payment -SSI (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 Amount[6]

[1] On September 6, 2023, this issue was transferred to PRRB Case No. 20-1609GC.
[2] On September 6, 2023, this issue was transferred to PRRB Case No. 20-1610GC.
[3] On September 6, 2023, this issue was transferred to PRRB Case No. 20-1611GC.
[4] On September 6, 2023, this issue was transferred to PRRB Case No. 20-1610GC.
[5] On September 6, 2023, this issue was transferred to PRRB Case No. 20-1613GC.
[6] On September 6, 2023, this issue was transferred to PRRB Case No. 20-1614GC.

As the Provider is commonly owned/controlled by Houston Methodist, 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 **September 6, 2023**, Houston Methodist transferred Issues 2, 3, 4, 5, and 6 to Houston Methodist CIRP groups. As a result of the transfers, there is one (1) remaining issue in this appeal: Issue 1 - DSH Payment (Provider Specific).

On **February 2, 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.

On **September 27, 2023**, the Provider timely filed its preliminary position paper (*hereinafter* "PPP").

On **January 19, 2024**, the Medicare Contractor ("MAC") filed its PPP.

A. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20-1609GC

In their Individual Appeal Request, 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)[7]

[7] Issue Statement at 1 (Feb. 1, 2023).

The Group issue Statement in Case No. 20-1609GC, to which the Provider transferred Issue No. 2 reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> 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.[8]

On September 27, 2023, the Board received the Provider's PPP in Case 23-0738. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> 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.

[8] Group Issue Statement, Case No. 20-1609GC.

> The Provider contends that its' SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS 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).[9]

The amount in controversy in the Provider's individual appeal request for Issue 1 is $16,604 and for Issue 2 is $16,605.

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 Percentage (Systemic Errors) issue that the Provider transferred to Case No. 21-1206GC.

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

[9] Provider's PPP at 2 (Sept. 27, 2023).

("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 Percentage (*Systemic Errors*) issue in group Case No. 21-1206GC 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 Percentage (Provider Specific) issue in Case No. 23-0738 is duplicative of the DSH/SSI Percentage (*Systemic Errors*) issue in Case No. 21-1206GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[13], the Board dismisses this aspect of the DSH Payment (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 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 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 21-1206GC.

To this end, the Board also reviewed the Provider's PPP to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 21-1206GC but instead, refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's 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.

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[10] Issue Statement at 1.
[11] *Id.*
[12] *Id.*
[13] PRRB Rules v. 3.1 (Nov. 2021).
[14] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

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. 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]

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:

---

[15] (Italics and underline emphasis added.)

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

This CMS webpage describes access to DSH data and instructs providers to send a request via email to access their DSH data.

Accordingly, *based on the record before it*, the Board finds that DSH Payment SSI (Provider Specific) issue in the instant appeal and the group issue in Case No. 21-1206GC are the same issue.[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.

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.

****

Based on the foregoing, the Board is dismissing the last remaining issue in this case: DSH Payment SSI (Provider Specific) - Issue No. 1. As no issues remain, the Board hereby closes Case No. 23-0738 and removes it from the Board's docket.

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

[16] Last modified on March 17, 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).

Board Members Participating:

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

For the Board:

4/17/2026

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

RE: ***Notice of Dismissal***
Bayfront Health – St. Petersburg, Prov. No. 10-0032, FYE 09/30/2018
Case No. 23-0011

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0011. Set forth below is the decision of the Board to dismiss the 2 remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) and Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 23-0011*

On **April 11, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2018. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **October 4, 2023**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage Unduly Narrow Definition of SSI Entitlement[1]
3. DSH Payment – Medicaid Eligible Days
4. DSH Payment – Medicare/SSI and Medicaid Fractions – Medicare Managed Care Part C Days[2]
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)[3]

[1] On May 30, 2023, this issue was transferred to Case No. 21-1206GC.
[2] On May 30, 2023, this issue was transferred to Case No. 20-2149GC.
[3] On May 30, 2023, this issue was transferred to Case No. 21-0066GC.

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 **May 30, 2023**, the Provider transferred Issues 2, 4 and 5 to CHS CIRP groups.

As a result of the case transfers, there are two (2) remaining issues in this appeal: Issue 1 (the DSH – SSI Percentage (Provider Specific)) and Issue 3 (the DSH – Medicaid Eligible Days).

On **October 12, 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.[4]

An updated Critical Due Date Notification was sent by the Board on **March 16, 2023**, establishing new deadlines in light of Alert 23, the resumption of normal Board operations following the COVID-19 pandemic.

On **May 30, 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 under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2018 cost report does not reflect an accurate number of Medicaid eligible days." As a result, the Provider included, as an Exhibit, the original "estimated impact" for this issue of $32,573 based on an *estimated* 100 days.

On **August 14, 2023**, the Medicare Contractor timely filed a Jurisdictional Challenge[5] with the Board over Issues 1 and 3 requesting that the Board dismiss these issues. Pursuant to Board Rule

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[4] (Emphasis added.)

[5] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of

44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **August 16, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **September 5, 2023**, the Medicare Contractor filed its preliminary position paper. With regard to Issue 3, the Medicare Contractor's position paper noted that: (1) the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position; and (2) the Provider had added the Section 1115 Waiver Days issue, which is outside the scope of the original appeal.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 21-1206GC - CHS CY 2018 DSH SSI Percentage CIRP Group

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

> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> 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).[6]

The Group issue Statement in Case No. 21-1206GC, to which the Provider transferred Issue No. 2, reads, in part:

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

Auburn, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

[6] Issue Statement at 1 (Oct. 4, 2023).

> Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[7]

On May 30, 2023, the Board received the Provider's preliminary position paper in 19-2704. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

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

[7] Group Appeal Issue Statement in Case No. 21-1206GC.

> some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[8]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $58,922.

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2. The portion related to SSI realignment should be dismissed because it was not briefed in the preliminary position paper and, if not abandoned, because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[9] The MAC further notes that its cost reporting year is identical to the federal fiscal year end, "questioning the right the Provider is attempting to preserve."[10]

Additionally, the MAC "asserts that the Provider did not file a complete position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3."[11] The MAC posits that the Provider "failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its Preliminary Position Paper."[12]

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC contends that the Provider failed to properly develop its arguments within its preliminary position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25.

---

[8] Provider's Preliminary Position Paper at 9 (May 30, 2023).
[9] Medicare Contractor's Jurisdictional Challenge at 5-6 (Aug. 14, 2023)
[10] *Id*. at 6.
[11] *Id*. at 7.
[12] *Id*. at 8.

The MAC argues the Provider has not submitted a Medicaid eligible days listing and therefore, requests the Board dismiss the issue.

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

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[13] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Decision of the Board

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

As set forth below, the Board hereby ***dismisses*** the Provider's two (2) remaining issues.

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Case No. 21-1206GC.

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

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

Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[14] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[15] The Provider argues in its issue statement, which was included in the appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[16]

The Board reviewed the Provider's PPP which refers to systemic *Baystate* data matching issues. 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 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.[17]

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,

[14] Issue Statement at 1.
[15] *Id.*
[16] *Id.*
[17] (Italics and underline emphasis added.)

> 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.[18]

Accordingly, *based on the record before it*, the Board dismisses this aspect of the SSI Provider Specific issue from the instant appeal.

2. *Second Aspect of Issue 1*

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

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Moreover, without this written request, the Medicare Contractor 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 Medicare Contractor 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.

[18] Last modified March 17, 2026.

B. DSH Payment – Medicaid Eligible Days

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

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

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

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

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

Board Rule 25 (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:

[19] (Bold emphasis added.)

Rule 25 Preliminary Position Papers[20]

> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will 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…Therefore, the Board requires preliminary position papers to present the ***fully*** developed positions of the parties and expects that parties will be diligent in planning and conducting any required investigation, discovery, and analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

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

25.1.1 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

[20] (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, 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

The Board requires the parties file a ***complete*** preliminary position paper that includes a fully developed narrative (Rule 25.1), 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. 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 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on March 16, 2023 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.[21]

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

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

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

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

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

[21] (Emphasis added.)

procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On May 30, 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 under separate cover.[22] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $32,573 based on an estimated 100 days). The Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that 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,

[22] Provider's Preliminary Position Paper at 8.

> 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)(i), 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 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.

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

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

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"[23] 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

[23] (Emphasis added.)

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.[24]

C. 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 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 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…
>
> (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…

[24] *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.

> (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…[25]

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 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 (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, but are not limited to: . . . ***Section 1115 waiver days (program/waiver specific). . .***[26]

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.[27]

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

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[25] 42 C.F.R. § 405.1835(b).
[26] (Bold and italic emphasis added).
[27] *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 –
>
> . . .
>
> (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.[28] 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 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)**

[28] 65 FR 47054, 47087 (Aug. 1, 2000).

> **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.

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 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 final position paper is perfunctory in that it only makes perfunctory conclusions.[29] 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 preliminary 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*.[30] 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]

---

[29] 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."

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

payment . . ."[31] 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."[32] 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.[33] Here, the Board makes the same finding based on similarly *overly generalized language.*

* * * * *

Based on the foregoing, the Board has dismissed the two (2) remaining issues in this case – (Issues 1 and 3). As no issues remain, the Board hereby closes Case No. 23-0011 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:

4/17/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[31] *Id*. at *11.
[32] *Id.*
[33] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Mr. Donald Anderson, Jr.
Director, Reimbursement Administration
Providence Health and Services
2001 Lind Avenue, SW
Renton, WA 98057

RE: **Determination re: Filing Requirements**
Providence St. Mary Medical Center (50-0002)
Appealed Period:FYE 12/31/2022
PRRB Case No.: 26-2285

Dear Mr. Anderson:

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 April 15, 2026, the Provider filed the above referenced appeal request, reportedly based on a Notice of Program Reimbursement ("NPR") dated 10/20/2025. The appeal request identified three (3) issues in dispute:

Nursing Allied Health Pass-Thru
Nursing Allied Health Managed Care
Rural Floor Budget Neutrality Factor

The final determination date was entered into OH CDMS as 10/20/2025. However, the support document uploaded for the final determination is a copy of the Appointment of Designated Representative for Individual Appeal letter and not a copy of the NPR, the final determination on which the appeal is based.

Upon review, the Board notes that the final determination was omitted from the jurisdictional documents required to establish the subject appeal.

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 above captioned 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, dated 10/20/2025, 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.

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 26-2285, in its entirety, and removes it from its docket.

The Board also notes if that NPR was issued October 20, 2025, the Provider would have until Thursday, April 23, 2026 to file the appeal (180 days plus the 5 day mailing presumption).

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.

FOR THE BOARD:

4/20/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Federal Specialized Services
Dean Wolfe, Noridian Healthcare Solutions (J-F)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision***
Northwestern Medicine CYs 2016 & 2017 DSH Unmatched Medicaid Days CIRP Group
PRRB Case No. 23-0347GC

Dear Mr. Putnam and Ms. VanArsdale:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the Medicare Contractor's Motion to Dismiss. The Board's decision is set forth below.

Procedural History

On **December 5, 2022**, Strategic Reimbursement Group, LLC ("Strategic") filed the calendar year ("CY") 2017 CIRP group. On the same date, Strategic transferred the Unmatched Medicaid Days issue from an individual appeal for Central Dupage Hospital (Prov. No. 14-0242) for FYE 08/31/2017 to the new group to which the Board assigned Case No. 23-0347GC.

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

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

[1] Statement of the Issue (Dec. 5, 2022).

On **November 7, 2023**, Strategic advised the Board that the subject group was fully formed with only a single provider. Therefore, Strategic requested that the Board expand the subject group to include CY 2016 to allow for the consolidation of another single participant CIRP group for the same issue under Case No. 23-0191GC.

On **November 16, 2023**, the Board granted the expansion of Case No. 23-0347GC to include CY 2016 and consolidated the sole provider in Case No. 23-0191GC, Northwestern Memorial Hospital (Prov. No. 14-0281) for FYE 8/31/2016 into the surviving group.

On **November 20, 2023**, Strategic transferred an additional provider to the group: Northwestern Memorial Hospital (Prov. No. 14-0281) for FYE 08/31/2017.

On **November 27, 2023**, Strategic advised the Board that the CIRP Group was fully formed and in accordance with Rule 20, was fully populated in OH CDMS.

On **November 29, 2023**, the Board issued the Group Completion Notice which set deadlines for the MAC's review of the providers in the case and the Parties' preliminary position paper (hereinafter "PPP") deadlines.

On **January 12, 2024**, Strategic filed the Groups' PPP. The Providers contend the necessary eligibility documentation was not available at the time of audit for the providers to meet its burden of production.[2] The Providers explain this was due to the "nature of processing Medicaid recipients' information as well as situations where eligibility is established 'retroactively' after the patient's stay…"[3] The Providers give multiple reasons for the inability to verify Medicaid eligibility for these days, including:

- Patients obtaining retroactive eligibility subsequent to the accumulation of the Medicaid days listing.
- Delays with the initial application for Medicaid benefits by the patient.
- Later reinstatement of Medicaid benefits after appeal.
- Identification of additional updated patient demographic information after the accumulation of the Medicaid days listing needed by the vendors to provide verification confirmation.
- Corrections made to patient information within state Medicaid systems (corrections to Social Security Numbers, birth dates, etc.).
- Identification of newborn's mother's demographic information acquired during mother's or newborn's subsequent hospital visits which leads to eligibility verification.[4]

[2] Providers' Preliminary Position Paper at 6 (Jan. 12, 2024).
[3] *Id*.
[4] *Id.* at 8.

The Providers claim they are working towards meeting the documentation requests pursuant to PRRB Alert 10, and that they have procedures in place "to identify and document their patients who are eligible for Medicaid coverage."[5] However, there remain Medicaid days which continue to be unmatched or unverified at the time of audit.[6] The Providers conclude the missing Medicaid days have resulted in an inaccurate Medicare DSH adjustment payment.[7]

On **May 20, 2024**, the MAC filed its PPP.

On **July 14, 2025**, the Board scheduled the case for a hearing on February 27, 2026. On February 19, 2026, the Board issued a Final Notice of Hearing scheduling an **April 27, 2026** hearing.

On **August 22, 2025**, Strategic filed a final PP for the group.

On **December 10, 2025**, the MAC filed a final PP for the group.

On **January 23, 2026**, the MAC filed a Motion to Dismiss the group.

MAC's Contentions in Motion to Dismiss

The MAC contends the CIRP Group abandoned their claim, arguing:

a. That the Providers have failed to furnish documentation in supports of their claims for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable.
b. That the Providers' failure to furnish such documentation (or describe why such documentation is unavailable) is in violation of PRRB Rules 7, 25.2.1 and 25.2.2.
c. That the Providers have effectively abandoned their claim for additional Medicaid Eligible Days. . .[8]

Group's Response

The Board Rules require that opposing party responses to motions must be filed within thirty (30) days from the date that the motion was sent to the opposing party and the Board.[9] The Provider has not filed a response to the Motion to Dismiss and the time for doing so has elapsed.

[5] *Id* at 6-7.
[6] *Id.*
[7] *Id.* at 9.
[8] Motion to Dismiss at 5-6 (Jan 23, 2026).
[9] Board Rule 44.3, v. 3.1 (Nov. 2021).

Analysis and Determination

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

42 C.F.R. § 405.1853 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*.

Board Rule 25 pertains to position papers:

> 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:
> . . .
>
> 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.

Finally, the regulations at 42 C.F.R. § 405.1868 state the following:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this

> subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.
>
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may-
>
> (1) Dismiss the appeal with prejudice;
>
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
>
> (3) Take any other remedial action it considers appropriate.

The Providers have alleged that certain "patient days pertaining to additional patient stays that were not paid by Medicaid but related to patients with Medicaid coverage during the stay" were omitted from the Medicaid fractions of their DSH payment calculations. The Providers did not submit an auditable listing of Medicaid days for review, nor have they provided any evidence regarding the merits of the specific Medicare payment claims regarding the Unmatched Medicaid Days issue. The Providers have had more than three years since this appeal was filed, to research, request, obtain, and submit this evidence to the Board in support of this appeal. For these reasons, the Board finds the group issue abandoned and dismisses the group appeal.

Conclusion

In sum, the Board finds the CIRP Group Appeal failed to develop its argument in its PPs. The Board dismisses the appeal in its entirety. Case No. 23-0347GC 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:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

4/20/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Case Number: 15-2050GC - Baptist Health 2005 Medicaid Fraction Dual Eligible (Pt A-Exhausted Benefit) Days CIRP

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board" or "PRRB") received the Providers' request to form a Common Issue Related Party ("CIRP") Group Appeal on **March 31, 2015**. The group was created with two (2) providers. Each Provider filed an individual appeal request from a revised Notice of Program Reimbursement ("NPR") and was directly added to the group when it was formed.

The Providers' Statement of the Group Issue describes the issue as follows:

> Baptist Health Exhausted Care Caid Dual Eligible Group (BHECC) contends that the Intermediary did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, BHECC disagrees with the calculation of the second computation of the disproportionate patient percentage, the Medicaid days proxy, set forth at 42 C.F.R. 412.106(b)(4) of the Secretary's Regulations.
>
> BHECC contends that the Intermediary failed to include all Medi-Medi patient days for Medicare Part A patients, whose Medicare Part A benefits were exhausted, but who were still eligible for Medicaid, in the Medicaid percentage of the Medicare DSH calculation. These days should have been included in the Medicaid percentage of the DSH calculation. *See* 42 CFR § 412.106 and Section § 1886(d)(5)(F)(vi)(II) of the Social Security Act.[1]

The Providers filed a Final Position Paper ("FPP") on **February 2, 2017**. The FPP repeats, almost verbatim, the Group Issue Statement. In a request to postpone the hearing, filed on **August 27, 2019**, the Providers have also represented that the appealed issue "deals with substantially similar issues" as *Empire Health Foundation, For Valley Hospital Medical Center*

[1] Group Appeal Request, Tab 2 (Mar. 31, 2015).

v. Price.[2] *Empire Health* dealt with "the Secretary's interpretation of the phrase 'entitled to benefits under [Medicare Part A]' in 42 U.S.C. § 1395ww."[3] The Supreme Court ultimately found that the Secretary "correctly construes the statutory language at issue."[4] This seemingly resolves the appealed issue in this case.[5]

Nevertheless, the Board issued several Notices of Hearing ("NOHs") in this case, the most recent being issued on **January 21, 2026** which set a hearing for **April 14, 2026**. The hearing date set in the January 21, 2026 NOH has passed and there was no request for postponement prior to the hearing. In fact, there has been no communication from the Providers' representative since October, 2024, when it requested a postponement of the hearing date that was upcoming at that time, which was granted.

Board Rule 41.2 (2023) 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***.[6]

As noted in Board Rule 41.2, failure to comply with the Board's deadlines or other requirements is addressed at 42 C.F.R. § 405.1868:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.

---

[2] 334 F. Supp. 3d 1134 (2018). *See* Request for Postponement (Aug. 27, 2019).
[3] *Empire Health Found. v. Price*, 334 F. Supp. 3d 1134, 1141 (E.D. Wash. 2018)
[4] 142 S.Ct. 2354, 2362 (2022).
[5] The Board notes that a second "Final Position Paper" was filed on February 20, 2024 which inappropriately and significantly expanded the scope of the originally appealed and briefed group issue. The Board views this second filing as a Supplemental Position Paper, which "should not present new positions, arguments or evidence" but should **narrow** the parties' positions. Board Rule 27.3 (2015).
[6] (Emphasis added.)

> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—
> (1) Dismiss the appeal with prejudice;
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
> (3) Take any other remedial action it considers appropriate.

Further, Board Rule 5.2 addresses the Representative's responsibilities:

> The case representative is responsible for being familiar with the following rules and procedures for litigating before the Board:
>
> - The Board's governing statue at 42 U.SC. §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 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.

As previously noted, the issue appealed in this case was decided by the Supreme Court in *Becerra v. Empire Health Foundation*. The Board, therefore, reasonably concludes that the issue under appeal has been fully settled and will close the case pursuant to Board Rule 41.2. More importantly, the Providers failed to appear for the hearing set for April 14, 2026. The Board received no request to postpone the hearing and has received no communication from the Providers' representative, despite the fact that the hearing date has passed. As such, the Provider's failure to appear for the scheduled hearing serves as an independent basis to dismiss

and close the case, pursuant to Board Rule 41.2. The Board, therefore, hereby dismisses Case 15-2050GC and removes it from its docket.

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

Board Members:

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

For the Board:

4/20/2026

X Kevin D. Smith, CPA

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

cc: Ed Lau, Esq. Federal Specialized Services
First Coast Services Options, Inc. c/o GuideWell Source (J-N)

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

To: Medicare Contractor Management Group
Center for Medicare
Centers for Medicare & Medicaid Services

From: Provider Reimbursement Review Board

Subject: ***Failure of the Medicare Contractors to Timely Submit Documentation***

Case Number: 25-1782GC - OSF Healthcare FFY 2025 Understated IPPS Standardized Amt. CIRP Group
Case Number: 26-0914GC - LifePoint Health FFY 2026 Understated IPPS Standardized Amt. CIRP Group

Contractors: Federal Specialized Services
National Government Services, Inc. (J-6)
Palmetto GBA c/o National Government Services, Inc. (J-M)

Pursuant to 42 C.F.R. § 405.1868, the Provider Reimbursement Review Board ("Board") "has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provision of section 1878 of the Act and of the regulations . . . The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders." Specifically, if a contractor fails to meet a filing deadline or other requirement established by the Board, subsection (c) permits the Board to take actions such as excluding untimely filed evidence; or issuing a written notice to CMS and requesting that CMS take appropriate action regarding the contractor's noncompliance with its contractual requirements.

Board Rule 44.6 (2023) – *Special Rules for Filing Challenges (Jurisdictional or Substantive Claim) in Group Cases When an EJR Request is Filed within 60 Days of the Final Schedule of Providers* – reads:

> If the final schedule of providers for a group appeal is filed concurrently with an EJR request, or 60 days has not yet transpired between the filing of the final SOP and the EJR request, then the Medicare contractor (or any other moving party) has five (5) business days to either:
>
> 1. File any jurisdictional and/or Substantive Claim Challenge(s) related to the group appeal (or participants therein, as relevant); or

> 2. Submit a filing wherein the Medicare contractor certifies that it will, *in fact*, be filing a challenge(s) (whether to a Jurisdictional or Substantive Claim Challenge) related to the group appeal (or participants therein, as relevant) but it has not yet had an opportunity to complete its review of the final schedule of providers and to finalize the filing for the challenge(s).
>
> If the Medicare contractor files the certification described above in No. 2, then the Medicare contractor must file the challenge(s) ***no later than twenty (20) days following the filing of the EJR request***. Following receipt of those challenges (and consistent with 42 C.F.R. §§ 405.1842(e)(3), 405.1873(b)(1), and 405.1873(d)(2) and Board Rule 42.1), the Board will issue a Scheduling Order setting a deadline for the Provider's response and will confirm therein that the 30-day period for the Board to rule on the EJR request has been stayed because the EJR request is incomplete and the Board does not yet have all the information necessary to rule on the EJR request. **NOTE: If the Medicare contractor files the certification, then the failure of the Medicare contractor to file any challenges within the 20-day deadline will be grounds for the Board to take remedial action pursuant to 42 C.F.R. § 405.1868(c)(1), unless the Medicare contractor establishes good cause.**[1]

In the above-referenced cases, the Providers' representative filed requests for Expedited Judicial Review ("EJR") on **December 30, 2025**. Both groups were also deemed fully formed on the same date as the requests for EJR, *i.e.*, December 30, 2025. Therefore, in accordance with Board Rule 44.6, the Medicare Contractor had five (5) business days to either file a jurisdictional challenge OR submit a filing certifying that the Medicare Contractor will be filing a jurisdictional challenge. The second option requires the challenge to be filed no later than twenty (20) days following the filing of the EJR request.

On **January 5, 2026**, both the Medicare Contractor, National Government Services, Inc. ("NGS") and the appeals support contractor, Federal Specialized Services ("FSS") filed, within five (5) business days of the EJR request, responses indicating that they would be filing a jurisdictional challenge. In Case No. 25-1782GC, NGS indicated:

> Based on our review, we believe there is a jurisdictional impediment related to the providers included on the Schedule of Providers. The appealed issue is intertwined with the FFY 1984 and 1985 budget neutrality adjustments to the standardized amounts and 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations) prohibit administrative and judicial review of those budget neutrality adjustments. **The MAC will file a jurisdictional challenge to the Board.**[2]

[1] (Bold/italics emphasis in original; bold/underline emphasis added.)
[2] Case No. 26-0941GC, MAC Rule 22 Jurisdictional Review at 1-2 (Jan. 5, 2026) (emphasis added).

Similarly, in Case No. 26-0941GC, NGS stated that "the MAC contends that the Board does not have jurisdiction over the IPPS Standardized Amount issue and **will be filing a jurisdictional challenge**."[3]

Based on the representations from both the Medicare Contractor and FSS, and pursuant to Board Rule 44.6, the Jurisdictional Challenges were due to be filed by Monday **January 19, 2026**, which was a Federal legal holiday. Therefore, pursuant to 42 C.F.R. § 405.1801(d)(3) and Board Rule 4.4.3, the due date would have been Tuesday **January 20, 2026**. The Board notes that technical difficulties with the electronic case management system, the Office of Hearings Case and Document Management System ("OH CDMS") could have further impacted the filing due date of the jurisdictional challenges, however nothing was filed even taking those difficulties into account.

Therefore, on the morning of Thursday, January 22, 2026, Board staff emailed the parties asking whether the Medicare Contactors and/or FSS would be filing jurisdictional challenges, as they indicated. A representative emailed back later in the day that challenges would not be filed "in light of the St. Mary's decision." Neither the Medicare Contractor nor FSS filed anything in the official records of the appeals that they would not, in fact, be filing jurisdictional challenges.

The decision that FSS referenced is *St. Mary's Regional Medical Ctr. v. Becerra* (D.D.C. Dec. 20, 2024), in which the court found in favor of the Providers in **December of 2024**, over a year before the EJR requests were even filed in these two appeals. Therefore, it is unclear to the Board why, on January 5, 2026 the Medicare Contractors and FSS indicated that they would file jurisdictional challenges, but then less than a month later, in light of a decision that had been issued over a year ago, challenges would not be filed.

The practical implications of the Medicare Contractor and FSS not filing jurisdictional challenges were substantial. Had the challenges been filed, the Board would have issued Scheduling Orders setting deadlines for the Providers' responses, and would have confirmed therein that the 30-day period for the Board to rule on the EJR requests was stayed because the EJR requests were incomplete and the Board did not yet have all the information necessary to rule on the EJR requests. Instead, the Board had to complete its jurisdictional review and findings on EJR within an abbreviated time frame in order to timely issue the EJR decisions within the 30-day regulatory timeframe.[4]

In conclusion, the Board is issuing this non-compliance letter, pursuant to 42 C.F.R. § 405.1868(c)(1), due to the failure of the Medicare Contractor and/or FSS to file jurisdictional challenges as they indicated that they would do in their January 5, 2026 and January 8, 2026 correspondences to the Board. Furthermore, the Board admonishes both the Medicare Contractors and FSS for failing to notify the Board that they would not be filing the jurisdictional challenges.

[3] Case No. 26-0941GC, MAC PRRB Rule 22 Jurisdictional Review at 1 (Jan. 8, 2026) (emphasis added).
[4] 42 C.F.R. § 405.1842(e)(1).

Board Members Participating:

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

For the Board:

4/20/2026

X Kevin D. Smith, CPA

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Detar Healthcare System, Prov. No. 45-0147, FYE 09/30/2018
Case No. 23-1428

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-1428. Set forth below is the decision of the Board to dismiss the 2 remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) and Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 23-1428*

On **December 22, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2018. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **June 7, 2023**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Unduly Narrow Definition of SSI Entitlement[1]
3. DSH Payment – Medicaid Eligible Days
4. DSH Payment – Medicare/SSI and Medicaid Fractions – Medicare Managed Care Part C Days[2]
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)[3]

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **June 15, 2023 and January 8, 2024**, the Provider transferred Issues 2, 4 and 5 to CHS CIRP groups.

[1] On June 15, 2023, this issue was transferred to Case No. 21-0078GC.
[2] On January 8, 2024, this issue was transferred to Case No. 20-2149GC.
[3] On January 8, 2024, this issue was transferred to Case No. 21-0066GC.

As a result of the case transfers, there are two (2) remaining issues in this appeal: Issue 1 (the DSH – SSI Percentage Provider Specific) and Issue 3 (the DSH – Medicaid Eligible Days).

On **June 8, 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. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

On **January 12, 2024**, the Provider timely filed its preliminary position paper.

On **March 21, 2024**, the Medicare Contractor filed a Request for an unredacted listing of the Medicaid Eligible days listing in connection with Issue 3. In this filing, the Medicare Contractor noted that the appeal request included an estimated 100 days in dispute, while the preliminary position paper included a redacted listing of 1,637 days and promised the unredacted listing was to be sent to the Medicare Contractor. As no listing was received, the Medicare Contractor formally filed the Request for the unredacted listing plus supporting documentation be provided to the Medicare Contractor on or before May 5, 2024 (*i.e.*, within 45 days). Notwithstanding the formal request, the Provider failed to file any response to the Medicare Contractor.

On **April 23, 2024**, the Medicare Contractor filed its preliminary position paper.

On **May 14, 2024**, the Medicare Contractor timely filed a Jurisdictional Challenge[5] with the Board over Issues 1 and 3 requesting that the Board dismiss these issues. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

---

[4] (Emphasis added.)

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

B. Description of Issue 1 in the Appeal Request and the Commonly Owned Entities in Case No. 21-1206GC

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

> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> 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).[6]

PRRB Case No. 21-1206GC is DSH/SSI Percentage (Systemic Errors) case involving multiple providers commonly owned by CHS. CHS is also the owner of Detar Healthcare System. The Group Issue Statement in Case No. 21-1206GC reads:

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

[6] Issue Statement at 1 (Sept. 11, 2019).

> 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.[7]

On January 12, 2024, the Board received the Provider's preliminary position paper in 23-1428. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[8]

C. 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 DSH calculations. The Provider describes Issue 3 as:

> **Statement of Issue**

[7] Group Issue Statement, Case No. 21-1206GC.
[8] Provider's Preliminary Position Paper at 8-9 (Jan. 12, 2024).

> 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): 6,30,49,S-D
>
> Estimated Reimbursement Amount: $55,870[9]

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

---

[9] Appeal Request at Issue 3.
[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 9 (Jan. 12, 2024).
[12] *Id.* at 9-10.

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2, which was transferred to PRRB Case No. 21-0078GC.[13] The portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and unnecessary as the Provider's cost reporting period is concurrent with the Federal Fiscal Year.[14] Further, did not brief the issue in its preliminary position paper.[15]

Finally, the MAC argues "the Provider did not file a **complete** preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3."[16] The MAC posits that the Provider "failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its Preliminary Position Paper."[17]

Issue 3 – DSH Payment – Medicaid Eligible Days

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

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

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

[13] Medicare Contractor's Jurisdictional Challenge at 4-6 (May 14, 2024).
[14] *Id*. at 6-7.
[15] *Id*. at 6.
[16] *Id*. at 7 (Emphasis added).
[17] *Id*. at 9.
[18] Board Rule 44.4.3, v. 3.2 (Dec. 2023).

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.

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[19] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[20] The Provider argues in its issue statement, which was included in the appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[21]

The commonly owned entities' DSH/SSI Percentage (Systemic Errors) issue in Group Case No. 21-1206GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 23-1428 is common to the DSH/SSI Percentage (Systemic Errors) issue being appealed by commonly owned entities in Case No. 21-1206GC. Because the issue is common amongst providers under common ownership, and commonly issues being appealed for fiscal years that end in the same calendar year must be appealed under a group appeal,[22] the Board is prepared to dismiss this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, CHS is pursuing that issue for the participants under Case No. 21-1206GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1).

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[19] Issue Statement at 1.
[20] *Id.*
[21] *Id.*
[22] PRRB Rule 12.3.1 (v. 3.2, Dec. 2023).

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.[23] Accordingly, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, 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" issue rather than being subsumed into the "systemic" issue appealed in Case No. 21-1206GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 21-1206GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records" but fails to explain how it can, explain how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2.[24] Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with 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 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents**
>
> 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]

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[23] 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).

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

[25] (Italics and underline emphasis added.)

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

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[26]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 21-1206GC.

Additionally, in its Preliminary Position Paper, the Provider states, "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 [sic] (Appellants' reply brief included as Exhibit P-3)." The Board finds that this incorporation by reference does not comply with the regulatory and Board rule requirements to *fully* develop the Provider's position in the Preliminary Position Paper. Particularly, 42 C.F.R. § 405.1853 provides 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*.[27]

An incorporation of arguments by reference from a different case simply fails to do so. Accordingly, the Board dismisses that portion of the issue as well. The Board also notes that the

[26] Last modified March 17, 2026.
[27] (Emphasis added).

Provider's fleeting reference to *Advocate Christ* does not change the issue being appealed or make it duplicative of the Dual Eligible Days issue for which the Provider is a participant in PRRB Case No. 21-0078GC.

2. *Second Aspect of Issue 1*

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

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Moreover, the Provider's cost reporting period is already aligned with the Federal fiscal year end. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

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

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

> 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.

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.[28]

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 preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

> **Rule 25 Preliminary Position Papers**[29]
>
> **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…Therefore, the Board requires preliminary position papers to present the ***fully*** developed positions of the parties and expects that parties will be diligent in planning and conducting any required investigation, discovery, and analysis well in advance of the filing deadline.
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the following sub-sections.
>
> **25.1.1 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

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

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 the Board

The Board requires the parties file a ***complete*** preliminary position paper that includes a fully developed narrative (Rule 25.1), 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. 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 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on June 8, 2023 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.[30]

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

[30] (Emphasis added.)

- upon failure to appear for a scheduled hearing.

On January 12, 2024, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[31] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather has failed to provide a complete, unredacted list of additional Medicaid eligible days to the MAC. While a redacted list was included as an exhibit with its Preliminary Position Paper, this version is deficient. The Provider's briefing of this issue in its position paper is, in relevant part, below:

> **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.
>
> 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

[31] Provider's Preliminary Position Paper at 10.

> 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 [MAC] included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover directly to the MAC, including Section 1115 waiver days (a redacted copy is attached), 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.
>
> 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.[32]

The redacted listing included with the preliminary position paper was 13 pages with roughly 1,637 Medicaid eligible days. The Provider's filing did not explain why the listing of so many days (again around 1,637 days) was being submitted at this late date or which it was not final (*i.e.*, why it was "pending finalization") at this late date, ***more than 5 years after the fiscal year at issue had closed***. NOTE—the roughly 1,637 included in this belated listing is *exponentially* larger than the original estimate of 100 days included with the appeal request.

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

[32] *Id*. at 9-10.

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"[33] 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 submit a finalized listing of Medicaid eligible days, 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.[34]

C. 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 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 June 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…

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[33] (Emphasis added.)

[34] *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.

> (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…[35]

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 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 (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, but are not limited to:
>
> . . .
>
> ***Section 1115 waiver days (program/waiver specific). . .***[36]

Effective August 21, 2008, following the appropriate notice and comment period, new Board

[35] 42 C.F.R. § 405.1835(b).
[36] (Bold and italic emphasis added).

regulations went into effect that limited the addition of issues to appeals.[37]

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.[38] 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 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)**

[37] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[38] 65 FR 47054, 47087 (Aug. 1, 2000).

> **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 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 preliminary position paper is perfunctory in that it only makes perfunctory conclusions.[39] 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 (Dec. 2023).

The Board's finding that neither the appeal request nor preliminary 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*.[40] 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 . . ."[41] 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."[42] The Court found that this was a description of the issue was a violation of Board rules and a proper

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[39] 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."

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

[41] *Id*. at *11.

[42] *Id.*

basis on which for the Board to dismiss the appeal.[43] Here, the Board makes the same finding based on similarly *overly generalized language*.

* * * * *

In summary, the Board hereby dismisses the portion of the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal related to SSI realignment as there is no final determination from which the Provider can appeal. The Board also dismisses Issue 3.

As the Provider is not currently participating in PRRB Case No. 21-1206GC and the portion of the DSH Payment/SSI Percentage (Provider Specific) issue pertaining to the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage is common of that case, ***the Board is requiring the Provider transfer the issue to PRRB Case No. 21-1206GC within ten (10) days of the date of this letter. If the Provider fails to do so, the issue will be dismissed and the case will be closed.***

Pending final disposition of 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 Participating:

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

For the Board:

4/20/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[43] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
AdventHealth Lake Wales, Prov. No. 10-0099, FYE 08/31/2019
Case No. 24-0047

Dear Mr. Summar:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 24-0047. Set forth below is the decision of the Board regarding the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific).

Background

A. *Procedural History for Case No. 24-0047*

On **April 26, 2023**, 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 **October 10, 2023**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

[1] Issue withdrawn March 20, 2026.
[2] On May 9, 2024, this issue was transferred to PRRB Case No. 23-0078GC.
[3] This issue was bifurcated by the Board into separate issues for the SSI Fraction (Issue No. 4) and the Medicaid Fraction (Issue No. 5). The remaining SSI Fraction issue was dismissed by the Board on May 9, 2024.
[4] This issue was created via the bifurcation of Issue No. 4 on May 9, 2024. It was subsequently transferred, on May 20, 2024, to PRRB 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 **May 9 and 20, 2024**, the Provider transferred Issues 3 and 5 to CHS CIRP groups.

As a result of the case transfers, there are two (2) remaining issues in this appeal: Issue 1 (the DSH – SSI Percentage Provider Specific) and Issue 2 (the DSH – Medicaid Eligible Days).

On **October 16, 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. 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 **June 5, 2024**, the Provider filed its preliminary position paper.

On **July 1, 2024**, the Medicare Contractor timely filed a Jurisdictional Challenge[6] with the Board over Issues 1 and 2 requesting that the Board dismiss these issues. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **August 26, 2024**, the Medicare Contractor filed its preliminary position paper.

B. Description of Issue 1 in the Appeal Request and the Commonly Owned Entities in Case No. 22-1031GC - CHS CY 2019 DSH SSI Percentage CIRP Group

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

---

[5] (Emphasis added).

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

> The Provider contends that 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 cause [sic] CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issue 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 its 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).[7]

PRRB Case No. 22-1031GC is a DSH/SSI Percentage (Systemic Errors) case involving multiple providers commonly owned by CHS. CHS is also the owner of AdventHealth Lake Wales. The Group Issue Statement in Case No. 22-1031GC reads, in part:

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

[7] Issue Statement at 1 (Oct. 10, 2023).

> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[8]

On February 20, 2024, the Board received the Provider's preliminary position paper in 24-0047. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Issue #1: Provider Specific**
>
> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[9]

MAC's Contentions

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

[8] Group Issue Statement, Case No. 22-1031GC.
[9] Provider's Preliminary Position Paper at 8-9 (Feb. 20, 2024).

The MAC argues "the Provider did not file a **complete** preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3."[10] The MAC posits that the Provider "failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its Preliminary Position Paper."[11]

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

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.

DSH Payment/SSI Percentage (Provider Specific)

Issue No. 1—the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that the Provider's commonly owned entities appealed in Case No. 22-1031GC. The Provider however, has failed to transfer the issue, and had attempted to brief the issue in the individual appeal.

Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[13] The Provider argues in its issue statement, which was included in the appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[14]

[10] Jurisdictional Challenge at 4 (Jul. 1, 2024).
[11] *Id*. at 6.
[12] Board Rule 44.4.3, v. 3.2 (Dec. 2023).
[13] *Id.*
[14] *Id.*

The Board reviewed the Provider's PPP which refers to systemic *Baystate* data matching issues. 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 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]

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 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."

[15] (Italics and underline emphasis added.)

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 dismisses this aspect of the SSI Provider Specific issue from the instant appeal.

* * * * *

Based on the foregoing, the Board is dismissing the last issue in this case: the SSI Percentage (Provider Specific) - Issue 1. As no issues remain, the Board hereby closes Case No. 24-0047 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:

4/20/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[16] Last modified March 17, 2026.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
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Arcadia, CA 91006

RE: **EJR Determination QRS Outlier Threshold CIRP Group**

Case Number: 14-3631GC - *QRS Memorial Hermann FFY 2012 Outlier Fixed Loss Threshold CIRP Group*

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Request for Expedited Judicial Review ("EJR") filed **February 26, 2026** in the above-referenced appeal. The Board's decision with respect to EJR is set forth below.

I. Background

The Providers submitted a request to form a Common Issue Related Party ("CIRP") group appeal on June 2, 2014 and described the group issue as:

Group Issue: Outlier Payments - Fixed Loss Threshold

Statement of Issue

Whether the Providers received the reimbursement Congress intended under the Medicare Act for treating certain cases that incurred extraordinarily high costs? Was the cost outlier threshold set improperly?

Statement of the Legal Basis

The Provider contends the Secretary's final determination of outlier payments for the fiscal year 2004 was arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law within the meaning of 5 U.S.C. Section 706(2)(A), and is short of statutory rights within the meaning of 5 U.S.C. Section 706(2)(c), because the Secretary acted in an arbitrary and capricious manner and abused her discretion when setting the outlier threshold and calculating outlier payments for federal fiscal year

> 2004. The Secretary failed to consider relevant factors and data which should have been taken into account when setting the criteria, failed to consider alternative methodologies when establishing the outlier thresholds and failed to demonstrate a reasonable connection between the thresholds and the factors considered. Among other things, the Secretary failed to consider relevant data which showed that the rate of increase in hospital costs per discharge was trending downward and that the relationship of hospital costs to hospital charges was changing. The Secretary thus failed to take into account the established pattern of declining cost-to-charge ratios, which play a significant part in the calculation of outlier payments, despite this problem being repeatedly pointed out in comments and despite proposed methods to account for this phenomenon and to more accurately estimate outlier payments so that thresholds could be set more accurately. Further, the Secretary failed to consider use of the "cost methodology," rather than the "charge methodology," in setting the outlier thresholds, despite the fact that the cost methodology had been more accurate in predicting outlier payments in prior years. Finally, the Secretary failed to require mid-year adjustments and failed to consider adjustments to the reconciliation process. These deficiencies in the Secretary's methodology were identified in the rulemaking comments. By ignoring the flaws in her methodology, the Secretary failed to act reasonably in calculating the amounts of outlier payment to which hospitals are entitled. As a result of these arbitrary and capricious actions, the threshold was set too high, the resulting amount of outlier payments fell short of the percentage required by the Medicare Act and hospitals did not receive the amount of outlier payments that Congress intended.[1]

The Board notes that the Providers ***incorrectly*** assert in the issue statement that they are appealing their outlier threshold payments for ***fiscal year 2004***, but the appeal actually concerns fiscal years ending in 2012. The parties have filed preliminary position papers, the group is fully formed, and the Providers' representative has confirmed, pursuant to Board Rule 20, that the group is fully populated in OH CDMS. On **February 26, 2026**, the Providers filed a request for Expedited Judicial Review ("EJR").

II. Relevant Law

Part A of the Medicare Act covers "inpatient hospital services." Originally, Medicare reimbursed hospitals based on the "reasonable costs" of these services.[2] Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[3] Under IPPS, Medicare pays

[1] Group Issue Statement at 1 (Jun. 2, 2014).
[2] *See* 42 U.S.C. § 1395f(b)(1).
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.

predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4] These predetermined, standardized amounts are calculated by the Secretary first determining a nationwide average allowable cost per discharge,[5] which is then further adjusted based on a wage index specific to the locality of the hospital.[6] Each discharge is also adjusted based on the severity of illness, which are classified as distinct diagnosis-related groups ("DRGs").[7] These DRGs are intended to weight the reimbursement based on "the relationship between the cost of treating patients within that group and the average cost of treating all Medicare patients."[8]

While the IPPS provides a fixed amount of reimbursement per patient regardless of actual costs incurred in rendering services,[9] Congress also authorized supplemental "outlier payments," or additional reimbursement for patients' care if the cost was atypically high.[10] Hospitals may request outlier payments "in any case where charges, adjusted to cost, exceed . . . the sum of the applicable DRG prospective payment rate . . . plus a fixed dollar amount determined by the Secretary."[11]

Ensuring that costs are "adjusted to cost" involves evaluating a hospital's "cost-to-charge ratio," which represents the hospitals "average markup" of inpatient hospital services.[12] Outlier payments may be requested if the adjusted costs exceed the DRG rate plus a "fixed dollar amount" – commonly referred to as the "fixed loss threshold."[13] This amount essentially makes a hospital responsible for a portion of the treatment's excessive costs.[14] The Secretary is mandated to ensure that the fixed loss threshold for a given fiscal year results in outlier payments between five (5) and six (6) percent of total payments projected or estimated to be made under the IPPS.[15] The sum of the DRG rate plus the fixed loss threshold is known as the "outlier threshold."[16] Hospitals are typically paid 80% of the costs above the applicable outlier threshold.[17]

As noted by the United States District Court for the District of Columbia, basing outlier payment eligibility on a hospital's own cost-to-charge ratio "led to rampant inflation of hospital charges, a problem that came to be known as 'turbo-charging.'"[18] To combat turbo-charging, the Secretary

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[4] *Id.*
[5] 42 U.S.C. § 1395ww(d)(2)(A)-(C).
[6] 42 U.S.C. § 1395ww(d)(2)(H).
[7] 42 U.S.C. § 1395ww(d)(4).
[8] *See Cape Cod Hosp. v. Sebelius*, 630F.3d 203, 205-206 (D.C. Cir. 2011).
[9] *See Sebelius v. Auburn Reg'l Med. Ctr.*, 133 S.Ct 817, 822 (2013).
[10] *See County of L.A. v. Shalala*, 192 F.3d 1005, 1009 (1999); 42 U.S.C. § 1395ww(d)(5)(A).
[11] 42 U.S.C. § 1395ww(d)(5)(A)(ii).
[12] *See Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d 46, 49-50 (D.C. Cir. 2015) (citing *Appalachian Reg'l Healthcare, Inc. v. Shalala*, 131 F.3d 1050, 1052 (D.C. Cir. 1997)); 42 C.F.R. § 412.84(i).
[13] *See Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d at 50.
[14] *See Boca Raton Comm. Hosp., Inc. v. Tenet Health Care Corp.*, 582 F.3d 1227, 1229 (11th Cir. 2009).
[15] 42 U.S.C. § 1395ww(d)(5)(A)(iv).
[16] *See Banner Health v. Price*, 867 F.3d 1323, 1329 (D.C Cir. 2017) (citing *Boca Raton v. Tenet Health*, 582 F.3d at 1229); 42 U.S.C. § 1395ww(d)(5)(A)(ii).
[17] 42 C.F.R. § 412.84(k).
[18] *Billings Clinic v. Azar*, 901 F.3d 301, 306 (D.C. Cir. 2018) (citing *Banner Health v. Price*, 87 F.3d at 1333).

began using more recent data and also reserved the right to recalculate a hospital's eligibility for outlier payments using actual cost data at the time of settlement, a process known as reconciliation.[19]

III. Positions of the Parties

As noted above, the Providers' group issue statement outlines a number of challenges to their outlier payments, claiming the process was arbitrary, capricious, an abuse-of discretion-or otherwise not in accordance with law within the meaning of the Administrative Procedure Act.[20] They take issue with the outlier thresholds set by the Secretary because they argue that she failed to consider relevant data which would have impacted their cost-to-charge ratios; failed to consider use of the more accurate "cost methodology" versus the "charge methodology"; and failed to require mid-year adjustments to the threshold or adjustments to the reconciliation process.[21]

The Providers have filed a Preliminary Position Paper alleging that CMS set the cost outlier threshold too high, meaning all acute hospitals participating in the IPPS received a 5.1% reduction in payment for each case, which reduction was used to fund extraordinarily high cost patient stays.[22] They essentially argue that the Secretary's methodology in calculating the outlier cost threshold invited the abusive turbo-charging carried out by some hospitals, and that the use of this methodology persisted "[d]espite multiple warnings from providers, and red flags raised by the data on which the Secretary relied, and without valid justification[.]"[23]

The Providers note that, for the fiscal years at issue in these appeals, outlier payments were set at 5.1 percent of operating DRG payments, but outlier payments ultimately totaled less than this.[24] They argue the outlier payments at issue are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law."[25] They claim that the Secretary failed to consider relevant data and alternative methodologies when establishing outlier thresholds, despite these deficiencies being identified in rulemaking comments.[26]

The Medicare Contractor argues that substantially identical arguments were considered, and rejected, by the D.C. District Court in *District Hosp. Partners, L.P. v. Sebelius*.[27] It asks the Board to adopt the reasoning of the court and affirm the adjustments to outlier payments or, in

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[19] *Id.* (citing 68 Fed. Reg. 34494, 34499 (June 9, 2003)).
[20] 5 U.S.C. § 706(2).
[21] Group Issue Statement at 1.
[22] Provider's Preliminary Position Paper at 11 (June 1, 2023),
[23] *Id.* at 12.
[24] *Id.* at 15 (FFY 2012 total outlier payments were 5.0%).
[25] *Id.* at 16.
[26] *Id.*
[27] Medicare Contractor's Preliminary Position Paper at 7 (Sept. 28, 2023) (citing 973 F. Supp. 2d, 1 (D.D.C. 2014). The case was ultimately affirmed in part, reversed in part, and remanded, though the general rationale of the District Court was affirmed. *Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d 46 (D.C. Cir. 2015).

the alternative, allow the Providers to seek expedited judicial review in accordance with 42 C.F.R. § 405.1842.[28]

A. Jurisdictional Challenge

Board Rule 44.4 (2023) – *Jurisdictional Challenges - Timing* – reads:

> Jurisdiction may be challenged at any time. However, the Board requests that preliminary jurisdictional reviews be completed pursuant to the timeframes below.
>
> 44.4.1 Individual Cases
>
> Consistent with the Medicare contractor's obligations in 42 C.F.R. § 405.1853(a) and Rule 25, the Board requests that the Medicare contractor preliminarily review the provider's claimed basis for jurisdiction and raise any identified jurisdiction challenges PRIOR TO **filing** the PJSO, if applicable, or PRIOR TO **filing** the Medicare contractor's preliminary position paper.
>
> If a request for expedited judicial review ("EJR") is filed in an individual case, the Medicare contractor must file any jurisdictional challenge impacting the Board's review of that EJR request within five (5) business days of the filing of the EJR request. In this situation, consistent with 42 C.F.R. § 405.1842(e)(3) and Board Rule 42.1, the Board would then issue a Scheduling Order setting a deadline for the Provider's response (but no more than 30 days).

The Providers in this case certified, pursuant to Board Rule 20, that their case was fully formed and fully populated in OH CDMS on **May 30, 2023**. The Petition for EJR was filed on **February 26, 2026**. Five (5) business days later was **March 5, 2026**, and the Medicare Contractor's designated representative, Federal Specialized Services ("FSS"), filed a response to the Request for EJR on that day, explaining:

> [T]he MAC will file a jurisdictional challenge as to providers 45-0068 and 45-0610. Each filed their appeal based on a failure to issue a timely determination. However, both providers filed their appeals based on their original cost reports and both have filed several amended cost reports.
>
> The two providers' appeals were filed on 6/2/14. Provider 45-0068's last amended cost report was filed on 3/3/14 and accepted on 3/20/14. This report was settled on 8/25/17 due to the prior year audit. Provider 45-

[28] *Id.* at 8.

> 0610's last amended cost report was filed on 3/12/14 and accepted on 4/4/14. That cost report was settled on 10/17/14.[29]

On **March 10, 2026**, FSS filed an ***untimely*** Jurisdictional Challenge, which elaborated on the arguments made in the ***timely*** March 5 challenge. The Board issued a Scheduling Order on **March 24, 2026** requiring the Providers to file a response to the Jurisdictional Challenge no later than **April 2, 2026**, but the Providers failed to file any response.

IV. Decision of the Board

A. Expedited Judicial Review

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.

i. Jurisdiction

A group of Providers generally have a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if:

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [30]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[31]

42 U.S.C. 1395oo(a)(1)(B) permits a provider to file an appeal if it "has not received [a] final determination from [the] intermediary on a timely basis after filing [its cost] report, where such report complied with the rules and regulations of the Secretary relating to such report[.]"

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[29] Response to Provider's Request for Expedited Judicial Review at 1 (Mar. 5, 2026).
[30] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[31] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

Medicare Contractors must issue an NPR within twelve months of receiving a Provider's perfected or amended cost report. Providers are afforded the right to appeal if this NPR is not timely received, pursuant to 42 C.F.R. § 405.1835(c), which states:

> (1) A final contractor determination for the provider's cost reporting period is not issued (**through no fault of the provider**) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report **or amended cost report** is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.
>
> (2) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section) . . .

In some instances, Providers file amended cost reports before twelve months has elapsed from the filing of their original cost reports. When that happens, the Medicare Contractor is afforded twelve months to issue an NPR following acceptance of that amended cost report. The right to appeal an untimely NPR, however, is only afforded when the failure to issue an NPR is <u>through no fault of the provider</u>. Filing an amended cost report, which resets the timeline to issue an NPR, is a provider action; therefore, the failure to issue an NPR on the original cost report is the provider's "fault." Filing an appeal before twelve months has elapsed from the acceptance of the amended cost report in these circumstances is premature. Based on the jurisdictional challenges filed and the records before the Board, the following cases and providers have filed premature appeals in this context:

- Memorial Hermann Texas Medical Center (Provider No. 45-0068; FYE 06/30/2012; Failure to Issue a Timely Determination)
- Memorial Hermann Memorial City Hospital (Provider No. 45-0610; FYE 06/30/2012; Failure to Issue a Timely Determination)

Indeed, though untimely, the Medicare Contractor's Jurisdictional Challenge explains that the original cost reports for both challenged Providers were received on December 3, 2012. Thus, the 12-month period for a timely issuance of an NPR ended on December 3, 2013. Prior to this 12-month period elapsing, however, both Providers filed amended cost reports in August and October, 2013, respectively, which were accepted by the Medicare Contractor.[32] Since these two appeals were premature, they are hereby ***dismissed,*** though Memorial Hermann Memorial City

[32] Medicare Administrative Contractor's Jurisdictional Challenge at 4 and n.3 (Mar. 10, 2026).

Hospital (Provider No. 45-0610; FYE 06/30/2012) still remains in the appeal as it also filed a timely appeal from its NPR.

The remainder of the Providers' documentation shows that the appeals were timely, and the estimated amount in controversy exceed $50,000, as required for a group appeal.[33]

a. Dissatisfaction - FYEs December 31, 2008 to December 31, 2016 (1727-R)

The Providers in this case have FYEs in 2012.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming an issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[34] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[35]

On August 21, 2008, new regulations governing the Board were effective.[36] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[37] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[38]

The Secretary did not appeal the decision in *Banner* and decided to largely apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on December 31, 2008 and which began

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[33] *See* 42 C.F.R. § 405.1837.
[34] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[35] *Bethesda* at 1258-59.
[36] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[37] 201 F. Supp. 3d 131 (D.D.C. 2016).
[38] *Id.* at 142.

before January 1, 2016, Under this ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

The Board has determined that the Outlier Threshold methodology at issue in this case is governed by CMS Ruling CMS-1727-R since the Providers are challenging the policy as set forth in 42 U.S.C. § 1395ww(d)(5) and 42 C.F.R. § 412.84 and that Board review of the issues is not otherwise precluded by statute or regulation.

V. Board's Decision Regarding the EJR Request

The Board finds that:

1) Memorial Hermann Texas Medical Center's (Provider No. 45-0068; FYE 06/30/2012) and Memorial Hermann Memorial City Hospital's (Provider No. 45-0610; FYE 06/30/2012) appeals taken from the failure of the Medicare Contractor to issue a timely final determination are premature and hereby ***dismissed*** from the instant appeal;

2) It has jurisdiction over the matter for the subject years and that the remaining participants are entitled to a hearing before the Board;

3) Based upon the participants' assertions regarding the Outlier Threshold issue as governed by 42 U.S.C. § 1395ww(d)(5) and 42 C.F.R. § 412.84, 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 question of whether the Outlier Threshold issue as governed by 42 U.S.C. § 1395ww(d)(5) and 42 C.F.R. § 412.84, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of the Outlier Threshold issue as governed by 42 U.S.C. § 1395ww(d)(5) and 42 C.F.R. § 412.84 properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' EJR Request for the issue and the subject years ***except for*** Memorial Hermann Texas Medical Center's (Provider No. 45-0068; FYE 06/30/2012) and Memorial Hermann Memorial City Hospital's (Provider No. 45-0610; FYE 06/30/2012) appeals taken from the failure of the Medicare Contractor to issue a timely final determination. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes Case 14-3631GC and removes it from its docket.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Shakeba DuBose, Esq.

FOR THE BOARD:

4/21/2026

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)
Scott Berends, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Expedited Judicial Review Determination***

Case Number: 25-4312GC - *Kettering Health Network CY 2012 Post-Allina II DSH Part C Days CIRP Group*
Case Number: 25-4318GC - *Kettering Health Network CY 2011 Post-Allina II DSH Part C Days CIRP Group*
Case Number: 25-4287GC - *Kettering Health Network CY 2007 Post-Allina II DSH Part C Days CIRP Group*
Case Number: 25-4744GC - *Kettering Health Network CY 2006 Post-Allina II DSH Part C Days CIRP Group*

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed on **February 18, 2026** in the above-referenced appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Providers in these Common Issue Related Party ("CIRP") group appeals are all appealing from revised Notices of Program Reimbursement ("RNPRs") which allegedly implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Providers' Fiscal Years Ended ("FYEs") in calendar years spanning 2006 to 2012.

The issue in these appeals is "the proper treatment in the Medicare disproportionate share hospital ("DSH") calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Allina II* litigation. The Providers contend that part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction for patients eligible for Medicaid."[2] The Providers are seeking to challenge the CMS policy adopted in the June 2023 Final Rule to be applied *retroactively* for periods prior to October 1, 2013.[3]

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] *E.g.,* Case No. 25-4744GC, Statement of Group Issue (June 16, 2025).
[3] *Id.* at 2-3.

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").[4] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[6] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] 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.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[11]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[11] (Emphasis added.)
[12] 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.[13]

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.[14]

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

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

In the September 4, 1990 Federal Register, the Secretary[15] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

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[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(4).
[15] of Health and Human Services.
[16] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[17]

With the creation of Medicare Part C in 1997,[18] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C, and following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[19] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[20] The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[21]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.[22] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[23] In response to a comment regarding this change, the Secretary explained that:

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days*

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[17] *Id.*
[18] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[19] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[20] *Id.*
[21] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[22] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[23] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).

> *associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[24]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[25] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[26] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[27]

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

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[28]

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[29] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005

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[24] *Id.* (emphasis added).
[25] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[26] *Id*. at 47411.
[27] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[28] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[29] 746 F. 3d 1102 (D.C. Cir. 2014).

IPPS rule.[30] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[31] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[32] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.[33] A number of hospitals appealed this action.[34] In *Azar v. Allina Health Services* ("*Allina II*"),[35] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[36] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[37] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[38]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[39] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in

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[30] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[31] *Id.* at 2011.
[32] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[33] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[34] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo****(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board,* ***pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[35] 139 S.Ct. 1804 (2019).
[36] *Id.* at 1817.
[37] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[38] 139 S.Ct. at 1814.
[39] 85 Fed. Reg. 47723 (Aug. 6, 2020).

> Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[40]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[41] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[42]

Finally, the following excerpts from the June 9, 2023 Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule or subsequent publication of SSI ratios to be an appealable "final determination":

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

[40] CMS Ruling 1739-R at 1-2.
[41] 88 Fed. Reg. 37772 (June 9, 2023).
[42] 88 Fed. Reg. at 37788 (emphasis in original).

*fractions for **each** applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[43]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[44]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions **contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised **NPRs** will provide hospitals with a **vehicle to appeal** the new final action* even if the Medicare fraction or DSH payment does not change numerically."[45]

4. "*When the Secretary's treatment of Part C days in this final action is reflected **in NPRs and revised NPRs**, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation **by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[46]

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

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are "entitled to [Part A] benefits" within the context of 42 U.S.C.§ 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.[47] It ruled,

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[43] 88 Fed. Reg. at 37774-75 (emphasis added).
[44] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[45] *Id.* at 37788 (emphasis added).
[46] *Id.* (emphasis added).
[47] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).

however, that the June 9, 2023 Final Rule is both impermissibly retroactive[48] and arbitrary and capricious.[49] The court ordered the parties to submit briefs addressing whether vacatur is the appropriate remedy for the situation, which have since been filed.[50]

Providers' Position:

A. Providers' Appeal Requests

The Providers' appeal requests include a "Statement of Jurisdiction" asserting that the Providers have met the applicable statutory conditions for appeal because they are dissatisfied with their revised NPRs which apply the June 9, 2023 retroactive final rule related to Part C days. They cite language from that final rule which outlined Providers' ability to challenge this final rule once they were issued NPRs implementing the rule.[51]

The "Statement of Group Issue" included with the group appeal requests state that the issue concerns "the proper treatment in the Medicare [DSH] calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Allina II* litigation."[52] The Providers contend that the Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.[53]

The Providers characterized the relevant background facts as follows:

1. In the FY 2005 IPPS Final Rule, CMS first announced a policy change to count Part C days in the SSI fraction and to exclude those days from the numerator of the Medicaid fraction.

2. In *Allina I*, the D.C. Circuit vacated that policy change.

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking. The Supreme Court's decision "did not address the D.C. Circuit's alternate ruling that the readopted standard was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the standard could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[54]

4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been

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[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.
[51] *E.g.,* Case No. 25-4744GC, Appeal Request, Statement of Jurisdiction at 1 (citations omitted).
[52] *E.g.,* Case No. 25-4744GC, Appeal Request, Statement of Group Issue at 1.
[53] *Id.*
[54] *Id.* (citing to 139 S. Ct. at 1816).

vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.[55]

Based on the above, the Providers maintain that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule "is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[56]

B. Providers' Petitions for EJR

The Providers have requested EJR over the "post-*Allina* retroactive Part C policy issue" because they believe they have met the requirements for a hearing before the Board, but the Board lacks the authority to decide the substantive and procedural validity of CMS' final rule published in the Federal Register on June 9, 2023.[57] They seek a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.[58] The request states, again, that "[t]he Providers contend that the new, post-*Allina* retroactive part C days rule, applied in the [NPRs] appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[59] Since the Board is bound by this regulation,[60] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

These cases were acknowledged as fully formed and fully populated in OH CDMS, and thus the Schedules of Providers were deemed final, pursuant to Board Rule 20, on **February 18, 2026**. The Requests for EJR were filed the same day. The Medicare Contractors' designated representative, Federal Specialized Services ("FSS"), then submitted timely[61] certifications that it would be filing Jurisdictional Challenges in these cases. Thus, pursuant to Board Rule 44.6, Jurisdictional Challenges were to be filed no later than **March 10, 2026**.

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[55] *Id.*
[56] *Id.* (citing 4 U.S.C. § 706(2)).
[57] *E.g.*, Case No. 25-4744GC, Provider's Petition for Expedited Judicial Review at 13 (Feb. 18, 2026).
[58] *Id.* at 16-17.
[59] *Id.* at 1-2.
[60] 42 C.F.R. § 405.1867.
[61] Board Rule 44.6 (2023) governs the timing of Jurisdictional and Substantive Claim Challenges in cases where a Request for EJR is filed less than sixty (60) days from the filing of a Final Schedule of Providers (or Board Rule 20 Certification filed in lieu of a Final SOP which certifies that the group is complete and fully populated in OH CDMS). In such instances, Board Rule 44.6 requires any party questioning the Board's jurisdiction or whether an appropriate cost report claim was made to file the challenge, or a certification that a challenge is forthcoming, within five (5) business days of the date the EJR Request was filed. The Requests for EJR in these cases were filed on **February 18, 2026**, so any challenges (or certification that a challenge was forthcoming) were due no later than close of business on **February 25, 2026**. Certifications were filed by FSS in these cases on **February 25, 2026**.

1. Jurisdictional Challenges

FSS filed Jurisdictional Challenges in these cases on **March 3 and 4, 2026**. On **March 11, 2026**, the Board issued a Scheduling Order requiring responses be filed no later than March 25, 2026. The Providers filed responses in all four (4) cases on **March 23, 2026**.

FSS is challenging the Board's jurisdiction over several providers, and the challenges are all essentially the same: "the appealed item, Part C Days, was not specifically revised in the noted RNPRs, from which the Providers takes their appeals."[62] Instead, the relevant (and often sole) adjustments made were "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."[63] FSS is challenging the Board's jurisdiction over the following Providers (collectively "the Challenged Providers"):

Case 25-4744GC
- Kettering Health Dayton (Provider No. 36-0133, RNPR date December 18, 2024)
  - Sole adjustment was for SSI realignment.
- Fort Hamilton Hughes Memorial Hospital (Provider No. 36-0132, RNPR date December 18, 2024)
  - Two adjustments were for SSI realignment, and the third was "to accept previous settlements as reported."
- Kettering Health Greene Memorial (Provider No. 36-0026, RNPR date December 30, 2024)
  - Two adjustments were for SSI realignment, and the third was "to report final settlement payments as tentative payments for proper cost report flow for all components of the hospital complex."[64]

Case 25-4287GC
- Fort Hamilton Hughes Memorial Hospital (Provider No. 36-0132, RNPR date December 18, 2024)
  - Sole adjustment was for SSI realignment.[65]

Case 25-4318GC
- Kettering Health Dayton (Provider No. 36-0133, RNPR date December 17, 2024)
  - Sole adjustment was for SSI realignment[66]

Case 25-4312GC
- Kettering Health Dayton (Provider No. 36-0133, RNPR date December 17, 2024)
  - Sole adjustment was for SSI realignment
- Kettering Health Miamisburg (Provider No. 36-0239, RNPR date December, 18, 2024)
  - Sole adjustment was for SSI realignment

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[62] *E.g.*, Case No. 25-4744GC, Medicare Administrative Contractor's Jurisdictional Challenge at 2 (Mar. 4, 2026).
[63] *Id.* at 3.
[64] *Id.* at 3-4.
[65] Case No. 25-4287GC, Medicare Administrative Contractor's Jurisdictional Challenge at 3 (Mar. 3, 2026).
[66] Case No. 25-4318GC, Medicare Administrative Contractor's Jurisdictional Challenge at 3 (Mar. 4, 2026).

2. Providers' Responses

The Providers filed materially identical responses in all four (4) cases on **March 23, 2026**. They argue that they have "the right to challenge any [NPR] issued following the June 2023 final rule, so long as the NPR reflects the interpretation adopted in the final action. The NPRs in question did just that. The MAC indisputably applied the June 2023 Part C days rule and February 2024 implementing transmittal in the Providers' revised NPRs at issue, by utilizing an updated SSI fraction including DSH Part C days."[67]

The Providers argue that they can appeal RNPRs that "**reflect** the interpretation" adopted in the June 2023 Final Rule.[68] They also note that the Board has granted EJR where there was no change in DSH reimbursement, but "incorporate[d] the new SSI fraction published **to** implement the June 2023 Final Rule[.]"[69]

The Providers explain that each of the Challenged Providers originally appealed the 2004 final DSH Part C Days Rule from an earlier NPR in group appeals.[70] All of the Providers' appeals were remanded to the Medicare Contractor pursuant to CMS Ruling 1739-R. The Providers filed complaints in district court which were eventually consolidated and later remanded for further action in light of the Supreme Court ruling in *Allina II*. The CMS Administrator then remanded those appeals to have the final Part C Final Rule applied.[71] RNPRs were later issued with revised SSI fractions "that included part C days."[72]

The Providers claim that this issue was, in fact, specifically revised "because the revised NPRs utilize updated SSI fractions that include DSH Part C days, applying the June 2023 final rule on the treatment of Part C days in the DSH calculation for periods prior to October 1, 2013. 42 C.F.R. § 405.1889(b)."[73] They emphasize that appeal rights exist when the RNPR reflects the application of the June 2023 final rule, even if nothing was actually revised and the DSH payment had no numerical change.[74]

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[67] *E.g.*, Case No. 25-4744GC, Providers' Response to MAC's Jurisdiction Challenge at 1-2 (Mar. 23, 2026).
[68] *Id.* at 11 (quoting 88 Fed. Reg. 37772, 37787, 37788 (June 9, 2023)) (emphasis added).
[69] *Id.* (quoting EJR Decisions in Cases 17-2193 and 18-1286 (emphasis added)).
[70] *See* Providers' Responses to MAC's Jurisdiction Challenge at 12 (the Providers in Case 25-4744GC appealed the 2004 final DSH part C days rule from an earlier NPR in group appeal numbers 13-1712GC and 13-1716GC on October 16, 2013; the Provider in Case 25-4287GC appealed the 2004 final DSH part C days rule from an earlier NPR in group appeal numbers 13-1712GC and 13-1716GC on May 24, 2013; the Provider in Case 25-4318GC appealed the 2004 final DSH part C days rule from an earlier NPR in group appeal numbers 14-2990GC and 14-2988GC on April 17, 2015; and the Providers in Case 25-4312GC appealed the 2004 final DSH part C days rule from earlier NPRs in group appeal numbers 15-1943GC and 15-1944GC on September 30, 2015, and April 17, 2015, respectively).
[71] *Id.*
[72] *Id.* at 13.
[73] *Id.* at 15.
[74] *Id.* at 16 (quoting 88 Fed. Reg. at 37788).

They also claim the Board has jurisdiction under 42 C.F.R. § 405.1877(g) because the RNPRs were issued in response to a court remand. They note that the RNPRs were issued following the court's remands of the Providers' appeals for the same fiscal years.[75]

Next, they claim that the DSH payment calculation is a singular issue, and that appealing the DSH payment is effectively an appeal to any aspect of DSH.[76] Finally, the Providers claim the Board has jurisdiction under 42 U.S.C. § 1395oo(d), which affords the Board jurisdiction over matters in the cost report even when the MAC did not make adjustments thereto.[77]

Decision of the Board:

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

A. Jurisdiction

Providers generally have a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if:

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [78]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $10,000 or more for an individual provider, or $50,000 or more for a group of providers.[79]

B. Specific Adjustment Required for RNPR

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

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[75] *Id.* at 16-17.
[76] *Id.* at 18-19.
[77] *Id.* at 19-21.
[78] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[79] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

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

Additionally, 42 C.F.R. § 405.1889[80] explains the effect of a cost report revision:

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

As outlined above, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[81] Additionally, the June 9, 2023 Final Rule afforded appeal rights for NPRs and RNPRs which did not contain specific revisions to Part C days, but nevertheless implemented the Final Rule related to Part C Days (typically "no change" or $0 RNPRs).[82]

In these cases, the question is whether **these specific RNPRs** were issued to implement the June 2023 Final rule or issued pursuant to a court remand of the Providers' Part C cases. The RNPRs specifically state, and the adjustments support the statement, that these particular RNPRs were issued to effectuate an SSI realignment and the Medicare Contractors insist that this is the reason they were issued. In evaluating the Petitions for EJR as they relate to the Challenged Providers, the Board relies on the Medicare Contractor's statements that it did not issue the RNPRs to implement the Part C Days issue. However, in light of the Providers' counter-references to its previous appeals and subsequent remands, in consideration of both parties' positions taken together, the Board concludes that the Medicare Contractor follows a different and distinct process for adjusting and documenting its adjustments for the retroactive inclusion of Part C Days in the Medicare Fraction in accordance with the implementation of the June 9, 2023 Final

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[80] *See also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).
[81] 42 C.F.R. § 405.1889(b)(1).
[82] *See supra* notes 43-45 and accompanying text.

Rule. The Board also concludes that the Medicare Contractor has yet to issue a final determination specific to Part C adjustments for the Challenged Providers. The Board's conclusion is supported by the record in Case 25-4287GC, which includes Exhibit P-4 to the Jurisdictional Challenge Response, a copy of the Board's August 9, 2021 Part C Days Remand that lists Fort Hamilton Hospital on the Schedule of Providers for Cases 13-1712GC and 13-1716GC. However, the RNPRs for the three (3) other providers in Case 25-4287GC specifically state, "This cost report is being issued to update the SSI ratio per the Part C remand order of PRRB Case #13-1712GC and Case #13-1716GC." By contrast, the RNPR for Fort Hamilton Hospital is specific to its realignment request.

C. Remaining Providers

For the remaining Providers in these four (4) appeals, the providers all appealed from revised NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. All the providers in the group appeals were directly added to the groups within 180 days of the issuance of their RNPRs and the amount in controversy exceeds $50,000 in each case.

Except for the Challenged Providers outlined above, the Board finds that the Providers in Cases 25-4744GC, 25-4287GC, 25-4318GC, and 25-4312GC have all filed timely appeals from their revised NPRs concerning the same common issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these RNPRs. The Board also finds that the amount in controversy in each CIRP group appeal exceeds $50,000 as required by 42 C.F.R. § 405.1837(a)(3). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

D. Board's Decision Regarding the EJR Requests

The Board finds that:

1) The Board finds that, ***except for*** the Challenged Providers, it has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in Cases 25-4744GC, 25-4287GC, 25-4318GC, and 25-4312GC, and that the Providers in each appeal are entitled to a hearing before the Board;

2) Based upon the Providers' assertions regarding the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether the Part C Days policy issue, as adopted on a retroactive basis in the June 9, 2023 Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject years, ***except for*** the Challenged Providers, which are all hereby dismissed from their respective cases.

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 Cases 25-4744GC, 25-4287GC, 25-4318GC, and 25-4312GC, the Board hereby closes them and will remove them from its docket.

Board Members Participating:

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

FOR THE BOARD:

4/21/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

cc: Judith Cummings, CGS Administrators (J-15)
Scott Berends, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Isaac Blumberg
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RE: ***Expedited Judicial Review Determination***

Case Number: 26-2116 - Lenox Hill Hospital (Provider Number 33-0119), FYE 12/31/2006
Case Number: 26-2117 - Lenox Hill Hospital (Provider Number 33-0119), FYE 12/31/2007

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed **March 29, 2026** in the above-referenced individual appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

On **March 27, 2026**, the Board received two individual appeal requests from Lenox Hill Hospital (Prov. No. 33-0119) appealing from two RNPRs dated March 13, 2026 concerning its Fiscal Years Ended ("FYEs") December 31, 2006 and 2007. The Provider's RNPRs implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule").[1]

The issue in this appeal is the proper treatment in the Medicare disproportionate share hospital ("DSH") adjustment calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days"). The Providers contend that part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction (for patients eligible for Medicaid).[2] The Providers are seeking to challenge the CMS policy adopted in the June 2023 Final Rule to be applied *retroactively* for periods prior to October 1, 2013.[3]

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] *E.g.*, Case No. 26-2116 Statement of Issue (CMS 1739R Challenge issue) at 1 (Mar. 27, 2026).
[3] *Id.* at 2-5.

program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[4] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[6] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] 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.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[11]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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

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[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[11] (Emphasis added.)
[12] 42 C.F.R. § 412.106(b)(2)-(3).

> 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.[13]

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.[14]

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

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

In the September 4, 1990 Federal Register, the Secretary[15] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[17]

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[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(4).
[15] of Health and Human Services.
[16] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[17] *Id.*

With the creation of Medicare Part C in 1997,[18] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C, and following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[19] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[20] The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[21]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.[22] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[23] In response to a comment regarding this change, the Secretary explained that:

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

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[18] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[19] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[20] *Id.*
[21] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[22] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[23] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).

> *at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[24]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[25] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[26] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[27]

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

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[28]

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[29] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[30] In vacating the final rule, it reasoned that this deprived the public of adequate

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

opportunity for notice and comment before the final rule was promulgated in 2004.[31] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[32] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.[33] A number of hospitals appealed this action.[34] In *Azar v. Allina Health Services* ("*Allina II*"),[35] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[36] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[37] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[38]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[39] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement

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[31] *Id.* at 2011.
[32] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[33] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[34] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo**(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board, **pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[35] 139 S.Ct. 1804 (2019).
[36] *Id.* at 1817.
[37] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[38] 139 S.Ct. at 1814.
[39] 85 Fed. Reg. 47723 (Aug. 6, 2020).

> (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[40]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[41] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[42]

Finally, the following excerpts from the June 9, 2023 Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule or subsequent publication of SSI ratios to be an appealable "final determination":

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports***. *In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[43]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court

[40] CMS Ruling 1739-R at 1-2.
[41] 88 Fed. Reg. 37772 (June 9, 2023).
[42] 88 Fed. Reg. at 37788 (emphasis in original).
[43] 88 Fed. Reg. at 37774-75 (emphasis added).

decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[44]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically."[45]

4. "*When the Secretary's treatment of Part C days in this final action is reflected* ***in NPRs and revised NPRs****, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation* ***by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[46]

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

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are "entitled to [Part A] benefits" within the context of 42 U.S.C.§ 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.[47] It ruled, however, that the June 9, 2023 Final Rule is both impermissibly retroactive[48] and arbitrary and capricious.[49] The court has ordered the parties to submit briefs on whether vacatur is the appropriate remedy for the situation, which have since been filed.[50]

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[44] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[45] *Id.* at 37788 (emphasis added).
[46] *Id.* (emphasis added).
[47] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).
[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.

Provider's Position:

A. Provider's Appeal Requests

The Provider's appeal requests argue that Medicare Part C days "should be reflected in the Medicaid percentage rather than the Medicare/SSI Fraction."[51] It seeks to invalidate the Final Rule published on June 9, 2023 and the SSI Ratio published thereafter to implement the Final Rule.[52] The Provider argues that the Final Rule is contrary to the statutory language of 42 U.S.C. § 1395ww(d)(5)(F)(vi) and that Secretary's interpretation of this statute deserves no deference following the Supreme Court's decision in *Loper Bright.*[53]

The Provider recounts how, prior to 2004, CMS did not include Part C Days in the SSI Ratio, along with the subsequent rulemaking and litigation which can be outlined as follows:

1. In the FY 2005 IPPS Final Rule, CMS first announced a policy change to count Part C days in the SSI fraction and to exclude those days from the numerator of the Medicaid fraction.

2. In *Allina I*, the D.C. Circuit vacated that policy change.

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking.

4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.

Based on the above, the Provider maintains that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule is substantively and procedurally invalid and must be set aside because it is contrary to law, arbitrary and capricious, and *per se* unreasonable.[54]

B. Provider's Petitions for EJR

The Provider has requested EJR over the post-*Allina* retroactive Part C policy issue outlined above. It argues that it filed its appeals within 180 days of the issuance of its RNPRs; that the amount in controversy exceeds $10,000 in both cases; that it challenges the validity of the June 2023 Final Rule; and that the Board cannot grant this relief because it is bound by the policy.[55] It notes that the June 2023 Final Rule affords appeal rights from RNPRs implementing the retroactive Part C Days policy even if a Provider's SSI Ratio does not change numerically.[56]

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[51] *E.g.*, Case No. 26-2116 Statement of Issue (CMS 1739F Challenge issue) at 1.
[52] *Id.* at ¶ 3.
[53] *Id.* at ¶¶ 4-5 (citing *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024)).
[54] *Id.* at ¶¶ 6-18.
[55] *E.g.*, Case No. 26-2116 Provider's Petition for Expedited Judicial Review at 1-4 (Mar. 29, 2026).
[56] *Id.* at 11.

On **April 2, 2026**, the Medicare Contractor's representative, Federal Specialized Services ("FSS"), filed responses to both Requests for EJR simply advising that "the MAC will not fie a jurisdictional challenge. The MAC will not file a substantive claim challenge."[57]

Decision of the Board:

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

A. Jurisdiction

An individual Provider generally has a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if

- It is dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination;[58] and
- The amount in controversy is $10,000 or more.[59]

This Provider appealed from revised NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. The Provider's appeals were filed within 180 days of the issuance of the RNPRs and the amount in controversy exceeds $10,000 in both cases.

The appeals both contain two separate "issues" – one a specific challenge over whether Part C Days should be in the Medicaid or Medicare Fraction, and a second which seeks attorney's fees and interest for the years of delay in tendering the Provider's DSH reimbursement. The second, separate "unreasonable delay" issue specifically states:

> **The issue in this Appeal is UNREASONABLE DELAY: whether DSH reimbursement for Providers' year in this appeal has been unreasonably delayed, should be made without further delay under the long-standing rulings of the *Northeast Decision, Allina I* and *Allina***

[57] *E.g.*, Case No. 26-2116, Response to Provider's Request for Expedited Judicial Review at 1 (Apr. 2, 2026).
[58] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[59] 42 U.S.C. § 1395oo(a)(2); 42 C.F.R. §§ 405.1835 – 1840.

> ***II*, and should include payment of attorney fees and interest for all the years of delay, as provided in 42 U.S.C. § 1395oo(f)(2).[60]**

The Part C Days issue statement has an entire section dedicated to the same arguments,[61] with a heading which reads:

> **Unreasonable Delay: Administration of these claims, as required by *Allina I, Northeast Hospital, and Allina II*, has been long and unreasonably delayed since 2010[.][62]**

This issue also seeks Provider's DSH payment and "payment of attorney fees and interest for all the years of delay, as provided in 42 U.S.C. § 1395oo(f)(2)."[63]

Since this argument for attorney's fees and interest is encompassed within the Part C Days issue, and the Board is granting EJR over that issue in its entirety, the "separate" Unreasonable Delay issue is hereby ***dismissed*** from the case as duplicative.

Additionally, the Providers have included several paragraphs in the Part C days issue statement which relate to "SSI Data Problems . . . in the Calculation of the Medicare Fraction (SSI Ratio)."[64] These paragraphs address issues unrelated to the Part C days issue, as they refer to the *Advocate Christ*[65] case and definitions of SSI entitlement.[66] Review of the RNPRs in both cases indicates that both RNPRs contain the identical phrase, "We have updated your facility's cost report to implement the CMS Administrator remand for Part C Days and recalculated your facility's reimbursement for the year ending . . . ."[67] As such, the only issue adjusted in the RNPR was the Part C days issue. 42 C.F.R. § 405.1889(b) states:

> (b) (1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decisions.

As such, only the Part C issue may be appealed from these RNPRs. The Board notes that the Providers did not identify this as a separate issue in the appeals, and therefore, for clarity, dismisses any arguments relating to SSI eligibility or *Advocate Christ* from these appeals.

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[60] *E.g.*, Case No. 26-2116, Statement of Issue (Unreasonable Delay) at 1 (Mar. 27, 2026).
[61] *E.g.*, Case No. 26-2116 Statement of Issue (CMS 1739R Challenge issue) at ¶¶ 19-24.
[62] *Id.*
[63] *Id.* at ¶ 19.
[64] Id. at ¶¶ 25-35.
[65] *Advocate Christ Medical Center v. Becerra*, 80 F.4th 346 (Sept. 1, 2023).
[66] *E.g.*, Case No. 26-2116, Statement of Issue (CMS 1739R Challenge issue) at ¶¶ 26-27.
[67] *E.g.*, Case No. 26-2116, RNPR Letter at 1 (Mar. 13, 2026).

The Board finds that the Provider in Cases 26-2116 and 26-2117 has filed timely appeals from its revised NPRs concerning the issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these RNPRs. The Board also finds that the amount in controversy exceeds $10,000 in each case as required by 42 C.F.R. § 405.1839(a)(1). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in Cases 26-2116 and 26-2117 and that the Provider is entitled to a hearing before the Board;

2) Based upon the Provider's assertions regarding the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether the Part C Days policy issue, as adopted on a retroactive basis in the June 9, 2023 Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's requests for EJR for the issue of the Part C days policy and its supporting Unreasonable Delay arguments ONLY for the subject years.

The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since the Board is dismissing the second (separate) Unreasonable Delay issue in these appeals as well as the SSI eligibility/*Advocate Christ* arguments, and no other issues will remain in the cases, the Board hereby closes Cases 26-2116 and 26-2117 and removes them from its docket.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Shakeba DuBose, Esq.

FOR THE BOARD:

4/21/2026

X Kevin D. Smith, CPA

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

cc: Danelle Decker, National Government Services, Inc. (J-K)
Scott Berends, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Paul Cauwenbergh
Woodlands of Maryland Heights
3201 Parkwood Lane
Maryland Heights, MO 63043

RE: ***Notice of Dismissal***

Case Number: 25-0978 - Woodlands of Maryland Heights (Provider Number 26-5523)
FFY 2025

Dear Mr. Cauwenbergh:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 25-0978. Set forth below is the decision of the Board regarding the remaining issue in this appeal challenging the Provider's Annual Payment Update reduction.

Background

A. *Procedural History for Case No. 25-0978*

On **July 1, 2024**, CMS notified Woodlands of Maryland Heights ("Provider" or "Woodlands") that it had failed to "submit CMIT Measure ID #00390 Influenza Vaccination Coverage among Healthcare Personnel (HCP) data".[1] The notice further informed Woodlands that, as a result of this failure, the Annual Payment Update ("APU") for Federal Fiscal Year ("FFY") 2025 would be reduced by two (2) percentage points.[2]

Woodlands requested a reconsideration of CMS' determination on **July 31, 2024**.[3] In a letter dated **October 4, 2024**, CMS notified Woodlands that CMS had reviewed its request for reconsideration and had "decided to uphold the decision to reduce the FY 2025 APU."[4]

On **December 4, 2024**, Woodlands timely appealed CMS' reconsideration decision to the Board.

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[1] Exhibit (hereinafter "Ex.") C-1 ("Non-Compliance that May Result in a 2% Reduction to Your FY 2025 Annual Payment Update for CCN 265523").
[2] *Id*.
[3] A letter appearing to be a reconsideration request and dated July 31, 2024, was submitted as an attachment to the Provider's Preliminary Position Paper and is on the 9th and 10th pages of the Provider's submission. There are no page numbers or exhibit numbers.
[4] Ex. C-2 ("Notice of Quality Reporting Program Noncompliance Decision Upheld") at C-0005.

On **December 10, 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.[5]

On **December 31, 2024**, the Provider timely filed its preliminary position paper.

On **November 20, 2025**, the Medicare Contractor timely filed its preliminary position paper.

On **March 3, 2026**, the Medicare Contractor filed a Motion to Dismiss with the Board requesting that the Board dismiss the appeal. Pursuant to Board Rule 44.3, the Provider had 30 days in which to file a response to the Medicare Contractor's Motion. However, the Provider ***failed*** to file any response.

B. Description of the Issue in the Appeal Request and the Provider's Preliminary Position Paper

In their Individual Appeal Request, the Provider summarizes the appealed issue as follows:

> I, [sic] am writting [sic] this Issue Statement in regard to Parkwood appeal of the 2 percent reduction penalty. I am the Administrator at Parkwood Skilled Nursing[6] and will be the person responsible for handeling [sic] the appeal. Parkwood completed the Influenza Vaccination Summary on the SAMS portal for Healthcare Personnel on 07/25/2024. Both that report and a letter indicating its completion has already been submitted to CMS on 07-31-24. This would meet the requirement for the appeal to be accepted. Acopy [sic] of the letter and the Influenza Vaccination Summary are attached.[7]

On December 31, 2024, the Board received the Provider's preliminary position paper in Case No. 25-0978. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

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[5] (Bold and underline emphasis added).
[6] Also known as Woodlands of Maryland Heights.
[7] Issue Statement at 1 (signed Nov. 15, 2024).

> I, [sic] am writting [sic] this Preliminary Position Paper. There is no further material facts that are needed to be provided in this appealed claim. There are no additional whitnesses [sic] needed for our claim. We are submitting with this letter copies of the Representation Letter, the Final Determination forms, The [sic] Issue Statement, the Audit Adjustment Support, and the Calculation support forms. We feel these documents will support our appeal for the 2 percent reduction for the Influenza Vaccination of Health Care Personnel (HCP). Please see attached copies of supporting documentation.
>
> If you would need any additional information please feel free to contact me on my cell phone (XXX) XXX-XXXX.[8]

MAC's Contentions

In their Motion to Dismiss, the Medicare Contractor "respectfully requests that the Board make the following findings and enter an order providing as follows:

a. That the Provider has filed to furnish documentation in support of its claim for reversal of CMS's non-compliance reconsideration decision.

b. That the Provider has not fully developed a narrative that states the material facts that support the Provider's claim, identified the controlling authority, or made conclusions of law that apply the material facts to the controlling authorities.

c. That the Provider's failure to do so (or describe why such documentation is unavailable) is in violation of PRRB Rules 7, 25.1.1, and 25.3.

d. That the Provider has effectively abandoned its challenge of the FY 2025 SNF QRP payment reduction.

e. That the Provider's claim for reversal is therefore dismissed."[9]

Provider's Response

The Board Rules require that responses to Motions must be filed within thirty (30) days of the filing of the Motion.[10] 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

[8] PII has been redacted by the Board.
[9] Medicare Administrative Contractor's Motion to Dismiss at 3 (Mar. 3, 2026).
[10] Board Rule 44.3, v. 3.2 (Dec. 2023).

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 sole issue in this appeal.

A. Amount in Controversy

A Provider qualifies for a right to a Board hearing, if:

> (1) The provider 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. *Exception:* If a final contractor determination is reopened under § 405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[11]

The regulation concerning this amount in controversy requirement is found at 42 C.F.R. § 405.1839:

> (a) ***Single provider appeals.***
>
> (1) In order to satisfy the amount in controversy requirement under § 405.1811(a)(2) or § 405.1811(c)(3) for a contractor hearing

[11] 42 C.F.R. § 405.1835(a)(1) – (3). *See also* 42 U.S.C. § 1395oo(a)(2).

> or the amount in controversy requirement under § 405.1835(a)(2) or § 405.1835(c)(3) for a Board hearing for a single provider, the provider must demonstrate that if its appeal were successful, the provider's total program reimbursement for each cost reporting period under appeal would increase by at least $1,000 but by less than $10,000 for a contractor hearing, or by at least $10,000 for a Board hearing, as applicable.
>
> (2) ***Aggregation of claims.*** For purposes of satisfying the applicable amount in controversy requirement for a single provider appeal to the contractor or the Board, the provider may aggregate claims for additional program payment for more than one specific matter at issue, provided each specific claim and issue is for the same cost reporting period. Aggregation of claims from more than one cost reporting period to meet the applicable amount in controversy requirement is prohibited, even if a specific claim or issue in the appeal recurs for multiple cost years.

During the Board's review of jurisdictional documents, pursuant to 42 C.F.R. § 405.1840(a), the Board reviewed Woodlands' Amount in Controversy support document. The calculation shows an amount in controversy of $6,934.20 for Medicare [Part] A, $11,482.12 for Managed Care, and $371.98 for Medicare [Part] B, for a total amount in controversy of $18,788.30 for the APU reduction issue.[12]

However, the Board finds that Medicare Managed Care is not affected by the QRP reductions, as it is paid by the Medicare Managed Care contracts and is not reimbursed on the cost report. Therefore, Medicare Managed Care should not be included in the Amount in Controversy for this issue. As such, if the reductions applied to Medicare Part A and Medicare Part B were considered, ignoring the Managed Care calculation, the Amount in Controversy would be only $7,306.18. This fails to meet the appeal requirements of an amount in controversy of at least $10,000. Therefore, the Board finds Woodlands' appeal fails to meet the jurisdictional requirements for a Board hearing and is dismissed.

B. Preliminary Position Paper

As the Board has found that the appeal does not meet the amount in controversy requirements as set forth in 42 U.S.C. § 1395oo(a)(2) and 42 C.F.R. § 405.1839(a), the Board need not reach the Motion to Dismiss raised by the Medicare Contractor with respect to the Provider's Preliminary Position Paper.

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[12] See Attachments to the Provider's Position Paper at unnumbered page 14 (*see also* n. 3 *supra*).

***

In summary, the Board has dismissed the only issue on appeal. As the only issue on appeal is dismissed, the case 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:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Shakeba DuBose, Esq.

For the Board:

4/22/2026

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Expedited Judicial Review Determination***

Case Number: 25-0839GC - Univ of Florida Health CY 2007 Post-Allina II DSH Part C Days CIRP Group

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petition for Expedited Judicial Review ("EJR") filed on **March 3, 2026** in the above-referenced appeal. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Providers in this Common Issue Related Party ("CIRP") group appeal are all appealing from revised Notices of Program Reimbursement ("RNPRs") which allegedly implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Providers' Fiscal Years Ended ("FYEs") in calendar year 2007.

The issue in these appeals is "the proper treatment in the Medicare disproportionate share hospital ("DSH") calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Allina II* litigation. The Providers contend that part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction for patients eligible for Medicaid)"[2] The Providers are seeking to challenge the CMS policy adopted in the June 2023 Final Rule to be applied *retroactively* for periods prior to October 1, 2013.[3]

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] Statement of Group Issue at 1 (Nov. 20, 2024).
[3] *Id.* at 2-3.

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").[4] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[6] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] 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.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[11]

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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.[13]

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.[14]

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

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

In the September 4, 1990 Federal Register, the Secretary[15] stated that:

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

[12] 42 C.F.R. § 412.106(b)(2)-(3).
[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(4).
[15] of Health and Human Services.

> included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[17]

With the creation of Medicare Part C in 1997,[18] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C, and following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[19] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[20] The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[21]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.[22] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[23] In response to a comment regarding this change, the Secretary explained that:

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[16] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[17] *Id.*
[18] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[19] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[20] *Id.*
[21] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[22] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[23] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[24]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[25] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[26] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[27]

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

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[24] *Id.* (emphasis added).
[25] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[26] *Id*. at 47411.
[27] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[28]

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[29] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[30] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[31] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[32] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.[33] A number of hospitals appealed this action.[34] In *Azar v. Allina Health Services* ("*Allina II*"),[35] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[36] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[37] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[38]

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[28] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[29] 746 F. 3d 1102 (D.C. Cir. 2014).
[30] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[31] *Id.* at 2011.
[32] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[33] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[34] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo****(a)(1)(B)* as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board, **pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[35] 139 S.Ct. 1804 (2019).
[36] *Id.* at 1817.
[37] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[38] 139 S.Ct. at 1814.

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[39] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[40]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[41] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[42]

Finally, the following excerpts from the June 9, 2023 Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule or subsequent publication of SSI ratios to be an appealable "final determination":

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[39] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[40] CMS Ruling 1739-R at 1-2.
[41] 88 Fed. Reg. 37772 (June 9, 2023).
[42] 88 Fed. Reg. at 37788 (emphasis in original).

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports***. *In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[43]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[44]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically."[45]

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

[43] 88 Fed. Reg. at 37774-75 (emphasis added).
[44] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[45] *Id.* at 37788 (emphasis added).

> notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[46]

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

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are "entitled to [Part A] benefits" within the context of 42 U.S.C.§ 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.[47] It ruled, however, that the June 9, 2023 Final Rule is both impermissibly retroactive[48] and arbitrary and capricious.[49] The court ordered the parties to submit briefs on whether vacatur is the appropriate remedy for the situation, which have since been filed.[50]

Providers' Position:

A. Providers' Appeal Request

The Providers' appeal request includes a "Statement of Jurisdiction" asserting that the Providers have met the applicable statutory conditions for appeal because they are dissatisfied with their revised NPRs which apply the June 9, 2023 retroactive final rule related to Part C days. They cite language from that final rule which outlined Providers' ability to challenge this final rule once they were issued NPRs implementing the rule.[51]

The "Statement of Group Issue" included with the group appeal request states that the issue concerns "the proper treatment in the Medicare [DSH] calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Allina II* litigation."[52] The Providers contend that the Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.[53]

The Providers characterized the relevant background facts as follows:

1. In the FY 2005 IPPS Final Rule, CMS first announced a policy change to count Part C days in the SSI fraction and to exclude those days from the numerator of the Medicaid fraction.

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[46] *Id.* (emphasis added).
[47] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).
[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.
[51] Appeal Request, Statement of Jurisdiction (citations omitted).
[52] Statement of Group Issue at 1.
[53] *Id.*

2. In *Allina I*, the D.C. Circuit vacated that policy change.

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking. The Supreme Court's decision "did not address the D.C. Circuit's alternate ruling that the readopted standard was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the standard could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[54]

4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.[55]

Based on the above, the Providers maintain that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule "is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[56]

B. Providers' Petition for EJR

The Providers have requested EJR over the "post-*Allina* retroactive Part C policy issue" because they believe they have met the requirements for a hearing before the Board, but the Board lacks the authority to decide the substantive and procedural validity of CMS' final rule published in the Federal Register on June 9, 2023.[57] They seek a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.[58] "The Providers contend that the new, post-*Allina* retroactive part C days rule, applied in the [NPRs] appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[59] Since the Board is bound by this regulation,[60] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

The Petition for EJR in this case was filed on **March 3, 2026**. The case was deemed fully formed in OH CDMS on the same day, but the Providers' designated representative had not yet

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[54] *Id.* (citing to 139 S. Ct. at 1816).
[55] *Id.*
[56] *Id.* (citing to 5 U.S.C. § 706(2)).
[57] Provider's Petition for Expedited Judicial Review at 13 (Mar. 3, 2026).
[58] *Id.* at 16.
[59] *Id.* at 1-2.
[60] 42 C.F.R. § 405.1867.

filed a certification that all of the participants were populated under the Issues/Providers Tab in OH CDS pursuant to Board Rule 20. In an order issued **March 26, 2026**, the Board ordered the Providers to file its certification no later than **April 13, 2026**. The Providers filed their certification on **March 27, 2026**.

On March 9, 2026, the Medicare Contractors' designated representative, Federal Specialized Services ("FSS"), submitted a timely[61] certification that it would be filing a Jurisdictional Challenge in this case. Thus, pursuant to Board Rule 44.6, any Jurisdictional Challenges were to be filed no later than **March 23, 2026**.

1. Jurisdictional Challenge

FSS filed a Jurisdictional Challenge in this case on **March 19, 2026**. On March 26, 2026, the Board issued a Scheduling Order requiring any response be filed no later than Monday, April 13, 2026.

FSS is challenging the Board's jurisdiction over UF Health Shands Hospital (Provider Number 10-0113, FYE 6/30/2007, RNPR dated 11/17/2025).[62] FSS argues that this Provider's "cost report was reopened pursuant to a Full Administrative Resolution of Case No. 13-1542GC which resolved the issue of Section 1115 waiver days. The resulting RNPR was dated 11/17/2025. The Provider cites Audit Adjustment No. 5 from the 11/17/2025 RNPR as a basis for appeal. This adjustment revised the DSH percentage due to the addition of Section 1115 waiver days."[63]

2. Providers' Response

The Providers filed a response to the Jurisdictional Challenge on **March 27, 2026**. They argue that they have "the right to challenge any [NPR] issued following the June 2023 final rule, so long as the NPR reflects the interpretation adopted in the final action. The NPR in question did just that. The MAC indisputably applied the June 2023 Part C days rule and February 2024 implementing transmittal in the Providers' revised NPR, by utilizing an updated SSI fraction including DSH Part C days."[64]

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[61] Board Rule 44.6 (2023) governs the timing of Jurisdictional and Substantive Claim Challenges in cases where a Request for EJR is filed less than sixty (60) days from the filing of a Final Schedule of Providers (or Board Rule 20 Certification filed in lieu of a Final SOP which certifies that the group is complete and fully populated in OH CDMS). In such instances, Board Rule 44.6 requires any party questioning the Board's jurisdiction or whether an appropriate cost report claim was made to file the challenge, or a certification that a challenge is forthcoming, within five (5) business days of the date the EJR Request was filed. The Requests for EJR in these cases were filed on **March 3, 2026**, so any challenges (or certification that a challenge was forthcoming) were due no later than close of business **March 10, 2026**. Certifications were filed by the Medicare Contractor or FSS in these cases between **March 5 and 9, 2026**.

[62] FSS also challenged the Board's jurisdiction over Shands Jacksonville (Provider No. 10-0001, FYE 06/30/2007 – based on RNPR dated 05/24/2024), but that Provider was withdrawn from the case on **March 27, 2026**.

[63] Medicare Administrative Contractor's Jurisdictional Challenge at 2 (Mar. 19, 2026).

[64] Providers' Response to MAC's Jurisdiction Challenge at 1 (Mar. 27, 2026).

The Providers argue that they can appeal RNPRs that "**reflect** the interpretation" adopted in the June 2023 Final Rule.[65] They also note that the Board has granted EJR where there was no change in DSH reimbursement, but "incorporate[d] the new SSI fraction published **to** implement the June 2023 Final Rule[.]"[66]

The Providers explain that UF Health Shands Hospital originally appealed the 2004 final DSH Part C Days Rule from an earlier NPR in group appeal numbers 13-1536GC and 13-2033GC.[67] The Provider requested EJR, which was granted on March 13, 2018.[68] The Provider filed a complaint in district court which was eventually consolidated and later remanded for further action in light of the Supreme Court ruling in *Allina II*. The CMS Administrator then remanded those appeals to have the final Part C Final Rule applied.[69] An RNPR was later issued with an SSI fraction "that included part C days."[70]

The Providers claim that this issue was, in fact, specifically revised "because the revised NPR utilizes an SSI fraction that includes DSH Part C days, applying the June 2023 final rule on the treatment of Part C days in the DSH calculation for periods prior to October 1, 2013. 42 C.F.R. § 405.1889(b)."[71] They emphasize that appeal rights exist when the RNPR reflects the application of the June 2023 final rule, even if nothing was actually revised and the DSH payment had no numerical change.[72]

The Providers also claim the Board has jurisdiction under 42 C.F.R. § 405.1877(g) because the RNPR was issued in response to a court remand. They note that the RNPR was issued following the court's remands of the Providers' appeal for the same fiscal years.[73]

Next, they claim that the DSH payment calculation is a singular issue, and that appealing the DSH payment is effectively an appeal to any aspect of DSH.[74] Finally, the Providers claim the Board has jurisdiction under 42 U.S.C. § 1395oo(d), which affords the Board jurisdiction over matters in the cost report even when the MAC did not make adjustments thereto.[75]

Decision of the Board:

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

[65] *Id.* at 10-11 (quoting 88 Fed. Reg. 37772, 37787, 37788 (June 9, 2023)) (emphasis added).
[66] *Id.* (quoting EJR Decisions in Cases 17-2193 and 18-1286 (emphasis added)).
[67] *Id.* at 12.
[68] *Id.*
[69] *Id.*
[70] *Id.*
[71] *Id.* at 15.
[72] *Id.* at 15-16 (quoting 88 Fed. Reg. at 37788).
[73] *Id.* at 16-17.
[74] *Id.* at 17-19.
[75] *Id.* at 19-21.

either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

A. Jurisdiction

Providers generally have a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if:

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [76]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $10,000 or more for an individual provider, or $50,000 or more for a group of providers.[77]

C. Specific Adjustment Required for RNPR

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

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

Additionally, 42 C.F.R. § 405.1889[78] explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.

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[76] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[77] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.
[78] *See also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

As outlined above, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[79] Additionally, the June 9, 2023 Final Rule afforded appeal rights for NPRs and RNPRs which did not contain specific revisions to Part C days, but nevertheless implemented the Final Rule related to Part C Days (typically "no change" or $0 RNPRs).[80]

In this case, the question is whether **this specific RNPR** was issued to implement the June 2023 Final rule or was issued pursuant to a court remand of the Providers' Part C cases. The adjustments show that this particular RNPR was issued to add Section 1115 Waiver Days (which increased the DSH%), which increased the Providers' Medicare payment by $7,897,656. No adjustment was made to the SSI percentage, nor was any mention made of it, or *Allina* or Part C Remand in the RNPR/Adjustments in question. In evaluating the Petition for EJR as it relates to UF Health Shands Hospital, the Board relies on the Medicare Contractor's statement that it did not issue the RNPR to implement the Part C Days issue. However, in light of the Providers' counter-references to its previous appeals and subsequent remands, in consideration of both parties' positions taken together, the Board concludes that the Medicare Contractor follows a different and distinct process for adjusting and documenting its adjustments for the retroactive inclusion of Part C Days in the Medicare Fraction in accordance with the implementation of the June 9, 2023 Final Rule. The Board also concludes that the Medicare Contractor has yet to issue a final determination specific to Part C adjustments for the Challenged Providers.

Based on the foregoing, the Board hereby ***dismisses*** UF Health Shands Hospital from Case 25-0839GC.

D. Remaining Provider

The sole remaining Provider in this appeal, Shands Jacksonville (Prov. No. 10-0001, FYE 6/30/2007), appealed from a revised NPR which implements the new, retroactive Part C days rule, as published in the June 9, 2023 Final Rule. The same Final Rule made clear that the Part C Days policy could be appealed from this RNPR. This Provider was directly added to the group within 180 days of the issuance of its RNPR.

The Board notes that since only one provider remains in Case No. 25-0839GC, it no longer mees the requirements for a group appeal. Nevertheless, the remaining Provider's listed amount in

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[79] 42 C.F.R. § 405.1889(b)(1).
[80] *See supra* notes 43-45 and accompanying text.

controversy exceeds $10,000 as required for an individual appeal and it meets the remaining requirements for a hearing before the Board. The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) For Shands Jacksonville (Prov. No. 10-0001, FYE 6/30/2007) ***only***, it has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject year, and that this Provider is entitled to a hearing before the Board;

2) The Board lacks jurisdiction over UF Health Shands Hospital (Prov. No. 10-0113, FYE 6/30/2007, RNPR dated 11/17/2025) because the appealed issue was not specifically adjusted in the RNPR, and the RNPR did not implement the retroactive Part C Days rule as published in the June 9, 2023 Final Rule;

3) Based upon the Provider's assertions regarding the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, there are no findings of fact for resolution by the Board;

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 question of whether the Part C Days policy issue, as adopted on a retroactive basis in the June 9, 2023 Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants Shands Jacksonville's (Prov. No. 10-0001, FYE 6/30/2007) request for EJR for the issue and the subject year. UF Health Shands Hospital (Prov. No. 10-0113, FYE 6/30/2007), however, is hereby dismissed from the appeal.

The Provider has 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 Case 25-0839GC, the Board hereby closes the case and removes it from its docket.

Board Members Participating:

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

FOR THE BOARD:

4/23/2026

X Kevin D. Smith, CPA

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

Enclosure: Schedule of Providers

cc: Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)
Scott Berends, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
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Via Electronic Delivery

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Boulevard, Suite 700
Los Angeles, CA 90064-1582

RE: ***Decision re: Request for Reconsideration***

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

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the Request for Reconsideration filed on **February 5, 2025** concerning the forty-one (41) individual cases listed in **Appendix A**. The providers appealed the publication of CMS Ruling 1498-R3 on the basis that CMS has failed to issue Notices of Program Reimbursement ("NPRs") in a reasonable amount of time. The decision of the Board ***denying*** the Request for Reconsideration is set forth below.

Procedural history:

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

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

[1] *Available at* https://www.cms.gov/files/document/cms-1498-r3.pdf (last accessed Apr. 23, 2026).
[2] *See, e.g.,* Case No. 24-2301, Statement of Issue at ¶¶ 1, 19.
[3] *Id.* at ¶¶ 1 (citing 657 F.3d 1, 16-17 (D.C. Cir. 2011)), 6.

hospitals would receive realignment based on the original SSI fractions calculated before CMS Ruling 1498";[4]

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

The Providers claim:

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

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[4] *Id.* at ¶¶ 4, 7.
[5] *Id.* at ¶¶ 8-18.
[6] *Id.* at ¶¶ 20-23.
[7] *Id.* at ¶¶ 17, 27.
[8] *Id.* at ¶¶ 28-29.
[9] *Id.* at ¶ 32.
[10] *Id.* at ¶¶ 33-47.
[11] *Id.* at ¶ 48.

With regard to the Board's jurisdiction, the Providers also argue that CMS Ruling 1498-R3 is an appealable "final determination," citing *Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 141 (D.C. Cir. 1986), *Cape Cod Hospital v. Sebelius*, 630 F.3d 203 (2011), and *Battle Creek Health System v. Becerra*, Civil Action No. 17-0545 (CKK) (D.D.C. 2023).[12]

Relevant Law:

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

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

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

The hospitals in *Alameda* received their NPRs and appealed to the Board based on issues later addressed in *Baystate*. Their claims were remanded, pursuant to 1498-R, and some hospitals later either requested a realignment or simply that their new NPRs be issued promptly. They ultimately filed suit in March, 2023 because they had still not received payments for fiscal years

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

ranging from 1988 to 2005. The hospitals in *Alameda* sought mandamus relief under § 706(1) of the APA, alleging undue delay in processing their revised payment determinations on remand.[19]

The court first looked to whether it had substantive jurisdiction over the claims under § 405(h) of the Medicare Act, noting this jurisdiction is more limited than general "federal question" jurisdiction. Section 405(h) channels most Medicare claims through an agency review system, which requires a hospital first present its claim to the Secretary, and then fully exhaust any administrative remedies prescribed by the Secretary.[20] It was undisputed that the hospitals in *Alameda* satisfied the presentment requirement, but also that they came directly to federal court rather than pursue any administrative remedies after their claims were remanded post-*Baystate*. The hospitals argued that this failure to exhaust their remedies was appropriate because there was no mechanism to obtain relief from the Board for unreasonable delay in receiving their NPRs or realignments, but the court noted that there ***is*** a mechanism, found in 42 U.S.C. § 1395oo(a)(1)(B), to appeal to the Board if a hospital does not receive a final determination in a timely manner.[21] The hospitals did not show that they pursued this remedy or that it was otherwise foreclosed.[22]

The court rejected two more of the hospitals' arguments that attempted to excuse their failure to exhaust. First, in *Shalala v. Ill. Council on Long Term Care, Inc.*,[23] the Supreme Court stated that § 405(h) of the Medicare Act does not apply when doing so would mean no review at all, rather than simply channel review, through the agency. It also stated that inconvenience alone is insufficient, and that the hardship must result in *complete* preclusion of review.[24] But the court in *Alameda* found the hospitals did not show "how channeling their undue delay claim through the agency would result in a 'complete preclusion of review.'"[25]

Second, the hospitals argued that the exhaustion requirement was waivable under a four-part test set forth in *Tataranowicz v. Sulivan*.[26] The court questioned the continued validity of this test following *Shalala v. Ill. Council on Long Term Care, Inc.*, but also noted that the first prong of the four-part test rendered the hospitals' request for waiver impermissible. The first prong of the test is that judicial resolution of a claim cannot interfere with the agency's efficient functioning, and the court found that that forcing CMS to calculate the Plaintiffs' revised payments before many other hospitals was impermissible interference.[27]

Finally, the court noted that mandamus jurisdiction derived from 28 U.S.C. § 1361 is not precluded by § 405(h) of the Medicare Act. But the court noted this would require the hospitals

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[19] *Id.* at *3.
[20] *Id.* at *4 (citations omitted).
[21] *Id.* (citing 42 U.S.C. § 1395oo(a)(1)(B)).
[22] *Id.*
[23] 529 U.S. 1 (2000).
[24] *Id.* at 19, 20-23.
[25] 2024 WL 3536620 at *5.
[26] 959 F.2d 268, 275 (D.C. Cir. 1992).
[27] 2024 WL 3536620 at *5.

to have shown there was a "clear and indisputable right to relief," and found that the hospitals in *Alameda* did not make such a showing. When used as the basis for a court to assert mandamus jurisdiction, claims of unreasonable delay are evaluated under the factors set forth in *Telecommunications Research & Action Center v. F.C.C. ("TRAC")*.[28] The court in *Alameda* found that the attempt to assert mandamus jurisdiction based on the delay in receiving an NPR was defeated by factor four: the effect of expediting delayed action on agency activities of a higher or competing priority, noting, "[t]hat factor prohibits relief where court-ordered relief would merely put the claimant at 'the head of the queue [and] would simply move all others back one space and produce no net gain.'"[29] The *Alameda* court found the hospitals were seeking special treatment in attempting to "move to the front of the line" and thus denied the request for mandamus relief.[30]

Board's Decision to Dismiss:

On **December 9, 2024**, the Board dismissed each of these forty-one (41) cases on its own motion. The basis for that dismissal was as follows (directly quoting from the December 9, 2024 Board letter):

> The Providers' appeals in the instant cases and the action brought by the hospitals in *Alameda* are similar, the biggest difference being the Providers here filed appeals with the Board and the hospitals in *Alameda* did not (they filed directly in federal court).
>
> Like some of the hospitals in *Alameda*, the Providers here requested a realignment, but the same Transmittals and Rulings discussed in *Alameda* have delayed the issuance of Providers' updated SSI Fractions and resultant revised DSH payments. The substantive arguments made by the Providers in these cases about this delay were rejected by the court in *Alameda*.
>
> As the court in *Alameda* held, the Providers must pursue its administrative remedies – *i.e.*, file claims with the Board – before seeking relief in federal court. The Board only has jurisdiction over an appeal if the Provider filed their appeal from a final determination. The Providers here concede that they have not received a Notice of Program Reimbursement. Indeed, that is the crux of its argument, that it has taken too long to get NPRs with the realignment of their SSI Fractions for the FYs at issue. The Board also has limited jurisdiction over appeals where a Medicare Contractor fails to issue an NPR in a timely manner. A Provider may obtain a hearing before the Board, but only if it files its appeal within 180 days after the twelve

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

month period in which the Medicare Contractor was to issue a final determination, as required by 42 C.F.R. § 405.1835.[31] The Providers' appeals do not meet these criteria.

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

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

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

Pursuant to 42 C.F.R. § 405.1835(a)(1), an individual provider generally has a right to a hearing before the Board "with respect to a final contractor or Secretary determination ***for the provider's cost reporting period***"[32] 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"[33] In other

[31] Medicare Contractors must issue an NPR within twelve months of receiving a Provider's perfected cost report. Providers are afforded the right to appeal if this NPR is not timely received pursuant to 42 C.F.R. § 405.1835(c), which states:

> (1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's *perfected cost* report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.
>
> (2) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section) . . .

[32] 42 C.F.R. § 405.1835(a) (emphasis added).
[33] 42 C.F.R. § 405.1835(a)(1) (emphasis added).

words, providers must appeal from a "final determination" that impacts payment for the period under appeal.[34]

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

* The amount in controversy is $10,000 or more.[35]

Satisfying the criteria set out in 42 C.F.R. § 405.1835(a) is required before the Board can exercise jurisdiction over an appeal.[36]

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

(b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing in the manner prescribed by the Board, and the request must include the elements described in paragraphs (b)(1) through (4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (2), or (3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.

(1) **A <u>demonstration</u> that the provider <u>satisfies the requirements</u> for a Board hearing as specified in paragraph (a) of this section**, including a specific identification of the final contractor or Secretary determination under appeal.

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

[35] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.

[36] 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.

> (2) **For each specific item under appeal**, a separate explanation of why, and a description of how, the provider is dissatisfied **with the specific aspects of the final . . . determination under appeal**, including an account of all of the following:
>
> > (i) **Why the provider believes Medicare <u>payment</u> is incorrect for each disputed item** (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because **it does not have access to underlying information concerning the calculation of <u>its payment</u>**).
> >
> > (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
>
> ****
>
> (3) A copy of the final contractor or Secretary determination under appeal **<u>and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section</u>**.[37]

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

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

Unlike DRG rates and other adjustments such as the wage index,[38] a

[37] (Italics emphasis in original and bold and underline emphasis added.)
[38] Another example is the Two-Midnight Rule which impacted *prospectively* set payment rates.

hospital's eligibility for a DSH payment (and, if eligible, the amount of that payment) during a particular fiscal year is not ***prospectively*** set or determined as part of the relevant IPPS final rule. In this regard, 42 U.S.C. § 1395ww(d)(5)(F) refers to the DSH adjustment being calculated "with respect to a [hospital's] cost reporting period" and uses days associated with inpatients stays *occurring during that cost reporting period*.[39] To this end, DSH eligibility ***and*** payment, if any, is determined, calculated, and finalized *annually* through the cost report audit/settlement process as made clear in 42 C.F.R. § 412.106(i) which sets forth the following instructions regarding the determination of a hospital's eligibility for a DSH payment for each fiscal year and, if so, how much:

> (i) *Manner and timing of [DSH] payments*. (1) **Interim** [DSH] **payments** are made **during the payment year to each hospital that is estimated to be eligible** for payments under this section at the time of the annual final rule for the hospital inpatient prospective payment system, **subject to the final determination of eligibility at the time of cost report settlement for each hospital**.
>
> (2) **Final payment determinations are made at the time of cost report settlement**, based on the **final** determination of each hospital's eligibility for payment under this section.[40]

The Secretary makes clear that this regulation is based on "our ***longstanding*** *process* of making ***interim*** *eligibility* determinations for Medicare DSH payments *with* ***final*** *determination* ***at cost report settlement***."[41] Examples of other adjustments to IPPS payment rates that

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

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

[41] 78 Fed. Reg. at 50627. *See also* Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2807.2(B)(5) (last revised Aug. 1993, Transmittal 371) (stating: "*At* ***final settlement*** *of the cost report*, the intermediary determines the final disproportionate share adjustment based on the actual bed size and disproportionate share patient percentage for the cost reporting period." (emphasis added)). In the preamble to the FY 2014 IPPS Final Rule, the Secretary discussed the DSH eligibility and payment process and the following are excerpts from that discussion:

> *Comment*: Several commenters requested that CMS undertake additional audits to verify the data used to compute the 25-percent empirically justified Medicare DSH payment adjustments. Other commenters requested that CMS grant additional time for hospitals to verify the data and adjust their cost reports to ensure that the data used to compute the adjustment are accurate and up to date. Some commenters requested that CMS establish procedures to allow a hospital initially determined not to be eligible for Medicare DSH payments to begin receiving empirically justified Medicare DSH payments

are based, in whole or in part, on certain data/costs claimed on the as-filed cost report and then determined and reimbursed through the cost report audit and settlement process include bad debts,[42] direct graduate medical education ("GME"),[43] and indirect GME.[44]

Similarly, the Board declines to follow D.C. District Court's decision in

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if data become available that indicate that the hospital would be eligible.
Response: As we have emphasized, we are maintaining the well-established methodology and payment processes used under the current Medicare DSH payment adjustment methodology for purposes of making the empirically justified Medicare DSH payment adjustments. Hospitals are quite familiar with the cost reporting requirements and auditing procedures employed under the current Medicare DSH payment adjustment methodology. Hospitals are also familiar with the current process of determining **interim eligibility** for Medicare DSH payments **with final determination at cost report settlement**. Therefore, we do not believe that it would be warranted to add additional complexity to these procedures by adopting any of these recommendations.

****

For the reasons discussed above regarding the empirically justified Medicare DSH payments [*i.e.*, the DSH payment calculation made under 42 U.S.C. § 1395ww(d)(5)(F)], we do not believe that it is necessary or advisable to depart from our longstanding process of making interim eligibility determinations for Medicare DSH payments with final determination at cost report settlement. As we discuss in greater detail in section V.E.3.f. of the preamble to this final rule, we will make interim eligibility determinations based on data from the most recently available SSI ratios and Medicaid fractions prior to the beginning of the payment year. We will then make final determinations of eligibility at the time of settlement of each hospital's cost report.

****

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

Id. at 50626-27 (emphasis added).

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

[43] 42 C.F.R. § 412.2(f)(7) (stating that hospitals receive an additional payment for "[t]he direct graduate medical education costs for approved residency programs in medicine, osteopathy, dentistry, and podiatry as described in §§413.75–413.83 of this chapter.").

[44] 42 C.F.R. §§ 412.2(f)(2), 412.105. *See also* PRM 15-1 § 2807.2(B)(6) (stating: "*At **final** settlement of the cost report*, the intermediary determines the indirect teaching adjustment based on the actual number of full time equivalent residents and average daily census for the cost reporting period. (emphasis added)).

Battle Creek[45] and instead finds the D.C. District Court's 2022 decision in *Memorial Hospital* to be instructive. The Providers in *Memorial Hospital* appealed ***the publication of their DSH SSI Fractions*** (which is one step *after* the case at hand where Provider is appealing CMS Ruling 1498-R3 adopting/finalizing a policy ***prior to*** the publication of the DSH SSI Fractions reflecting that Ruling[46]). The providers in *Memorial Hospital* argued that there are certain instances where a provider can appeal prior to receiving an NPR and gave citations to certain D.C. Circuit cases in support. However, the D.C. District Court distinguished these cases because "the secretarial determination at issue was either the only determination on which payment depended or clearly promulgated as a final rule."[47] The D.C. District Court ultimately agreed with the Board that this was not an appealable final determination. In its discussion, the D.C. District Court agreed with the Secretary that the publication of the SSI ratios, *even if the publication of the SSI fractions had been issued as "final,"* could and would not be a final determination "as to the amount of payment" because the SSI fractions are "just one of the variables that determines whether hospitals receive a DSH payment ***and***, ***if so***, *for how much*."[48] The D.C. District Court concluded:

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

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

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

[47] 2022 WL 888190 at *8.

[48] *Id.* at *9 (emphasis added).

> effectively fixes the hospital's reimbursement rate, then that decision is a 'final determination' as referred to 42 U.S.C. § 1395oo(a)(1)(A)(ii).").[49]

Accordingly, the Court upheld the Board's decision to dismiss because the DSH SSI fraction was only one of the variables that determine whether a hospital receives a DSH payment (and, if so, for how much) and the publication of a hospital's SSI fraction is not a determination as to the amount of payment received.[50]

This is what makes these cases distinguishable from the facts presented in the D.C. Circuit's decisions in *Washington Hospital* where the determination that was appealed finalized the only hospital-specific variable used in setting the per-patient payment amount. Specifically, the hospitals in *Washington Hospital* appealed their "Final Notice of Base Period Cost and Target Amount Per Discharge" and the D.C. Circuit found: (a) "the ***only variable*** *factor* in the final determination as to the amount of payment under § 1395ww(d) is the hospital's target amount . . . .";[51] and (b) "That amount is the per-patient amount calculated under § 1395ww(d) and is final once the Secretary has published the DRG amounts (as he has) and finally determined the hospital's target amount. Here each of the hospitals has received a 'Final Notice of Base Period Cost and Target Amount per Discharge.' The statute requires no more to trigger the hospital's right to appeal PPS Payments to the PRRB."[52]

Similar to the D.C. District Court's decision in *Memorial Hospital*, while the policy at issue in these cases was promulgated/finalized in the issuance of CMS Ruling 1498-R3, it is ***not*** a "final determination" as to the amount of the DSH payment to be received by Providers for the FYs at issue. Rather, 1498-R3 reflects "just one of the variables that determines whether hospitals receive a DSH payment [for the relevant fiscal year] ***and***, ***if so***, *for how much*"; and any "***final*** *payment* determination"[53] on whether a hospital receives a DSH payment for a particular fiscal year and, if so, for how much *is made during the cost report audit/settlement process as explained at 42 C.F.R. § 412.106(i)*.[54] In this regard, the Board again notes that 1498-R3 did not make a determination on any specific hospital's DSH eligibility and, if so, the amount of DSH payment. Rather, as it relates to these appeals, the Ruling adopts a policy that is to be

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[49] *Id.* at *8.
[50] *Id.* at *9.
[51] 795 F.2d at 147 (emphasis added).
[52] *Id.* at 148 (footnote omitted).
[53] 42 C.F.R. § 412.106(i)(2) (emphasis added).
[54] 2022 WL 888190 at *9 (emphasis added).

applied *retroactively* but only to certain hospitals and makes clear that *new SSI percentages* would be calculated or recalculated.

The Providers in the cases listed in **Appendix A** have not received Revised NPRs with revised SSI fractions based on their realignment requests for the FYs at issue from which they could appeal. Nor did the Providers timely appeal the failure of the Medicare Contractor to issue a timely determination pursuant to 42 C.F.R. § 405.1835(c). Additionally, the substantive arguments for the basis of this appeal about the lawfulness of the delay have already been rejected by *Alameda.* Accordingly, the Board finds it is appropriate to dismiss the appeals listed in **Appendix A** and remove them from the Board's docket, since satisfying the criteria set out in 42 C.F.R. § 405.1835(a) is required before the Board can exercise jurisdiction over an appeal,[55] and since Providers had failed to demonstrate in their hearing requests that those criteria have been met for the years under appeal.[56] The Board further notes that three of the providers are appealing cost reporting periods which are congruent with the federal fiscal year (ending on 9/30), and thus, any requested realignment would have no effect on settlement, and the appeal would have $0 amount in controversy.[57] These cases could also be dismissed for not meeting the necessary amount in controversy, as this is the only issue in these cases.

Request for Reconsideration:

On **February 5, 2025**, the Providers filed a Request for Reconsideration. They insist that the *Alameda* decision does not form the basis for a dismissal in these cases, but requires their appeals here in order to pursue a remedy.[58] Indeed, they claim *Alameda* requires they attempt to exhaust their remedies before the Board before pursuing them in federal court, and that the Board's dismissal renders such exhaustion impossible.[59] They argue that the Board mischaracterized the *Alameda* decision in stating that the substantive arguments made in these cases about delay were rejected by the court, but that the court only determined a procedural issue (exhaustion) in that case.[60]

The Providers also argue the Board's reliance on 42 C.F.R. § 405.1835(c) (right to a hearing based on an untimely contractor determination) was misplaced. The Providers claim "[t]he 180-day time deadline to file appeals arises from the final ACTION by CMS on a cost report or

[55] 42 C.F.R. § 405.1840(a), (b).
[56] 42 C.F.R. § 405.1835(b).
[57] Case Numbers 24-2326, 24-2327, and 24-2390 identify providers with FYE of 9/30 (1999 and/or 2000). If the providers' cost reporting period (ending 9/30) is the same as the federal fiscal year (ending 9/30) there would be no realignment of the SSI percentage possible, as the data used would be exactly the same in both cases.
[58] Request for Reconsideration at 1 (Feb. 5, 2025).
[59] *Id.*
[60] *Id.* at 2.

amended cost report, not INACTION on an appeal or a remand. . . . If the 180-day rule applied to the CMS inaction, there would be absolutely no remedy and the MAC would not need to ever issue an revised NPR if it failed to do so within twelve months of the cost report and the provider did not appeal within 180 days thereafter."[61]

Finally, the Providers reiterate that Rule 1498-R3 was an appealable "final action", relying on the D.C. District Court's decision in *Battle Creek*. The Board notes that this decision was recently reversed by the D.C. Circuit Court in August, 2025.[62]

Decision of the Board:

The Board hereby ***denies*** the request for reconsideration. The Providers' arguments are not persuasive. The controlling statutes and regulations provide the Providers with a limited right to a hearing before the Board, and specifically require any appeal be taken from a final determination or the failure to timely issue a final determination.[63] The Board is bound by these controlling authorities.[64] As thoroughly explained in its December 9, 2024 decision, Ruling 1498-R3 does not meet the criteria of a final determination. The Providers' reliance on the D.C. District Court's decision in *Battle Creek* is not persuasive, since, as previously noted, this decision was recently reversed by the D.C. Circuit Court.[65]

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.
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For the Board:

4/23/2026

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

[61] *Id.*
[62] *Battle Creek Health Sys. v. Kennedy*, 2025 WL 2423686 (D.C. Cir. 2025).
[63] 42 U.S.C. § 1395oo(a)(1); 42 C.F.R. § 405.1835.
[64] 42 C.F.R. § 405.1867.
[65] *Battle Creek Health Sys. v. Kennedy*, 2025 WL 2423686 (D.C. Cir. 2025).

Appendix A
(41 Cases)

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Leslie Goldsmith, Esq.
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Washington, D.C. 20004

RE: ***Expedited Judicial Review Decision***

Case Number: 25-4472GC - Corewell Health CY 2021 Capital DSH CIRP Group
Case Number: 25-4715GC - HonorHealth CY 2022 Capital DSH CIRP Group
Case Number: 26-0311GC - Penn State Health CY 2023 Capital DSH CIRP Group
Case Number: 26-0316GC - Cone Health CY 2022 Capital DSH CIRP Group
Case Number: 24-2226GC - Hartford Health CY 2022 Capital DSH CIRP Group

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the **March 30, 2026** consolidated request[1] for expedited judicial review ("EJR") for the above-referenced common issue related party ("CIRP") group appeals. The decision with respect to EJR is set forth below.[2]

Issue under Dispute

In these group cases, the Providers are challenging:

> [T]he validity of the regulation at 42 C.F.R. § 412.320(a)(1)(iii), which bars hospitals that are geographically urban and reclassify as rural under 42 C.F.R. § 412.103 from receiving a capital disproportionate share hospital ("DSH") add-on payment, known as the capital DSH adjustment. The Providers challenge the validity of 42 C.F.R. § 412.320(a)(1)(iii) on a number of grounds including that the regulation (a) is inconsistent with the controlling Medicare statute, (b) was adopted in violation of the Administrative Procedure Act, and (c) is arbitrary and capricious.[3]

[1] Providers' Petition for Expedited Judicial Review (Mar. 30, 2026) ("Request for EJR").
[2] The Request for EJR encompasses nine (9) group cases. Pursuant to Board Rule 44.6 (2023), the Medicare Contractor and/or its representative made filings which indicated they would be submitting Substantive Claim Challenges in Cases 25-3514G, 25-3521GC, 25-3813GC, and 25-2434G, which will be addressed by the Board under separate cover.
[3] Request for EJR at 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.[4] This case focuses on the capital IPPS.

1. Geographic Reclassification

In 1989, Congress created the Medicare Geographic Classification Review Board ("MGCRB") which implemented a geographic reclassification system in which IPPS hospitals can be reclassified to a different wage index area[5] for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.[6] This includes an IPPS hospital reclassifying from a rural to an urban labor market, or vice versa.

2. Operating DSH Adjustment Under Operating IPPS

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under operating IPPS.[7] Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[8]

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.[9] One of the adjustments is the hospital-specific Disproportionate Share Hospital ("DSH") adjustment as set forth at 42 U.S.C. § 1395ww(d)(5)(F), which requires the Secretary to provide an adjustment (*i.e.*, an increase in the operating IPPS payment) to hospitals that "serve [] a significantly disproportionate number of low-income patients."[10]

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[4] Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), *available at* https://oig.hhs.gov/oas/reports/region1/11700500.pdf (last visited Nov. 20, 2025) ("*Significant Vulnerabilities*").
[5] *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).
[6] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). *See also Significant Vulnerabilities* at 4-5.
[7] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[8] *Id.*
[9] *See* 42 U.S.C. § 1395ww(d)(5).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

A hospital may qualify for a DSH adjustment to its operating IPPS payments based on its disproportionate patient percentage ("DPP").[11] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[12]

The DSH adjustment provided under operating IPPS is ***not*** at issue in this case. The DSH adjustment is relevant because certain standards set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment that the Secretary adopted for purposes of capital IPPS.

3. Capital DSH Adjustment Under Capital IPPS

A hospital's *capital* costs are paid separately under capital IPPS (*i.e*., separate and apart from payment for a hospital's *operating* costs under the operating IPPS). Specifically, on December 22,1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987 ("OBRA-87") and OBRA-87 § 4006(b) required the Secretary to establish the capital IPPS for cost reporting periods beginning in FY 1992.[13] OBRA-87 § 4006(b) was codified at 42 U.S.C. § 1395ww(g) which states, in pertinent part:

> **(g) Prospective payment for capital-related costs; return on equity capital for hospitals**
>
> (1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall,* for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .
>
> (B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;
>
> (ii) *may provide for 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

[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[12] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[13] Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).

> (iv) may provide for suitable adjustment to reflect hospital occupancy rate.
>
> (C) In this paragraph, the term ''capital-related costs'' has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.[14]

Significantly, the statute governing capital IPPS does not specifically mandate or address the use of a capital DSH adjustment. Rather, it specifies generally that the Secretary "may provide for an adjustment to account variations in relative costs." As described below, the Secretary exercised his discretion to establish the c*apital* DSH adjustment at issue in this case which is limited in that it ***only*** applies to *urban* hospitals with 100 or more beds and that serve low income patients.[15]

A. Initial Implementation of Capital IPPS and the Capital DSH Adjustment

To the end, the Secretary published a final rule on August 30, 1991 to establish the capital IPPS.[16] In implementing the capital IPPS, the Secretary recognized that he had discretion on whether to apply many of the adjustments statutorily required under operating IPPS to capital IPPS:

> We are persuaded by the argument advanced by some commenters, including ProPAC, that in the long run the ***same*** adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. *While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process),* ***we have the latitude to develop adjustments based on combined costs for the capital prospective payment system***.
>
> We do not believe that it would be appropriate to use the current operating payment adjustments in the capital prospective payment system either permanently or on an interim basis until legislation is enacted changing the operating adjustments to the level appropriate

[14] (Underline and italics emphasis added.)
[15] 42 C.F.R. § 412.320(a)(1). *See also* MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 3 (rev. Nov. 2021), *available at* https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Jan. 6, 2026).
[16] 56 Fed. Reg. 43356 (Aug. 30, 1991).

> for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME) exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should reflect only the higher Medicare costs associated with teaching activity and treating low income patients.[17]

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more than 100 beds. The proposal was described as follows:

> In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to ({1 +DSHP)$^{0-4176}$ - 1)), where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.
>
> Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.[18]

In adopting his proposal, the Secretary gave the following justification:

> *Comment*: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.

[17] *Id.* at 43369-70 (emphasis added).
[18] *Id* at 43377.

> *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 patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries**.[19]

In response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to rural hospitals with 500 or more beds:

> As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1,1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these

[19] *Id.* at 43409-10 (bold and underline emphasis added).

> hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(l){ii) of the regulations.[20]

Similarly, in response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to other classes of hospitals such as "[a]ll small urban hospitals, hospitals with high Medicare usage, rural hospitals, rural hospitals with at least 100 beds, rural referral centers, or those hospitals with high 'total government' usage":

> In developing the capital disproportionate share adjustment for this final rule, we examined the relationship between the disproportionate share patient percentage and total costs per case for each class of hospital that is currently receiving an operating payment adjustment. We believe that only those hospitals that merit the adjustment according to our regression analysis should receive additional capital payments for serving low income patients. The regression results did not indicate any significant relationship between total costs per case and disproportionate share patient percentage for any of the special groups mentioned above.[21]

In response to comments, the Secretary also looked at setting a threshold DSH percentage to qualify for a capital DSH adjustment but rejected that alternative 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.[22]

Further, in response to comments, the Secretary rejected not providing *any* capital DSH adjustment based on the explanation:

---

[20] *Id.*
[21] *Id.* at 43378.
[22] *Id.* at 43379.

> We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We believe that it is appropriate for Medicare's payment to recognize these higher Medicare patient care costs.[23]

Finally, the Secretary addressed how MGCRB reclassifications, in certain circumstances, affect whether an IPPS hospital qualifies for the capital DSH adjustment:

> *Comment*: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.
>
> *Response*: Any hospital that is reclassified to an urban area by the MGCRB for purposes of its standardized amount is considered to be urban for all prospective payment purposes other than the wage index. As such, if any hospital reclassified by the MGCRB to an urban area for purposes of the standardized amount has at least 100 beds, it would be eligible for capital disproportionate share payments. We note that a rural hospital reclassified for purposes of the wage index only is still considered a rural hospital, and as such, will not be eligible for capital disproportionate share payments.[24]

The resulting regulations governing capital IPPS were codified at 42 C.F.R. Part 412, Subpart M (§§ 412.300 to 412.374). The regulation governing the capital DSH adjustment was codified at § 412.320 which, at initial implementation, stated:

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).
>
> (b) *Payment adjustment factor*. (1) <u>If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments</u>, the disproportionate share payment adjustment factor equals [e raised to the power of

[23] (Emphasis added.)
[24] *Id.*

> (.2025 X the hospital's disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.
>
> (2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.[25]

B. Reclassification of Certain IPPS Urban Hospitals as Rural for Purposes of Operating IPPS Pursuant to BBRA § 401 and Impact on Capital IPPS Adjustments

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA") and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.[26] 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.[27]

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

[25] *Id*. at 43452-53.
[26] BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).
[27] 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added.)

urban area. ***That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes***. In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.

****

Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB 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.[28]

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**.

[28] 65 Fed. Reg. 47054, 47088-89 (Aug. 1, 2000).

> (a) *General criteria*. A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
>
> 1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration which is available via the ORHP website at http:// www.nal.usda.gov/orph or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857.
>
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
>
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.[29]

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",[30] 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 <u>or</u> rural areas** within the United States and within each such

[29] 65 Fed. Reg. 47026, 47048.
[30] 56 Fed. Reg. at 43452.

> 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**.[31]

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.

C. Changes to Operating IPPS Required by MMA § 401 and Their Effect on Capital IPPS

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") and MMA § 401 to equalize operating IPPS payments between urban and rural hospitals.[32] 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.[33] 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.[34]

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.[35] 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

[31] (Bold and underline emphasis added.)
[32] Pub. L. 108–173
[33] 69 Fed. Reg. 48916, 49026 (Aug. 11, 2004).
[34] *Id.*
[35] *Id.*

hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.

(b) *Geographic classifications*. (1) For purposes of this section, the following definitions apply:

(i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.

(ii) The term *urban area* means—

(A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(C) The term *rural area* means any area outside an urban area.

(D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

(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.[36]

Significantly, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: "A hospital is classified as a 'disproportionate share hospital' for the purposes of capital prospective payments if the hospital is located, *for purposes of receiving payment under § 412.63(a)*, in an urban area."[37] As a result of the FY 2005 IPPS Final Rule, § 412.320(a) was updated to reference § 412.64 as it relates to FYs 2005 forward:

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a ''disproportionate share hospital'' for the purposes of capital prospective payments <u>if either of the following conditions is met</u>:
>
> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (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) <u>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</u>.[38]

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).

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[36] *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).
[37] (Emphasis added.)
[38] 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

Finally, in the preamble to the FY 2005 IPPS Final Rule, the Secretary included the following discussion on the impact of the new CBSAs on geographic reclassifications:

> Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB's new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.
>
> ****
>
> The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those 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.[39]

D. August 18, 2006 Revisions to the Capital DSH Adjustment

In the FY 2007 Proposed IPPS Rule, the Secretary[40] 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.[41]

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and Budget's ("OBM's") new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005.[42]

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

[39] 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004).
[40] of the Department of Health and Human Services.
[41] 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).
[42] *Id.*

> 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.[43]

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.[44]

As a result of the FY 2007 IPPS Final Rule, the regulation, subparagraph (iii) was added to 42 C.F.R. § 412.320(a)(1) so that revised § 412.320(a) read, in pertinent part:

> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if either of the following conditions is met:
>
> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (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**

[43] 71 Fed. Reg. 47870, 48104 (Aug. 18, 2006)
[44] *Id.* at 48105.

> **hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.[45]**

E. 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*"),[46] wherein the hospital made the following contentions:

> Toledo Hospital contends that the Secretary's 2006rulemaking 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.[47]

In *Toledo*, U.S. District Court for the District of Columbia ("D.C. District Court") outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.[48] The Court also noted how Congress enacted legislation in 1999[49] 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.[50] 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).[51] 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.[52]

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

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[45] (Bold emphasis added.)
[46] 621 F.Supp.3d 13 (D.D.C. 2021).
[47] *Id.* at *25 (citations omitted).
[48] *Id.* at *18-19.
[49] 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.
[50] *Toledo* at *19.
[51] *Id.* at *19-20.
[52] *Id.* at *21.

C.F.R. § 412.320(a)(1)(iii) violated the plain language of the Medicare Act and that it was promulgated in in an arbitrary and capricious manner.[53]

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.[54] 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."[55]

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."[56]

    - "[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements."[57]

    - "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)."[58]

    - "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."[59]

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

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[53] *Id.* at *22.
[54] *Id.* at *23-25.
[55] *Id.* at *29.
[56] *Id.*
[57] *Id.*
[58] *Id.*
[59] *Id.*

adjudication."[60] Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants' eligibility for a capital DSH adjustment.[61]

Providers' Request for EJR

As background, "[e]ach of the Providers is an acute care hospital paid by Medicare pursuant to the inpatient and capital [prospective payment systems]. During the years under appeal, the hospitals were all geographically located in urban areas, operated more than 100 beds, served low-income patients and, for all or part of the year, received [§] 401 rural reclassifications pursuant to 42 C.F.R. § 412.103."[62]

The Providers are challenging the validity of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent with the underlying operating PPS statute, in particular 42 U.S.C. § 1395ww(d)(8)(B), which states that hospitals that have undergone a rural reclassification are rural only for purposes of this subsection 1395ww(d). The Providers note that "[t]he capital PPS provisions are located in an entirely different section of the statute, in 42 U.S.C. § 1395ww(g), and therefore a rural reclassification under the subsection (d) operating PPS provisions does not apply for subsection (g) capital PPS purposes."[63]

The Providers believe that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(g), and the regulation must be found invalid.[64] The Providers assert that "the Secretary has implicitly acknowledged that he cannot apply rural status for hospitals that have undergone a rural reclassification to payment provisions outside of subsection (d)," and provides as an example, that "the Secretary has stated with respect to direct graduate medical education ("GME") that no adjustment to the direct GME cap are available for urban hospitals that have reclassified as rural because subsection (d) reclassification 'affects only payments under section 1886(d) of the Act' and 'payment for direct GME are made under section 1886(h) of the Act.'"[65] Further, the regulation fails to take into account any variation in cost based on location, as the capital PPS statute permits at 42 U.S.C. § 1395ww(g)(1)(B)(ii).[66]

The Providers assert that "[t]he Secretary's adoption of the regulation was arbitrary and capricious and violates the Administrative Procedure Act" because he "failed to establish that the adoption of the exception to the capital DSH adjustment, for providers that reclassified as rural, took 'into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located.'"[67]

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[60] *Id.* at *30.
[61] *Id.*
[62] Request for EJR at 7.
[63] *Id.* at 1, 7.
[64] *See id.* at 7-8.
[65] *Id.* at 8 (citing 70 Fed. Reg. 47278, 47437 (Aug. 12, 2005)).
[66] *Id.*
[67] *Id.* at 8-9.

Though 42 C.F.R. § 412.320(a)(1)(iii) has not been vacated, the Providers argue that the merits of their position were adopted by the D.C. District Court in *Toledo*.[68] Further, the Providers contend that the Secretary adopted the FY 2024 hospital IPPS proposed rule in which the Secretary, in response to *Toledo*, proposed to amend 42 C.F.R. § 412.320(a)(1)(iii). Specifically, effective for discharges occurring on or after October 1, 2023, an urban hospital that is reclassified as rural under § 412.103 "will no longer be considered rural for purposes of determining capital DSH eligibility. Instead, for purposes of § 412.320, the geographic classifications specified under § 412.64 will apply."[69] However, the Providers explain that "for the periods under appeal, CMS and its contractors have continued to apply the 2006 regulation, denying capital DSH to the Providers for these periods."[70]

The Providers further contend that since the Board is bound by the regulation being challenged,[71] namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), it lacks the authority to decide the legal question presented in the Providers' Request for EJR. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.[72]

Medicare Contractor's Response:

Following receipt of the Consolidated Request for EJR on **March 30, 2026**, the Medicare Contractor and its representative, Federal Specialized Services ("FSS") filed notices certifying that they would be filing Substantive Claim Challenges in Cases 25-3514G, 25-3521GC, 25-3813GC, and 25-2434G. FSS, however, did not certify that it would file challenges in 25-4472GC, 25-4715GC, 26-0311GC, 26-0316GC, and 24-2226GC within the time required by the Board's Rules.[73]

Board Decision:

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

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[68] *Id.* at 9-10.
[69] *Id.* at 10 (citing 88 Fed. Reg. 58640, 59117, 59334 (Aug. 28, 2023).
[70] *Id.*
[71] *See* 42 C.F.R. § 405.1867.
[72] Request for EJR at 10-12.
[73] Board Rule 44.5.2 (2023) typically requires a party questioning whether a participant included an appropriate claim on the cost report at issue to file its Substantive Claim Challenge within 60 days of the group filing its Final Schedule of Providers ("SOP"). When an EJR Request is filed within 60 days of the Final SOP, the moving party must certify that it will be filing a challenge within five business days and then must file the actual challenge within 20 days following the filing of the EJR Request. The Consolidated EJR Request in the case was filed on March 30, 2026. By April 6, 2026 (five business days after the EJR Request), FSS or the Medicare Contractor itself had certified that it would be filing substantive claim challenges in Cases 25-3514G, 25-3521GC, 25-3813GC, and 25-2434G only.

1. Jurisdiction

A group of Providers generally have a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if:

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [74]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[75]

The Providers have appealed from original NPRs or from the failure of the Medicare Contractor to issue a timely NPR.

Based on its review of the record, the Board finds that each of the participants in these group appeals filed their appeal within 180 days of the issuance of their respective final determinations or failure to issue a determination as required by 42 C.F.R. § 405.1835; that the providers in each case appealed the issue in their respective appeals; and that the Board is not precluded by regulation or statute from reviewing the issue in these appeals. Finally, in each case, the amount in controversy meets the $50,000 threshold for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3).

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[74] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986). Medicare Contractors must issue an NPR within twelve months of receiving a Provider's perfected or amended cost report. Providers are afforded the right to appeal if this NPR is not timely received pursuant to 42 C.F.R. § 405.1835(c), which states:

> (1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's *perfected cost report* or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.
>
> (2) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section) . . .

[75] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

2. *Jurisdiction – Appropriate Cost Report Claim (FYEs beginning on or after December 31 ,2016)*

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[76] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[77] 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 all the participants in these five (5) cases have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement for the Board's ***jurisdiction*** is not applicable.

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

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

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

[76] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[77] *Id.* at 70555.

> believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) Self-disallowance procedures. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.

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

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

These regulations are applicable to the cost reporting periods under appeal for all of the participants in these group appeals, which all have cost reporting periods ending on or after December 31, 2016. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[78] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[79] In these five (5) cases, the Medicare Contractor failed to certify that it would be filing a Substantive Claim Challenge[80] within the time frame specified by Board Rule 44.6 (2023) for any of the Providers with FYEs December 31, 2016 or later.

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[81] 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).

4. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that the participants in Cases 25-4472GC, 25-4715GC, 26-0311GC, 26-0316GC, and 24-2226GC are entitled to a hearing before the Board;

2) Board review of whether the Providers' cost reports included an appropriate claim for a specific item as required by 42 C.F.R. § 405.1873(a) has not been triggered;

3) Based upon the participants' assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), there are no findings of fact for resolution by the Board;

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

5) It is without the authority to decide the legal question of whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid.

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[78] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[79] *See* 42 C.F.R. § 405.1873(a).
[80] Board Rule 44.5 states: "The Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."
[81] 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."

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' EJR Request for the issue and the subject years in Case Nos. 25-4472GC, 25-4715GC, 26-0311GC, 26-0316GC, and 24-2226GC. 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 the cases and will remove them from its docket.

Board Members Participating:

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

FOR THE BOARD:

4/24/2026

X Kevin D. Smith, CPA

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

Enclosure: Schedules of Providers

cc: Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-L)
Dean Wolfe, Noridian Healthcare Solutions (J-F)
Byron Lamprecht, WPS Government Health Administrators (J-8)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Danelle Decker, National Government Services, Inc. (J-K)
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DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Michael Newell
Southwest Consulting Associates
28505 North Dallas Parkway, Suite 620
Plano, TX 75093-8724

RE: ***Expedited Judicial Review Determination***

Southwest Consulting Medicare Part C Days Groups
Case Numbers: 25-0122GC *et al.* (12 Cases – *See* **Appendix A**)

Dear Mr. Newell:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed on **March 31, 2026** in the above-referenced group appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Board received requests to establish Common Issue Related Party ("CIRP") and optional groups for these twelve (12) groups between **October, 2024** and **December, 2025**. All twelve (12) groups contain providers appealing from revised Notices of Program Reimbursement ("RNPRs") which implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Providers' Fiscal Years Ending ("FYEs") spanning from 2005 to 2014.

The issue in this appeal is "the proper treatment in the Medicare disproportionate share hospital ("DSH") calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Allina II* litigation. The Providers contend that part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction for patients eligible for Medicaid."[2] The Providers are seeking to challenge the CMS policy adopted in the June 2023 Final Rule to be applied *retroactively* for periods prior to October 1, 2013.[3]

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] *E.g.*, Case No. 25-0122GC, Statement of Group Issue at 1 (Oct. 8, 2024).
[3] *Id.* at 2.

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").[4] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[6] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] 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.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[11]

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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.[13]

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.[14]

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

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

In the September 4, 1990 Federal Register, the Secretary[15] stated that:

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

[12] 42 C.F.R. § 412.106(b)(2)-(3).
[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(4).
[15] of Health and Human Services.

> included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[17]

With the creation of Medicare Part C in 1997,[18] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C, and following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[19] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[20] The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[21]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.[22] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[23] In response to a comment regarding this change, the Secretary explained that:

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[16] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[17] *Id.*
[18] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[19] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[20] *Id.*
[21] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[22] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[23] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[24]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[25] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[26] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[27]

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

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[24] *Id.* (emphasis added).
[25] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[26] *Id*. at 47411.
[27] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[28]

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[29] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[30] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[31] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[32] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.[33] A number of hospitals appealed this action.[34] In *Azar v. Allina Health Services* ("*Allina II*"),[35] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[36] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[37] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[38]

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[28] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[29] 746 F. 3d 1102 (D.C. Cir. 2014).
[30] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[31] *Id.* at 2011.
[32] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[33] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[34] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo****(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board, **pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[35] 139 S.Ct. 1804 (2019).
[36] *Id.* at 1817.
[37] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[38] 139 S.Ct. at 1814.

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[39] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[40]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[41] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[42]

Finally, the following excerpts from the June 9, 2023 Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule or subsequent publication of SSI ratios to be an appealable "final determination":

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[39] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[40] CMS Ruling 1739-R at 1-2.
[41] 88 Fed. Reg. 37772 (June 9, 2023).
[42] 88 Fed. Reg. at 37788 (emphasis in original).

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports***. *In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[43]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[44]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically."[45]

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

[43] 88 Fed. Reg. at 37774-75 (emphasis added).
[44] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[45] *Id.* at 37788 (emphasis added).

> notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[46]

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

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are "entitled to [Part A] benefits" within the context of 42 U.S.C.§ 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.[47] It ruled, however, that the June 9, 2023 Final Rule is both impermissible retroactive[48] arbitrary and capricious.[49] The court ordered the parties to submit briefs on whether vacatur is the appropriate remedy in this situation, which have since been filed.[50]

Providers' Position:

A. Providers' Appeal Requests

The Providers' appeal requests include a "Statement of Jurisdiction" asserting that the Providers have met the applicable statutory conditions for appeal because they are dissatisfied with their revised NPRs which apply the June 9, 2023 retroactive final rule related to Part C days. They cite language from that final rule which outlined Providers' ability to challenge this final rule once they were issued NPRs implementing the rule.[51]

The "Statement of Group Issue" included with the appeal requests state that the issue concerns "the proper treatment in the Medicare [DSH] calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Allina II* litigation."[52] The Providers contend that the Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.[53]

The Providers characterized the relevant background facts as follows:

1. In the FY 2005 IPPS Final Rule, CMS first announced a policy change to count Part C days in the SSI fraction and to exclude those days from the numerator of the Medicaid fraction.

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[46] *Id.* (emphasis added).
[47] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).
[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.
[51] *E.g.*, Case No. 25-0122GC, Appeal Request, Statement of Jurisdiction at 1 (citations omitted).
[52] *E.g.*, Case No. 25-0122GC, Appeal Request, Statement of Group Issue at 1.
[53] *Id.*

2. In *Allina I*, the D.C. Circuit vacated that policy change.

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking. The Supreme Court's decision "did not address the D.C. Circuit's alternate ruling that the readopted standard was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the standard could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[54]

4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.

Based on the above, the Providers maintain that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule "is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[55]

B. Providers' Petitions for EJR

The Providers have requested EJR over the "post-*Allina* retroactive Part C policy issue" because they believe they have met the requirements for a hearing before the Board, but the Board lacks the authority to decide the substantive and procedural validity of CMS' final rule published in the Federal Register on June 9, 2023.[56] They seek a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.[57] The request states again that "[t]he Providers contend that the new, post-*Allina* retroactive part C days rule, applied in the [NPRs and RNPRs] appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[58] Since the Board is bound by this regulation,[59] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

On **April 7, 2026**, the Medicare Contractor's representative, Federal Specialized Services, filed a timely, consolidated response to the Requests for EJR for all twelve (12) cases. It simply

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[54] *E.g.*, Case No. 25-0122GC, Appeal Request, Statement of Issue at 1 (citing to 139 S. Ct. at 1816).
[55] *Id.* (citing 5 U.S.C. § 706(2)).
[56] *E.g.*, Case No. 25-0122GC, Providers' Petition for Expedited Judicial Review at 13 (Mar. 31, 2026).
[57] *Id.* at 16.
[58] *Id.* at 1-2.
[59] 42 C.F.R. § 405.1867.

advised that, in each case, that it "will not file a jurisdictional challenge. The MAC will not file a substantive claim challenge."[60]

Decision of the Board:

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

A. Jurisdiction

A group of Providers generally have a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if:

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [61]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[62]

For these twelve (12) groups, the providers all appealed from revised NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. All the providers were directly added to their respective groups within 180 days of the issuance of their RNPRs and the amount in controversy exceeds $50,000 in each case.

The Board finds that the Providers in the twelve (12) cases listed in **Appendix A** have all filed timely appeals from their revised NPRs concerning the same common issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these RNPRs. The Board also finds that the amount in controversy in each case exceeds $50,000 as required by 42 C.F.R. § 405.1837(a)(3). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

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[60] *E.g.*, Case No. 25-0122GC, Response to Provider's Request for Expedited Judicial Review at 1 (Apr. 7, 2026).
[61] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[62] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in the twelve (12) Cases listed in **Appendix A** and that the Providers in each group appeal are entitled to a hearing before the Board;

2) Based upon the Providers' assertions regarding the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether the Part C Days policy issue, as adopted on a retroactive basis in the June 9, 2023 Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject years.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes all twelve (12) cases and removes them from its docket.

Board Members Participating:

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

FOR THE BOARD:

4/24/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

cc: Danelle Decker, National Government Services, Inc. (J-K)
Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-L, J-H)
Byron Lamprecht, WPS Government Health Administrators (J-5)
Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-M)
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Scott Berends, Federal Specialized Services

Appendix A

25-5676GC	*SCL Health CYs 2005- 2007 & 2013 DSH Medicare Part C Days CIRP Group*
25-0437G	*Southwest Consulting CY 2010 Medicare Part C Group*
26-0321G	*Southwest Consulting CY 2010 DSH Medicare Part C Days Group*
25-0190GC	*Catholic Hlth Initiatives CY 2014 Pre-10/01/2013 Medicare Part C CIRP Group*
25-0122GC	*Catholic Hlth Initiatives CY 2011 Medicare Part C CIRP Group*
26-0092G	*Southwest Consulting CY 2012 DSH Medicare Part C Days Group*
26-0720G	*Southwest Consulting CY 2007 DSH Medicare Part C Days Group*
26-0090G	*Southwest Consulting CY 2013 DSH Medicare Part C Days Group*
25-5906G	*Southwest Consulting CY 2011 DSH Medicare Part C Days Group*
25-4042GC	*UPMC CY 2014 DSH Medicare Part C CIRP Group*
25-0781G	*Southwest Consulting CY 2009 Medicare Part C Group*
26-0025G	*Southwest Consulting CY 2011 DSH Medicare Part C Days Group*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

Lorinda Durnil, RN
Regional Director of MDS
Vivage Beecan Health
720 S. Colorado Boulevard, Suite 211
Glendale, CO 80246

RE: ***Board Determination – Failure to Respond to Show Cause Order***
Case No. 25-4231GC – Vivage Beecan Health FFY2025 2% Quality Reporting CIRP Group

Dear Ms. Durnil:

The Provider Reimbursement Review Board ("Board") has reviewed the subject common issue related party ("CIRP") group appeal which was deemed complete and for which a Show Cause Order was issued on April 8, 2026. The summary of the pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

On **March 19**, **2025**, Vivage Beecan Health ("Vivage") filed individual appeals on behalf of nine related providers all appealing 2% Quality Reporting determinations.

On **April 3, 2025**, the Board formed the "Vivage Beecan Health FFY 2025 2% Quality Reporting CIRP Group" under Case No. 25-4231GC because the related providers were pursuing a common issue and were required under the regulations to pursue the issue in a common issue related party ("CIRP") group.[1] The "2% Quality Reporting" issue for each respective provider was transferred to the new group from the nine individual cases resulting in the closure of Case Nos. 25-3910, 25-3915, 25-3918, 25-3921, 25-3922, 25- 3924, 25-4173, 25-4174 and 25-4175. On the same date, the Board issued an Acknowledgement and Critical Due Dates notification ("ACDD"), which gave the Group Representative a deadline of **April 3, 2026** to file the "Group's Comments Regarding Full Formation – The comments *must advise* the Board whether the group is complete, ***and if not***, *must specifically identify* which providers within the related party chain organization have not yet received a final determination for the appealed year. See Board Rule 19."[2]

On April 8, 2026, after there was no response to the full formation comments, the Board issued a Show Cause Order and notice deeming Case No. 25-4231GC to be fully formed. The Board's Order required the Representative to submit its comments within 15 days (**i.e.**, by *Thursday, **April 23, 2026***), showing cause as to why the case should not be dismissed.

[1] See 42 C.F.R. 405.1837.
[2] The ACDD also included the following dismissal warning: "The parties are responsible for pursuing the appeal in accordance with the Board's Rules. The parties must meet the following due dates regardless of any outstanding jurisdictional challenges, motions, or subpoena requests. If the Group misses any of its due dates, the Board will dismiss the appeal. If the Medicare Contractor fails to meet its deadlines, the Board will take actions described under 42 C.F.R. § 405.1868."

To date there has been no response to the Board's Show Cause Order.

Board Determination:

Board Rule 4.4.2 states the following:

> ***All filings*** other than an appeal request or request to add issues (*e.g.*, position papers and other responsive documents) ***must be received by the Board no later than the date specified on the Board's notice*** or, if silent, the date specified in these Rules. ***If a party fails to file by the established due date***, ***the Board may take action as described in 42 C.F.R. § 405.1868***. For example, Rule 23.4 addresses the timely filing of preliminary position papers and specifies that the Board will dismiss the appeal if the representative for the provider(s) fails to file their preliminary position paper or PJSO by the established due date.[3]

Further, Board Rule 41.2 permits the Board to dismiss a case if it has a reasonable basis to believe that the issues have been fully settled or abandoned, ***or the group fails to comply with Board filing deadlines***.

After a review of the facts in this case, the Board finds dismissal of the group to be appropriate based on Vivage Beecan Health's failure to initially respond to the Comments regarding Full Formation **and its subsequent failure to respond** to the Board's Show Cause Order. Vivage Beecan Health has failed to meet its responsibilities per Board Rule 5.2, which require the representative to meet Board deadlines and respond timely to correspondence or requests from the Board. The Rule specifically notes that, "[f]ailure 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." In addition, Vivage Beecan Health failed to comply with Board 19.2, which requires that "at the one-year mark . . . , they must notify the Board if the group is complete and, if not, which providers have not yet received a final determination for the specified fiscal year and intend to join the group." Accordingly, Case No. 25-4231GC is hereby dismissed 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:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

4/27/2026

X Kevin D. Smith, CPA

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

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

[3] Bold/Italics emphasis added.

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: ***Board Decision – Dismissal of DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues***
Jefferson Memorial Hospital (Provider No. 44-0056)
FYE 09/30/2016
Case No. 23-1345

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-1345. Set forth below is the decision of the Board to dismiss the remaining two (2) issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") SSI (Provider Specific) and DSH- Medicaid Eligible Days issues.

Background:

A. *Procedural History for Case No. 23-1345*

On **November 3, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2016.

On **April 21, 2023**, the Board received the Provider's individual appeal request. The Appeal Request was filed by Community Health Systems, Inc. ("CHS") and included five (5) issues:

1. DSH Pymt/SSI % (Provider Specific)
2. DSH/SSI - Unduly Narrow Definition of SSI Entitlement
3. DSH Pymt - Medicaid Eligible Days
4. Medicare Managed Care Part C – SSI & Medicaid Fractions
5. Dual Eligible Days – SSI & Medicaid Fractions

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 **April 24, 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.[1]

On **November 21, 2023,** CHS transferred Issues 2, 4 and 5 to CIRP groups. As a result, there are two (2) remaining issues in this appeal: DSH Pymt/SSI % (Provider Specific) (Issue #1) and DSH Pymt - Medicaid Eligible Days (Issue #3).

On **December 15, 2023**, CHS filed the Provider's PPP.

On **March 13, 2024,** the MAC filed its PPP.

On **April 1, 2024**, the MAC filed a Jurisdictional Challenge over the DSH Pymt/SSI % (Provider Specific) and DSH Pymt - Medicaid Eligible Days issues.

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

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

[1] (Emphasis added.)

> 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.[2]

The Group issue Statement in Case No. 19-1409GC, to which the Provider transferred Issue 2 (the SSI Percentage), reads in part:

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

[2] Issue Statement at 1 (April 21, 2023).
[3] Group Issue Statement, Case No. 19-1409GC.

On December 15, 2023, the Provider filed its PPP. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Issue #1: Provider Specific**
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[4]

The amount in controversy listed on the calculation support for both SSI Percentage Issues 1 and 2 in the Provider's individual appeal request is $8,218.

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**

[4] Provider's PPP at 8-9 (Dec. 15, 2023).

> 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): 1, 11, 13, S-D
>
> Estimated Reimbursement Amount: $28,694[5]

Regarding the Medicaid eligible days issue in its PPP the Provider argues that, pursuant to the *Jewish Hospital* case[6] 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.[7] 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).[8]

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

In its Jurisdictional Challenge, the MAC argues that the Board lacks jurisdiction over the DSH – SSI Provider Specific issue. According to the Provider's appeal request, this issue 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 two components related to SSI data accuracy should be dismissed because they are duplicative of the DSH SSI Percentage issue

[5] Appeal Request at Issue 3.
[6] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[7] Provider's PPP at 9.
[8] *Id.* at 9-10.

being pursued by the Provider in Case No. 19-1409GC. Additionally, the portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies. In addition, the MAC argues that the issue should be dismissed because the Provider failed to file a complete position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25. Finally, the MAC notes that the Provider's FYE ends in 9/30 which is the same as the federal fiscal year end ("FFY"). Therefore, whether the computation was based on the hospital FYE or the FFY, it would be the same.[9]

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

With regard to Medicaid Eligible Days issue, the MAC argued 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.)[10] In addition, the MAC contends that the Provider did not file a complete PPP in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2. and 25.3.[11] Therefore, since the Medicaid Eligible Days issue was not properly developed, the Provider did not provide a list of additional Medicaid days, nor did it explain why it could not produce the documentation, the MAC contends the Provider has abandoned the issue.[12]

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 May 30, 2023. The Provider's originally characterized the Medicaid eligible days issue in its initial appeal request using 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.

It was not until the PPP submission that the Provider raised the issue – (*which was 162 days 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.[13]

[9] MAC's Jurisdictional Challenge at 2 (April 1, 2024).
[10] Id. at 11.
[11] *Id*. at 11.
[12] *Id*. at 12.
[13] *Id*. at 16.

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[14] The Provider did not file a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

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 Nos. 1 and 3.

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 that would be used to determine the DSH percentage—is duplicative of the SSI Percentage (Systemic Errors) issue that the Provider transferred to Case No. 19-1409GC.

The SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[15] 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)."[16] 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

[14] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[15] Issue Statement at 1.
[16] *Id.*

computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[17]

The Provider's SSI Percentage (*Systemic Errors*) issue in group Case No. 19-1409GC 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 Percentage (Provider Specific) issue in Case No. 23-1345 is duplicative of the DSH/SSI Percentage (*Systemic Errors*) issue in Case No. 19-1409GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[18], the Board dismisses this aspect of the SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations, and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[19] 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 Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No.19-1409GC.

To this end, the Board also reviewed the Provider's PPP to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 19-1409GC but instead, refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's 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 Documents[20]

[17] *Id.*
[18] PRRB Rules v. 3.1 (Nov. 2021).
[19] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[20] PRRB Rules v. 3.1 (Nov. 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. Once the documents become available, promptly forward them to the Board and the opposing party.[21]

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 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.[22]

Accordingly, *based on the record before it*, the Board finds that SSI Percentage (Provider Specific) issue in the instant appeal and the group issue in Case No. 19-1409GC are the same issue.[23] 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.

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[21] (Italics and underline emphasis added.)
[22] Last accessed Feb. 6, 2026.
[23] 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 CHS CIRP group per 42 C.F.R. § 405.1837(b)(1).

Additionally, in its PPP, the Provider states, "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 [sic] (Appellants' reply brief included as Exhibit P-3)." The Board finds that this incorporation by reference does not comply with the regulatory and Board rule requirements to *fully* develop the Provider's position in the PPP. Particularly 42 C.F.R. § 405.1853 provides 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*.[24]

An incorporation of arguments by reference from a different case simply fails to do so. Accordingly, the Board dismisses that portion of the issue as well.

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. . In addition, the Board concurs with the MAC that there would be no change in the computation had one been requested as the hospital's FYE and the FFY both end on September 30. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

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

---

[24] (Emphasis added).

> 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*.[25]

[25] (Emphasis added).

Similarly, with regard to position papers,[26] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[27] 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 April 21, 2023 (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.[28] ***To-date, no listing has been provided.*** Accordingly, the Provider has abandoned the issue by failing to properly develop its arguments and provide supporting documents, and by failing to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[29] Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board takes administrative notice that it has made similar dismissals in other cases involving CHS providers.[30]

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[26] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.
[27] (Emphasis added).
[28] Provider's PPP at 10.
[29] *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.
[30] An example of a CHS individual provider case in which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

C. 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. 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 April 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 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.[31]

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 examples are not exhaustive lists of categories or issues.

[31] 42 C.F.R. § 405.1835(b).

A. Disproportionate Share Hospital Payments

> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[32]

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.[33]

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.[34] 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 period. For purposes of this second computation, the following requirements apply:

[32] (Bold and italic emphasis added).
[33] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[34] 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 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 PPP, the Provider 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*.[35] 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 . . ."[36] The Court

[35] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[36] *Id*. at *11.

found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[37] 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.[38] Here, the Board makes the same finding based on similarly *overly generalized language.*

****

Based on the foregoing, the Board is dismissing the two (2) remaining issues in this case: "DSH Pymt SSI % (Provider Specific)" - Issue 1 and "DSH Pymt - Medicaid Eligible Days" (*including Section 1115 Waiver Days*)- Issue 3. As no issues remain, the Board hereby closes Case No. 23-1345 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:

4/28/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Cecile Huggins, Palmetto GBA (J-J)
Wilson C. Leong, Esq., Federal Specialized Services

[37] *Id.*
[38] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Mary Black Memorial Hospital (Prov. No. 42-0083), FYE 06/30/2018
Case No. 22-1245

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-1245. 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. 22-1245*

On **February 11, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2018.

On **August 4, 2022**, 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 five (5) issues:

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

On **August 5, 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 February 27, 2026, this issue was withdrawn.
[2] On March 15, 2023, this issue was transferred to Case No. 21-1206GC.
[3] On March 15, 2023, this issue was transferred to Case No. 20-2149GC.
[4] On March 15, 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:

> 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 **March 15, 2023,** CHS transferred Issues 2, 4 and 5 to various CHS CIRP groups in accordance with the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). As a result, there were two (2) remaining issues in this appeal: Issue 1: DSH Pymt/SSI % (Provider Specific) and Issue 3: DSH Pymt - Medicaid Eligible Days.

On **March 22, 2023**, CHS timely filed the Provider's PPP.

On **April 4, 2023**, a Critical Due Dates notice was issued with revised PPP deadlines.

On **June 20, 2023**, the Medicare Contractor ("MAC") filed its PPP.

On **July 17, 2023**, the MAC filed a Jurisdictional Challenge over the DSH - SSI (Provider Specific) issue. The issue was subsequently withdrawn on February 27, 2026.

On July 20, 2023, CHS requested the representative be changed to Quality Reimbursement Services, Inc. ("QRS"). The Board effectuated the change to QRS on the following day.

On **September 22 2025**, the Board issued a Notice of Hearing scheduling the case for a **June 5, 2026** hearing**.**

On **January 27, 2026,** the MAC filed a copy of a request to the Provider for a Medicaid Eligible Days Listing.

On **March 4, 2026**, the Provider filed its final PP.

On **March 23, 2026**, the MAC filed its final PP.

On **March 23, 2026**, the MAC filed a Motion to Dismiss the Medicaid Eligible Days issue.

B. ***Description of Issue 3 in the Individual Appeal Request***

[5] (Emphasis added).

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): 1, 24, 25, 26, 30, 31, 32, 38, 39, 40, S-D
>
> Estimated Reimbursement Amount: $40,403

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[6] 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.[7]

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

In its Motion to Dismiss, 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 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.)[8] As of March 2026, when the MAC filed its Motion to Dismiss, it had not received a listing of additional Medicaid eligible days, even though the Provider indicated one would be

[6] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[7] Provider's PPP at 8 (March 22, 2023).
[8] MAC's Motion to Dismiss at 2 (March 23, 2026).

sent at the time it filed its PPP, and even after the MAC requested one via email on May 5, 2023 and on January 27, 2026 (copy of which was uploaded in OH CDMS).

Although the MAC acknowledges the Provider submitted **a redacted** listing of eligible days with its final PP, the listing included a notation that "Listing pending finalization upon receipt of State eligibility data." The MAC contends that Provider has not yet provided a **complete, unredacted, auditable listing**, nor has it explained why such documentation is unavailable as required in Board Rules 7 and 25.2.2. Finally, 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.[9]

Provider's Response to the Motion to Dismiss

The Board Rules require that Provider Responses to the MAC's Motion to Dismiss must be filed within thirty (30) days from the date the motion was sent to the Board and the opposing party.[10] The Provider did not file a response to the Motion to Dismiss and the time for doing so has elapsed. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

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

As set forth below, the Board hereby dismisses the Provider's Issue No. 3.

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.

[9] *Id.* at 4-5.
[10] Board Rule 44.3, v. 3.1 (Nov. 2021).

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*.[11]

Similarly, with regard to position papers,[12] 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,

[11] (Emphasis added).
[12] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.
[13] (Emphasis added).

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 August 4, 2022 (more than 3.5 years 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 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 $40,403 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*

[14] Provider's PPP at 9.

> *Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' 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.

In its March 23, 2026 Motion to Dismiss, the MAC requested dismissal of the Medicaid eligible days issue because:

(1) the Provider failed to file a complete Position Papers;
(2) 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. The Provider also 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
(3) the Provider failed to furnish an auditable Medicaid Eligible Days listing within its final PP;

Therefore, 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.[15]

As noted, QRS included a redacted "Eligibility Listing" as an exhibit to its final position paper. The 25-page listing showed 3,256 "Additional ME Days."[16] The Listing does not, however,

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[15] *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.
[16] Provider Final PP Exhibit P-1 (March 4. 2026)

explain why the number of days included was over the initial 100 days the Provider claimed in its appeal, nor did it explain why it was being submitted at such a late date as the filing ***was almost 3 years past the deadline for including it with the Provider's PPP*** for which the deadline was April 1, 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 provide any supporting documentation for those days).

The Board rejects the Provider's attempts to include the eligible days listing included *as an exhibit with its final position paper* because:

1. The upload was filed almost ***3 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 of the roughly 3,256 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 more than 3.5 years after this appeal was filed and more than 7.5 years after the fiscal year at issue had closed).

3. Neither the Board Rules, nor the August 5, 2022 ACDD notice, permit the Provider to file a "Supplement" to its PPP (nor did the Provider allege the final PP exhibit was a being filed as a supplement).

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 Final PP Exhibit as 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 listing submitted cannot be considered a refinement of the PPP paper since no specific days or listing were included with the PPP (indeed the *tentative* 3,256 days listed in the late exhibit is, without

explanation, *significantly* larger than the original estimated 100 days included with the appeal request).[17]

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"[18] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. 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.

Accordingly, the Provider has abandoned the issue by failing to properly develop its arguments and provide supporting documents, and by failing to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[19] Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.

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Based on the foregoing, the Board is dismissing the last remaining issue in this case: "DSH Pymt - Medicaid Eligible Days" - Issue 3. As no issues remain, the Board hereby closes Case No. 22-1245 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:

4/28/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Cecile Huggins, Palmetto GBA (J-J)
Wilson C. Leong, Esq., Federal Specialized Services

[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.)
[19] *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
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RE: ***EJR Determination***

Case 19-1723GC: *Ardent Health FFY 2019 Understated IPPS Standardized Amount CIRP Group*
Case 19-1735GC: *Lifepoint Health FFY 2019 Understated IPPS Standardized Amount CIRP Group*
Case 19-1763GC: *CHS FFY 2019 Understated IPPS Standardized Amount CIRP Group*
Case 19-0233GC: *Quorum Health FFY 2019 IPPS Understated Standardized Payment Amt. CIRP*
Case 19-1628GC: *Archbold FFY 2019 Understated IPPS Standardized Amount CIRP Group*

Dear Mr. Jenkins:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests and Requests for Expedited Judicial Review ("EJR") filed by the Providers in the above-referenced Common Issue Related Party ("CIRP") group cases. In these cases, the Providers challenge their Inpatient Prospective Payment System ("IPPS") payments for their fiscal years ("FYs") ending in 2019 as calculated and published in the FFY 2019 Final Rule. As the basis of their challenges, the Providers allege that the respective rates are understated due to an embedded "Transfer/Discharge Error" that has unlawfully been in place since the establishment of the inaugural amounts for federal fiscal year ("FFY") 1984. As such, the Providers have requested Expedited Judicial Review ("EJR") to challenge the FFY 2019 IPPS rates, and the decision of the Board Majority ***GRANTING*** the Request is set forth below.

BACKGROUND:

A. Group Issue –Alleged Improper Inclusion of Transfers in Calculating 1984 IPPS Standardized Amount

1. Initial Appeal and Issue Statement

The Board received a request on **February 1, 2019**, filed by the Providers' designated representative, Hospital Reimbursement Group, ("Providers' Representative"), to establish a CIRP group appealing from the FFY 2019 IPPS Final Rule published in the Federal Register on **August 17, 2018**[1]. The Board received three additional requests to establish CIRP groups on **February 11, 2019**.[2]

The Providers' Statement of Issue Under Appeal in these cases states:

> The common issue before the PRRB is whether the hospitals have been underpaid for the periods covered by the 2019 federal fiscal year because the inpatient hospital prospective payment system (PPS) standardized amounts are understated for the 2019 federal year due to the Secretary's failure to properly distinguish between patient transfers and discharges in establishing the PPS 1983 base year amounts.[3]

The Group Issue Statement for Case 19-0233GC, which was received on **November 5, 2018**, makes the same general argument:

> The standardized amount was initially computed in 1983 system using 1981 hospital cost report data. The standardized amount was developed on the basis of an average cost per discharge computation. 42 U.S.C. § 1395ww(d)(2). The base year 1981 data did not distinguish between patient discharges and patient transfers. Both were classified as discharges. Therefore, the 1981 data over-counted discharges, by including both discharges and transfers in the base year data.
>
> The result of this error was to spread total operating costs over an artificially high number of discharges, thereby yielding a lower average cost-per-discharge. This in turn lead to an initial computation of the standardized amount that was lower than it would have been had the total number of patient discharges been accurately computed.
>
> This initial computational error at the inception of the PPS has never been corrected. As each year's standardized amount is updated based on the previous year's amount, the standardized amount has been lower than it should have been in every year since the inception of PPS in 1984. *See Saint Francis Med. Ctr. v. Azar*, 894 F.3d 290 (D.C. Cir. 2018). Providers contend that it was arbitrary, capricious and inconsistent with law for the Secretary to fail to adjust the 1981 cost report data to reflect the correct number of

[1] Case 19-1763GC.
[2] Cases 19-1735GC, 19-1628GC, and 19-1723GC.
[3] *E.g.*, Case 19-1763GC, Statement of Issue Under Appeal (Feb. 1, 2019).

> Medicare discharges, and to provide appropriate revisions to the PPS standardized amount. 5 U.S.C. § 706(2)(A).[4]

On **April 6, 2023**, the Board issued a decision denying the Providers' requests for Expedited Judicial Review ("EJR") and dismissing these five (5) cases, finding that: (1) the appealed issue was *inextricably* intertwined with the FFY 1984 and 1985 budget neutrality adjustments to the standardized amounts; (2) 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations) prohibit administrative and judicial review of those budget neutrality adjustments; and (3) thus, that the Board did not have substantive jurisdiction over the issue.

The Providers subsequently filed a Complaint in the United States District Court for the District of Columbia, which issued a Memorandum Opinion on December 20, 2024, granting, in part, the Providers' request for summary judgment. In that opinion, the court found "that the plaintiffs' challenge to the inaugural standardized amount calculation is not 'inextricably intertwined' with the unreviewable budget neutrality adjustments, and that the PRRB therefore has subject matter jurisdiction over the plaintiffs' challenge."[5] The court issued an order remanding the case to CMS for further proceedings consistent with its opinion. The Secretary later filed a motion to clarify that order, and on September 26, 2025, the court issued a memorandum and order clarifying that the ruling "was limited in scope to the preclusion question that formed the basis of the PRRB decision below."[6]

On **January 26, 2026**, the Board received an order from the Administrator dated January 23, 2026 wherein the Deputy Administrator and Chief of Staff for the Centers for Medicare and Medicaid Services specifically ORDERED:

- THAT the PRRB's April 6, 2023 jurisdictional denial based on the preclusion issue is vacated;
- THAT the PRRB is to reinstate the cases and resume proceedings to resolve the Providers' Expedited Judicial Review requests in accordance with the December 20, 2024, and September 26, 2025 memorandum opinions and orders; and
- THAT the PRRB's proceedings pursuant to this order will be subject to 42 C.F.R. § 405.1801, *et. seq.*

On **March 3, 2026**, pursuant to the Administrator's Order, the Board reopened Case Numbers 19-0233GC, 19-1678GC, 19-1723GC, 19-1735GC, and 19-1763GC. The Board reinstated the previously filed requests for EJR and set deadlines for the parties to supplement the record, as necessary.

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[4] Case 19-0233GC, Group Issue Statement (Nov. 5, 2018).
[5] *St Mary's Regional Hospital v. Becerra*, 2024 WL 5186641, *17 (D.D.C. Dec. 20, 2024).
[6] *St Mary's Regional Hospital v Kennedy*, Case No. 1:23-cv-1594-RCL, 6 (D.D.C. Sept. 26, 2025).

2. Requests for EJR

The Providers originally filed a Consolidated Request for EJR in each case on **August 10, 2020**, which is the same date the cases were deemed complete and fully formed. The Requests for EJR briefly expand upon their issue statement, explaining:

> The issue in these group appeals is whether the Providers' FFY 2019 IPPS payments were unlawfully low because CMS calculated them based on 1981 discharge data that was improperly incorporated into the base payment rates for IPPS hospitals in FFY 1984, thereby causing IPPS underpayments in that and all subsequent FFYs, including FFY 2019. *See* Exhibit A; *see also* 42 U.S.C. §1395ww(d)(2); 42 C.F.R. Part 412. As explained in detail in the Providers' preliminary position papers ("PPPs") filed in these group appeals (Exhibit B (B-1 to B-6)), correction of erroneous 1981 "predicate fact" data to assure that the Providers' FFY 2019 IPPS payments are correct is permitted under *Kaiser Found. Hosp. v. Sebelius*, 708 F.3d 226 (D.C. Cir. 2013). The revisions that CMS adopted in 2013 to one of its regulations, 78 Fed. Reg. 74,826, 75,162–69 (Dec. 10, 2013) (revising 42 C.F.R. §405.1885), which sought to overturn the *Kaiser* decision, was found not to apply to Board appeals in *Saint Francis Medical Center v. Azar*, 894 F. 3d 290 (D.C. Cir. 2018).
>
> Notably, these Providers have pioneered this reimbursement challenge for years; it was their appeals (for earlier FFYs) that resulted in the *Saint Francis* decision.[] In *Saint Francis*, the Providers challenged their IPPS payments for the years under appeal in that case as incorrectly understated because CMS determined those payments based on errors in the application of 1981 cost-reporting data that was used to calculate the standardized amounts for IPPS purposes for FFY 1984. *Id.* at 293. Likewise here, the Providers contend that the 1981 data erroneously characterized transfers of patients from one hospital to another as patient discharges, thus overstating the number of discharges and understating the allowable operating costs, which are calculated on a "per discharge" basis. *Id*. at 293. Because that determination was embedded in the standardized amount in FFY 1984, it has affected IPPS payment determinations ever since, including in FFY 2019. *See* 42 U.S.C. §1395ww(d)(2); *see also* 42 C.F.R. Part 412.[7]

[7] Request for Consolidated Expedited Judicial Review, 2-3 (Aug. 10, 2020) (original emphasis) ("Request for EJR").

The Providers argue that 42 U.S.C. § 1395ww(d)(2)(A) mandates the Secretary determine the allowable operating *costs per discharge* of inpatient hospital services but that when implementing the IPPS, the Secretary in fact calculated the average *costs per discharge or transfer* because the Secretary did not remove or adjust for transfers that were included in the 1981 base year data.[8] The Providers contend that:

> The result was that CMS treated all 1981 transfers as if they were discharges for purposes of calculating the "average cost per discharge" for FFY 1984. Instead of calculating the average cost per IPPS discharge, as required by statute, CMS calculated the average cost per discharge or transfer, which increased the number of "discharges." This caused the "average cost per discharge" that CMS calculated for IPPS purposes for FFY 1984 to be too low because transfers were *ipso facto* paid less than discharges under the "reasonable cost" system. This is because the transferring hospital, by definition, did not provide all of the care necessary to treat the patient.
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> ***
>
> Thus, the method that CMS used to create the initial IPPS payment rates for FFY 1984 caused FFY 1984 IPPS payments to be less than what would have been paid under the previous "reasonable cost" system, which means that IPPS hospitals were underpaid for FFY 1984 both on a per claim basis and in the aggregate.[9]

The Providers argue that "[t]he understatement of average costs per discharge affected not only the FFY 1984 standardized amounts; all subsequent standardized amounts were similarly understated."[10]

The Providers also claim that this calculation error was implicitly recognized when the Secretary implemented the PPS for capital costs in FFY 1992, where he "acknowledged that counting transfers [as discharges] was improper."[11] There, the Secretary applied a correction factor of 0.9% in the Capital PPS rates to remove the effect of transfers, but has never applied a similar correction for IPPS.[12]

The Providers averred that they were entitled to EJR of their appeals as the Board has jurisdiction to conduct a hearing on the specific matters at issue, but lacks the authority to decide the specific

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[8] *Id.* at 3-5 (citing 48 Fed. Reg. 39751, 39763-39764 (Sept. 1, 1983).
[9] *Id.* at 5.
[10] *Id.* at 6.
[11] *Id.* (citing 56 Fed. Reg. 43,358, 43,383, 43,386–97 (Aug. 30, 1991)).
[12] *Id.*

legal questions relevant to the matters at issue.[13] To demonstrate that they meet the criteria for granting EJR, first, the Providers argue that these groups' challenges to the FFY 2019 IPPS standardized amount and payment rates published in the FFY 2019 Final Rule stem from an appealable final determination,[14] and that the appeals were timely filed.[15]

The Providers also contend that the $50,000 amount in controversy ("AIC") requirement has been met in each case, whereby each estimate "was calculated by multiplying each Provider's expected total applicable IPPS reimbursement for FFY 2019 by 0.9%, . . . [which] is the correction factor CMS used in the Capital PPS Final Rule to assure that transfers are not treated as discharges for purposes of calculating payments due under Capital PPS."[16] In evaluating the AIC, the Providers acknowledge that the 1981 MedPAR data would be the best data for evaluating any AIC, however, despite their requests, CMS has not provided that data. Thus, instead, they rely on an analysis of alternative data that resulted in an estimated correction factor of 0.65%, which also exceeds the AIC threshold of $50,000.[17]

As previously noted, the Board denied the **August 10, 2020** Consolidated Request for EJR on **April 6, 2023**. The Board, following an order from the Administrator, reopened the five cases in that Consolidated Request on **March 3, 2026**, and directed the parties to supplement the record as necessary. On **April 2, 2026**, the Providers filed a Supplement to Reinstated Request for Expedited Judicial Review ("EJR Supplement").

In the EJR Supplement, relying on a D.C. District Court opinion in *St. Mary's Regional Medical Center v. Becerra,*[18] the Providers assert that 42 U.S.C. § 1395ww(d)(7) does not preclude the Board's jurisdiction over these appeals. Notwithstanding the Board's jurisdiction, Providers argue that EJR is appropriate since the Board "lacks the authority to decide the legal question presented or to grant the relief requested[,]" since the Board must comply with all Provisions of Title XVIII of the Social Security Act and regulations issued thereunder.[19] Particularly, the Providers contend that:

> [b]ecause the Board lacks authority to invalidate the standardized amount or payment rates in question or to grant the relief the Providers are seeking, EJR must be granted because "[t]he Board lacks the authority to decide [the] specific legal question relevant to the specific matter at issue." 42 C.F.R. § 405.1842(f)(1)(ii).[20]

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[13] *Id.* at 10.
[14] *Id.* at 8 (citing *Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986); *District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993); CCH Medicare & Medicaid Guide ¶ 41,025; PRRB Rules 7.1.1, 7.1.2.3).
[15] *Id.* at 10.
[16] *Id.* at 9.
[17] *Id.* at 9-10.
[18] Memorandum Opinion, No. 1:23-cv-1594-RCL, 2024 WL 5186641 (D.D.C. Dec. 20, 2024).
[19] EJR Supplement at 4 (citing 42 C.F.R. § 405.1867).
[20] *Id.*

Finally, the Providers address whether EJR is appropriate at this time. The Providers claim their EJR Request is complete as required by 42 C.F.R. § 405.1842(e)(2). This regulatory provision establishes that a Request for EJR is complete if the Board receives a request from a provider that includes sufficient information and documentation for the Board to determine whether to grant or deny EJR. In making their determination, the Board has to determine whether (1) it has jurisdiction, and (2) it has the authority to decide the specific legal question presented based on whether it is a challenge to the constitutionality of a provision of a statute, or a challenge to the substantive or procedural validity of a regulation or CMS Ruling. The Providers state that they have met the requirements for a complete EJR Request by providing the requisite information on which the Board can make its determination for granting or denying the Request.[21]

Additionally, the Providers acknowledge that Board Rule 42.3 requires that a Request for EJR confirm the group is fully formed and that there are no factual disputes. However, the Providers argue "that these requirements are not prerequisites for EJR under the statute or regulation governing EJR" but nevertheless they are satisfied because the group is fully formed and there are no factual issues in need of resolution or further development for a determination on the EJR Request.[22]

Referring back to the underlying dismissals subject of the D.C. District Court's opinion in *St. Mary's,* the Providers point to the Board's prior suggestion that the record was in need further development as to questions of jurisdiction, actual damages or actual injury, and material fact disputes—all prior to determining whether EJR was appropriate.[23]

Importantly, in this case, the Providers insist that the record does not need further development before EJR is granted, particularly as it relates to meeting the jurisdictional amount in controversy threshold. In support of their position that they have met the AIC, the Providers submitted an analysis which explains how they have quantified their AIC estimate based on a proposed adjustment factor.[24] The report assumes the correction factor for IPPS should be 0.9% (the same as the Capital PPS correction factor adopted for FFY 1992) "[i]f transfer practices were approximately the same in the base period for the initial implementation of IPPS as in FFY 1989."[25] Alternatively, the report explains that, using alternative data to evaluate the actual transfers for FFY 1981, the average costs per discharge for FFY 1984 was understated by 0.65%.[26]

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[21] *Id.* at 4-5.
[22] *Id.* at 5 (citing 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842).
[23] *See generally* PRRB Cases 19-1723GC *et al.*
[24] Request for EJR, Exhibit 5, referring to the report of Constantijn Panis, Ph.D. (the "Panis Report"). The author's professional summary indicates that he is "an expert in healthcare, demographic issues, statistics, and forecasting." *Id*. at 38. The Panis Report analyzes available alternative hospital data (in the absence of the 1981 MedPAR file) and calculates an estimated correction factor. For sake of clarity, the Board reviewed the Panis Report solely to assess whether the AIC meets the jurisdictional threshold.
[25] *Id.* at ⁋ 9.
[26] *Id.* at ⁋ 10.

The report also assumes that the FFY 1981 MedPAR data file would contain transfer status data and would allow the calculation of an accurate transfer correction factor to be applied to FFY 1984 (which would carry forward to all subsequent FFYs).[27] However, since that MedPAR data is not available, the report explains that alternative data was used: (a) the 1981 National Hospital Discharge Survey ("NHDS") to calculate the transfer rate and (b) several years of MedPAR files to calculate the average payment percentage on transfer cases.[28] NHDS data contains both Medicare and non-Medicare stay data, including length of stay and transfer status and is available at https://www.cdc.gov/nchs/nhds.[29] The report removed non-Medicare stays to create its data sample.[30] The report also evaluated MedPAR data from 1997 through 2017 to estimate the average payment percentage of transfer cases in 1981, assuming there is nothing that would have caused a difference in the average ratio of length of stay to deviate from 1997 to 1981.[31] Using this data, the report explains that the correction factor could range from 0.62 to 0.71%, or could simply be deemed the same as used for FFY 1992 when adjusting the Capital PPS (0.9%).[32]

Ultimately, the Providers do not believe any findings related to this report are necessary for the Board to grant EJR because it was simply submitted to demonstrate that the jurisdictional AIC has been satisfied.[33] Moreover, the Providers contend that the calculation of any precise damages would only be necessary after a court invalidates the FFY 2019 standardized amount and payment rates and remands to the Secretary for further proceedings.[34]

B. Board Jurisdiction

1. St. Mary's Regional Medical Center v. Becerra

The Board has historically found that the Board lacks substantive jurisdiction over the issue presented in these appeals relying on a statutory review preclusion provision. On appeal of such findings, the D.C. District Court's decision in *St. Mary's Regional Medical Center v. Becerra*,[35] concerned the same underlying group appeals at issue in this decision – namely whether the Secretary miscalculated the standardized amount in FY 1984 by including transfer cases in the denominator – and the Court decided whether section 1395ww(d)(7)(A) bars review of this issue.

Here, relative to a challenge relating back to FY 1984, it is important to note that while there are time limits on when a provider can challenge their payment determinations, providers are generally permitted to challenge "predicate facts." Specifically, courts have permitted providers to modify

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[27] *Id.* at ¶ 43.
[28] *Id.* at ¶ 44.
[29] *Id.* and n.9.
[30] *Id.* at ¶ 44.
[31] *Id.* at ¶ 47.
[32] *Id.* at ¶ 56.
[33] EJR Supplement at 6.
[34] *Id.* (citing *Tri-County Hospice, Inc. v. Sebelius*, 788 F. Supp. 2d 1274, 1276 (E.D. Okla. 2010) (stating that requiring factual findings as to damages would "render[] nugatory the word 'expedited' in EJR")).
[35] 2024 WL 5186641 (D.D.C. 2024).

"predicate facts in closed years provided the change will only impact the total reimbursement determination in open years."[36] Predicate fact challenges are permitted "no matter how long ago the facts were established, so long as the providers raise their challenge in a timely administrative appeal and seek damages only for underpayment during an open cost year."[37]

Accordingly, in *St. Mary's*, the court considered the Providers' challenge to their FY 2019 IPPS payments, alleging that when calculating "allowable operating costs per discharge" in calculating the IPPS, "the Secretary erroneously counted inter-hospital transfers as 'discharges,' . . . [which] depressed the inaugural standardized amounts and, . . . has perpetuated chronic underpayment up to the present day."[38] In April 2023, the Board dismissed the underlying providers' appeals in *St. Mary's* for lack of subject matter jurisdiction, finding the standardized amounts at issue were inextricably intertwined with the budget neutrality adjustments which were precluded from administrative review.[39] With regard to whether the providers had standing to bring their case before the Board, the court in *St. Mary's* addressed the Board's findings ***and rejected them all***.

Where the Board opined that the original standardized amount calculations were actually inflated, rather than deflated, the Court found that this did not obviate "the independent, judicially cognizable injury which the plaintiffs now allege—to wit, that the Secretary's supposedly unlawful categorization of transfers as discharges exerted downward pressure on their compensation."[40] The Court went on to hold that the injury alleged by St. Mary's was not erased by "some unrelated benefit of equal or greater value" claimed to be conferred by the Secretary.[41] Moreover, the summation of the gravity of the alleged errors would be relevant to the issue of damages during the litigation phase, if reached, but irrelevant to the ponderance of jurisdiction.[42]

The Court also rejected the Board's acceptance of the notion that other adjustments to the standardized amount "between 1985 and 1997 may have broken the chain between the inaugural calculations and the allegedly depressed 2019 standardized amounts."[43] The Court seemed skeptical,[44] and while it did not outright reject this argument, it was not sufficiently explored to defeat the Provider's jurisdictional claim of standing.

The Court then looked to whether the statutory preclusion provisions actually precluded review of the 1984 standardized amounts. Contrary to the Board's finding, the Court held that the statutes

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[36] *Id.* (citing *Kaiser Found. Hosps. v. Sebelius*, 708 F.3d 226, 232-233 (D.C. Cir. 2013)).
[37] *Id.* (citing *St. Francis Med. Ctr. v. Azar*, 894 F.3d 290, 294 (D.D.C. 2018)).
[38] *St. Mary's.* at *4.
[39] PRRB Cases 19-1723GC *et al.*
[40] *St. Mary's* at *7.
[41] *Id.*
[42] *St. Mary's* at *7.
[43] *Id.*
[44] *Id.* ("[T]he Secretary himself reiterated that the current standardized amount is the result of adjusting and updating the original standardized amounts, necessarily—if implicitly—disclaiming the possibility that subsequent statutory or regulatory changes have washed away any trace of the inaugural calculations.") (citing 83 Fed. Reg. 41144, 41713 (Aug. 17, 2018)).

did not explicitly preclude review,[45] and also found that the calculation of the 1984 standardized amounts is not "inexplicably intertwined" with the budget neutrality adjustments, especially in light of the Administrative Procedure Act's strong presumption of judicial review.[46]

Ultimately, the Court remanded the case for further proceedings.[47] The Secretary then filed a motion for clarification or partial reconsideration of the Court's decision. On September 26, 2025, the Court issued a Memorandum & Order granting the Secretary's motion to confirm that the Court's holdings are limited to the Board's subject matter jurisdiction over the dispute relative to reviewing the matter absent the purported statutory review preclusion, and denying the motion for partial reconsideration.[48] The cases underling *St. Mary's* are the subject of the reinstated Consolidated Request for EJR and EJR Supplement.

2. Jurisdictional and Substantive Claim Challenges

a. Jurisdictional Challenges

Following the Provider's supplementation of the record, and pursuant to the Board's March 3, 2026 Notice of Reopening, the Medicare Contractor's designated representative, Federal Specialized Services ("FSS") submitted a responsive filing on **April 10, 2026**.[49]

FSS maintains that the Providers have not established that the legal question posed for the inaugural FFY 1984 standardized amounts has any relevance to the FFY 2019 standardized amounts. It notes that 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842(a)(1) both permit a provider to seek EJR over a legal question relevant to the matter(s) in controversy or matter(s) at issue.[50] FSS also cites *Mercy General Hospital v. Becerra*,[51] which affirms the notion that EJR is only appropriate for legal questions relevant to the matters in controversy or matters at issue. The case also suggests the Board is within its authority to deny EJR, or request more information before granting EJR, if it is unable to determine whether it has jurisdiction or authority, including when the Board is unable to determine whether a legal question or challenge is relevant.[52] This argument ultimately concerns whether there is a causal link between the FFY 1984 standardized amounts to the FFY 2019 standardized amounts at issue, and suggests the causal link has been broken by numerous adjustments to the standardized amounts that have been made across the intervening

[45] *Id.* at *11-12.
[46] *Id.* at *13-17.
[47] *Id.* at *19.
[48] *St. Mary's Reg'l Med. Ctr. v. Kennedy*, No. 1:23-cv-01594-RCL (Sept. 26, 2025).
[49] Response to Providers' Request for Expedited Judicial Review (Apr. 10, 2026) ("Response to EJR Supplement").
[50] Response to EJR Supplement at 6-7.
[51] 643 F.Supp.3d 16 (D.D.C. 2022).
[52] *Id.* at 28.

40+ years.[53] This is generally supported by "Appendix A" in previous decisions on this issue where the Board found it lacked subject matter jurisdiction over this issue.[54]

Finally, FSS argues that the amount in controversy is unclear and warrants additional briefing. It disputes the assertion that any purported error in the FFY 1984 standardized amounts, and any lingering effects more than thirty years later, would or should be corrected by a straight-line correction factor.[55] Once again, it points to the many adjustments to the standardized rate since 1986, including discretionary adjustments under 42 U.S.C. § 1395ww(e)(4), to demonstrate the fact-specific and complex nature of this issue.[56] It urges the Board to require additional briefing so the Board can definitively determine whether the jurisdictional minimum amount in controversy has been met, which is a prerequisite for EJR.[57]

The Providers filed a Reply to the Response to the Supplement to EJR on **April 17, 2026**. The Reply counters FSS' Response by outlining the same points and authorities discussed in the Board's EJR Determination for Cases 25-1782GC and 26-0941GC issued on January 29, 2026.

b. Substantive Claim Challenges and Responses

In three of these cases, FSS has also filed Substantive Claim Challenges, arguing that certain providers did not make an appropriate cost report claim in compliance with 42 C.F.R. §§ 405.1873 and 413.24(j).

i. Case 19-1735GC

On **April 26, 2022**, FSS filed a Substantive Claim Challenge arguing that the following thirty-four of the seventy-three participating providers failed to include an appropriate cost claim for the disputed issue. For all of the Providers below, the Medicare Contractor contends that there is nothing in the record to show where the Provider attempted to claim the disputed items for full reimbursement following a belief that the items comported with Medicare Program policy. It also contends that that none of the exceptions in 42 C.F.R. §412.24(j)(3)(i)-(iii) apply. The deficiencies regarding each Provider's self-disallowance are outlined, below. These Providers shall be collectively referred to as "Case 19-1735GC Challenged Providers."

- Andalusia Regional Hospital (Provider No. 01-0036, FYE 3/31/2019)
  - Cost report listed protested items and had a cover letter noting what items, but there was no calculation schedule
- Canyon Vista Medical Center (Provider No. 03-0043, FYEs 04/30/2019 and 04/30/2020)
  - No protested items on cost report

[53] Response to EJR Supplement at 5.
[54] *See, e.g.*, PRRB Cases 25-3211GC and 25-3212GC, EJR Determination (Sept. 25, 2025).
[55] Response to EJR Supplement at 8.
[56] *Id.* at 9-15.
[57] *Id.* at 15.

- St. Mary's Regional Medical Center (Provider No. 04-0041, FYE 8/31/2020)
    - Cost report listed protested items and had a cover letter noting what items, but there was no calculation schedule
- National Park Medical Center (Provider No. 04-0078, FYE 8/31/2020)
    - Cost report listed protested items and had a cover letter noting what items, but there was no calculation schedule
- Saline Memorial Hospital (Provider No. 04-0084, FYE 6/30/2020)
    - Protested $873,963 on cost report, but documentation only substantiates $855,579
- Colorado Plains Medical Center (Provider No. 06-0044, FYEs 10/31/2018 and 10/31/2019)
    - FY 2018 did not protest anything on cost report
    - FY 2019 Protested items but not the item under appeal
- St. Francis Hospital (Provider No. 11-0129, FYE 12/31/2018)
    - Cost report listed protested items and had a cover letter noting what items, but there was no calculation schedule
- St. Joseph Regional Medical Center (Provider No.13-0003, FYEs 06/30/2019 and 06/30/2020)
    - Both FYs did not protest anything on the cost report
- Clark Memorial Hospital (Provider No. 15-0009, FYE 7/31/2020)
    - Cost report listed protested items and had a cover letter noting what items, but there was no calculation schedule
- Ottumwa Regional Health Center (Provider No.16-0089, FYEs 04/30/2019 and 04/30/2020)
    - Both FYs did not protest anything on the cost report
- Western Plains Medical Complex (Provider No.17-0175, FYE 02/28/2019)
    - Cost report had protested items, but not the item under appeal
- Teche Regional Medical Center (Provider No. 19-0014, FYEs 12/31/2018 and 09/30/2019)
    - Both FYs did not protest anything on the cost report
- UP Health System Marquette (Provider No. 23-0054, FYEs 06/30/2019 and 06/30/2020)
    - Both FYs did not protest anything on the cost report
- UP Health System Portage (Provider No. 23-0108, FYEs 11/30/2018 and 11/30/2019)
    - Both FYs did not protest anything on the cost report
- Northeastern Nevada Regional Hospital (Provider No. 29-0008, FYEs 06/30/2019 and 06/30/2020)
    - Both FYs did not protest anything on the cost report
- Los Alamos Medical Center (Provider No. 32-0033, FYEs 12/31/2018 and 12/31/2019)
    - Both FYs did not protest anything on the cost report
- Harris Regional Hospital (Provider No. 34-0016, FYE 07/31/2020)
    - Cost report listed protest amount, but there was no schedule of DSH protest amounts
- Central Carolina Hospital (Provider No. 34-0020, FYE12/31/2018)
    - Cost report listed protested items and had a cover letter noting what items, but there was no calculation schedule
- Nason Hospital (Provider No. 39-0062, FYE 06/30/2019)
    - Cost report did not protest anything
- Wilson Medical Center (Provider No. 34-0126, FYE 2/29/2020)

    - Protested $423,669 on cost report, but documentation totals $755,521
- Southwestern Medical Center (Provider No. 37-0097, FYE 10/31/2018)
    - Cost report listed protested items and had a cover letter noting what items, but there was no calculation schedule
- Conemaugh Miners Medical Center (Provider No. 39-0130, FYEs 06/30/2019 and 06/30/2020)
    - Both FYs did not protest anything on the cost report
- Southern Tennessee Regional Health System Pulaski (Provider No. 44-0020, FYE 12/31/2018)
    - Cost report listed protested items and had a cover letter noting what items, but there was no calculation schedule
- Southern Tennessee Regional Health System Pulaski (Provider No. 44-0058, FYE 12/31/2018)
    - Cost report listed protested items and had a cover letter noting what items, but there was no calculation schedule
- Crockett Hospital (Provider No. 44-0175, FYE 11/30/2018)
    - Cost report listed protested items and had a cover letter noting what items, but there was no calculation schedule
- Paris Regional Medical Center (Provider No. 45-0196, FYEs 06/30/2019 and 06/30/2020)
    - Both FYs did not protest anything on the cost report
- Palestine Regional Medical Center (Provider No. 45-0747, FYE 12/31/2018)
    - Cost report identified a dollar amount of protested items, but no summary of the items or explanation of how this amount was calculated was included with the cost report
- Ennis Regional Medical Center (Provider No. 45-0833, FYE 4/30/2020)
    - Cost report listed protested items and had a cover letter noting what items, but there was no calculation schedule
- Fauquier Hospital (Provider No. 49-0023, FYE 10/31/2018)
    - Cost report listed protested items and had a cover letter noting what items, but there was no calculation schedule
- Wythe County Community Hospital (Provider No. 49-0111, FYE 10/31/2018)
    - Nothing was protested on the cost report
- Kennewick General Hospital (Provider No. 50-0053, FYE 12/31/2018)
    - Nothing was protested on the cost report
- Logan Regional Medical Center (Provider No. 51-0048, FYE 09/30/2019)
    - Nothing was protested on the cost report
- Raleigh General Hospital (Provider No. 51-0070, FYE 05/31/2020)
    - Cost report identified a dollar amount of protested items, but no summary of the items or explanation of how this amount was calculated was included with the cost report
- Sagewest Health Care (Provider No. 53-0008, FYEs 12/31/2018 and 12/31/2019)

- Both FYs did not protest anything on the cost report [58]

The Provider's representative filed a response to the Substantive Claim Challenge on **May 26, 2022**.

First, it argues that the Substantive Claim Challenge was untimely. The Final Schedule of Providers was filed August 1, 2020, but the Substantive Claim Challenge was not filed until April 26, 2022. Board Rule 44.5 typically requires a challenge be filed within sixty (60) days of the filing of a Final Schedule of Providers. The Board finds, however, that the deadlines to file these challenges were indefinitely stayed via Board Alert 19[59] due to the public health emergency created by the COVID-19 pandemic. This indefinite stay was lifted effective December 7, 2022 via Board Alert 23,[60] which stated "***Effective Wednesday, December 7, 2022***, Board Order No. 3 ceases suspension of deadlines and will hold parties to the deadline specified in: (1) *any* Board rule or instruction; and/or (2) *any* Board notice or correspondence issued ***on or after that date.***"[61] There was no correspondence in this case, or any general notice applicable to this case, which re-established deadlines for Substantive Claim Challenges. As such, the stay for the deadlines for Substantive Claim Challenge was never lifted and FSS' filings was not untimely.

Next, the Providers argue that the self-disallowance requirement in 42 C.F.R. § 413.24(j) is impermissible, citing *Bethesda Hosp. Ass'n v. Bowen*[62] and *Banner Heart Hospital v. Burwell*[63] in support.[64] The Providers give notice to the Board that they plan to challenge the validity of this requirement.[65]

The Providers then argue that even if the self-disallowance requirement is generally permissible, it cannot be applied to the appeals here because they were taken from the Federal Register and filed before the Providers' respective cost reports were filed.[66] The Board finds, however, that this is not relevant since the cost reports have since been filed. Indeed, pursuant to 42 C.F.R. § 405.1873(a), when a provider files an appeal seeking reimbursement for a specific item, and any party questions whether the provider's cost report included an appropriate claim for that specific item, the Board is required to address that question. 42 C.F.R. § 405.1873(b) permits the parties to submit arguments and evidence regarding whether the cost report included the claim, and 42 C.F.R. § 405.1873(d) **requires** the Board to make findings in this regard.

Next, the Providers claim that compliance with the self-disallowance regulation is impossible because they are not challenging a "specific item," but rather all IPPS payments based on an

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[58] Medicare Administrative Contractor's Substantive Claim Letter, 1-2, 5-26 (Apr. 26, 2022).
[59] Available at https://www.cms.gov/files/document/prrb-alerts.pdf.
[60] Available at https://www.cms.gov/medicare/regulations-guidance/providerreimbursement-review-board/current-prrb-alerts) (emphasis in original.
[61] *See id.*
[62] 485 U.S. 399 (1988).
[63] 201 F.Supp.3d 131 (D.D.C. 2016)
[64] Response to EJR Supplement at 4.
[65] *Id.* at 23.
[66] *Id.* at 4-5.

understated standardized amount.[67] The Board rejects this argument, noting other Providers in this appeal have self-disallowed an amount for this issue as a protested item and explained their position when submitting their cost reports (thus complying with the regulations).

Fifth, the Providers believe the Secretary and CMS have known the Providers have been challenging this issue for two decades, so "it is unreasonable and gratuitous to require a cost-report protest to provide notice of the Understated Standardized Amount Issue."[68] The Board also rejects this argument because it is bound by 42 C.F.R. §§ 405.1873 and 413.24(j), and constructive notice of a claim does not meet the requirements set forth therein.

Sixth, they argue that since their "cost report claims sought reimbursement for all amounts due under law and the Understated Standardized Amount Issue seeks payment only of amounts that would have been paid had the law been properly applied" there is no basis to find the understated standardized amount issue is not reimbursable.[69] Again, the Board is bound by 42 C.F.R. §§ 405.1873 and 413.24(j) which requires Providers make an appropriate claim on their cost reports for **specific** items under appeal, not vague claims of any or all payments due to the Provider. Based on the foregoing, the Board also rejects this argument.

Next, the Providers argue that thirteen Providers **did** comply with the substantive claim regulations by providing "actual notice of the claimed costs in the transmittal letters and related documents accompanying their filed cost reports."[70] These are providers which the Medicare Contractor argued "did not submit a calculation of protested items." The Providers argue that they submitted a description of the understated standardized amount claim on their transmittal letter (which the Medicare Contractor conceded), "and also identified total Part A protested amounts on line 75 of Worksheet E of its cost report, which included the Understated Standardized Amount Issue claims."[71]

The Board rejects this argument as the proffered "compliance" is insufficient. The regulation at 42 C.F.R. § 413.24(j) requires providers to include an appropriate claim for the specific item by either (1) claiming full reimbursement on the cost report in accordance with Medicare policy, or (2) self-disallowing the item if it seeks payment that it believes the Medicare Contractor lacks the authority or discretion to award. Pursuant to § 413.24(j)(2), to properly self-disallow an 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

[67] *Id.* at 5.
[68] *Id.* a 5-6.
[69] *Id.* at 6.
[70] *Id.*
[71] *Id.* at 20-21.

> (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.[72]

Simply submitting a list of items being protested, along with a lump sum amount on Line 75 of Worksheet E of the cost report, does not comply with these requirements. Specific amounts, and explanations of how those amounts were calculated, are required for **each** specific item.

Finally, the Providers take issue with the two following Providers who did comply with these requirements where the Medicare Contractor claims the summary protested amounts are not identical to the amounts actually claimed on Line 75, Worksheet E:

- Wilson Medical Center (Provider No. 34-0126, FYE 2/28/2020) (Exhibit C-31)
- Saline Memorial Hospital (Provider No. 04-0084, FYE 6/30/2020) (Exhibit C-8)[73]

The Board agrees that these discrepancies do not amount to a failure to comply with the requirements of 42 C.F.R. §§ 405.1873 and 413.24(j). The Medicare Contractor was on notice of the issue, an amount claimed, and how that amount was calculated. The difference for Saline Hospital was approximately 2%, and for Wilson Medical Center, the amount protested on the cost report was less than the amount in the summary, meaning they reduced the amount summarized rather than trying to inflate it. Thus, the Board finds that these two Providers did make an appropriate claim on their cost reports for the specific issue under appeal.

ii. Case 19-1763GC

On **May 31, 2022**, FSS filed a Substantive Claim Challenge arguing that sixty-six (66) participating Providers covering eighty-eight (88) of the 181 applicable cost reporting periods failed to include an appropriate cost claim for the disputed issue. These Providers are collectively referred to as the "Case 19-1763GC Challenged Providers." The Medicare Contractor attached a spreadsheet at Exhibit C-3 describing the deficiencies identified.

The Providers filed a Response to the Substantive Claim Challenge on **June 30, 2022**. They make the same argument about timeliness, though Alert 19 was still applicable to these deadlines. They also make all of the same generic arguments about the lawfulness of 42 C.F.R. §§ 405.1873 and 413.24(j). The Board's rationale in rejecting these arguments in Case 19-1735GC, above, are applicable to this case, as well. More importantly, the Providers attach their own spreadsheet at Exhibit B to their Response refuting the Medicare Contractor's contentions.

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[72] (Bold and underline emphasis added.)
[73] *Id.* at 21.

Some of these entries seem to concede that the regulations were not followed. For example, South Baldwin Regional Medical Center (01-0083) states:

> According to Community Health Systems, the protest amounts support file was inadvertently not submitted with the filed cost report. However, this documentation was prepared at the time of filing, and a protest amount was included in line 75 of the worksheet E Part A of the cost report.

Thus, the required support was not submitted with the cost report as required, and being "prepared" at the time (but not filed) is insufficient. A similar statement is made for eight other providers' cost reports.

More importantly, however, is that none of the cost reports or supporting worksheets are included in the record for these challenged providers. 42 C.F.R. § 405.1873(b)(1) sets forth the preliminary steps for its evaluation of whether a provider included an appropriate claim for the specific item under appeal:

> ***Preliminary steps.*** The Board must give the parties an adequate opportunity to submit factual evidence and legal argument regarding the question of whether the provider's cost report included an appropriate claim for the specific item under appeal. **Upon receipt of timely submitted factual evidence or legal argument (if any), the Board must review such evidence and argument** and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with, for the specific item under appeal, the cost report claim requirements prescribed in § 413.24(j) of this chapter. **In reaching such specific factual findings and legal conclusions, the Board must follow the procedures set forth in § 413.24(j)(3) of this chapter for determining whether the provider's cost report included an appropriate claim for the specific item under appeal**. The Board must promptly give a copy of such written specific factual findings and legal conclusions to each party to the appeal, and such factual findings and legal conclusions must be included in the record of administrative proceedings for the appeal (as prescribed in § 405.1865).[74]

The procedures set forth in 42 C.F.R. § 413.24(j)(3) specify:

> ***Procedures for determining whether there is an appropriate cost report claim.*** Whether the provider's cost report for its cost reporting period includes an appropriate claim for a specific item (as prescribed in paragraph (j)(1) of this section) must be determined by reference to the cost report that

[74] (Emphasis added.)

> the provider submits originally to, and was accepted by, the contractor for such period . . .

The spreadsheets do "reference" the applicable cost reports, but the Board itself is unable to make any determination or findings of fact related to these cost reports or the related worksheets because they are not in the record. Without these documents, the Board is unable to make any finding that these Providers complied with the requirements set forth in 42 C.F.R. § 413.24(j). The Provider generally carries the burden of production of evidence and the burden of proof to establish that it is entitled to relief on the merits of the matter at issue.[75]

Based on the record before it, the Board finds that the Case 19-1763GC Challenged Providers. did not make an appropriate claim on their cost reports for the specific matter at issue. For any other providers' cost reports that were not challenged, the requirement to make similar findings of fact and conclusions of law has not been triggered so the Board declines to do so.

iii. Case 19-0233GC

The Medicare Contractor filed a Substantive Claim Challenge on **June 2, 2022**. Its argument is summarized as follows:

> The Providers had not filed their impacted cost reports when they filed their appeal. The applicable costs have now been filed. The Providers have not updated the Office of Hearings Case and Document Management System (OH CDMS) with protest related documents that might have been submitted with their as-filed cost reports, demonstrating that they self-disallowed and made a claim for the appealed item. In the absence of such documents, the MAC is filing this substantive claim challenge.[76]
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> ***
>
> The providers' representative has never up-loaded documentation into OH CDMS to prove the providers made a claim on their cost reports for the appealed issue, in accordance with 42 C.F.R. § 413.24(j)(2)(ii) and Board Rule 7.3.3. In the absence of this documentation, the MAC contends that the providers did not self-disallow the appealed item in accordance with Medicare Policy.[77]

First, the Board notes that this is not a specific, affirmative argument that the Providers failed to comply with 42 C.F.R. § 413.24(j) **when filing its cost report**. The Medicare Contractor merely

[75] 42 C.F.R. § 405.1871(a)(3).
[76] Medicare Administrative Contractor's Substantive Claim Letter, 1 (June 2, 2022).
[77] *Id.* at 4.

states that the Providers did not upload supporting documentation to OH CDMS when the cost reports were filed, some time after the appeals were filed.

The regulations do not require the Providers to upload documents to OH CDMS to be in compliance with 42 C.F.R. § 413.24(j). If the cost reports were filed, the Medicare Contractor should be able to review them and provide details to the Board with regard to any actual deficiencies. It has not done so here.

The Providers filed a response to this challenge on **July 5, 2022**. On the same day, they also filed in OH CDMS, a consolidated PDF with excerpts of their cost reports, protest summaries, and protest calculation worksheets illustrating how each of the remaining providers in this group complied with 42 C.F.R. § 413.24(j).

In reviewing the arguments made and the documentation submitted, the Board rejects the Medicare Contractor's generic Substantive Claim Challenge in this case. The appeals were taken from a Federal Register prior to the cost reports being filed. The appeals were properly filed and, at the time, it was impossible for the Providers to have made any claim on a cost report that had not been filed. In other cases, even within this Consolidated Request for EJR, once the cost reports are filed, if the Providers did not make an appropriate claim for the issue under appeal, the Medicare Contractor raises this point and explains what was included in (or omitted from) the cost report. The challenge in this case is not actually alleging non-compliance with 42 C.F.R. § 413.24(j), but arguing that protest documents were not uploaded to OH CDMS. Additionally, in response to this allegation, the Providers submitted documents that seem to illustrate compliance with 42 C.F.R. § 413.24(j).

3. Board Findings on Jurisdiction and Appropriate Cost Report Claims

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

a. Preliminary and Subject Matter Jurisdiction

Pursuant to 42 C.F.R. § 405.1840(a)(2)(i), the Board must make a preliminary jurisdictional determination "(that is, whether the request for hearing was timely, and whether the amount in controversy requirement has been met), if any, over the matters at issue in the appeal before [] determining its authority to decide a legal question relevant to a matter at issue" (i.e., expedited judicial review).

As previously noted, all of the participants in these group cases appealed from the FFY 2019 IPPS Final Rule.[78] The Board Majority has determined that: (1) the appeals were timely filed, and (2) the participants' documentation in the group appeal shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[79] In finding that the groups meet the $50,000 amount in controversy, the Board Majority recognizes that amounts in controversy are calculated by applying an *estimated* correction factor of 0.65%.[80] Accordingly, the Board Majority finds that the amounts claimed were made in good faith and are sufficient to meet the *jurisdictional threshold* required for the Providers to be entitled to a hearing on the issue presented.[81]

As to any concerns about the accuracy of these estimates (specifically with regard to the data used and the assumptions made in the calculations), or expert qualification, or any questions of whether the Providers would ultimately be able to prove actual damages, the Board Majority acknowledges that such concerns involve *underlying factual matters* that would be addressed during a case on the merits and damages, *if reached*. But the foregoing are not to be used as blocks to a jurisdictional finding for purposes of determining a right to a hearing or the appropriateness of EJR for a legal challenge outside of the Board's authority.

Next, we recognize that in prior Board decisions for these specific cases, the Board found that the Transfer/Discharge Error was *inextricably* tied with the FFY 1985 budget neutrality adjustment ("BNA") to the standardized amounts *for purposes of future FFYs* under the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), and both 1395ww(d)(2)(F) and 1395ww(d)(3)(C) which reference 1395ww(e)(1)(B), as demonstrated by the fact that the FFY 1985 budget-neutrality adjusted rates were used as the basis for the determination of rates for FFY 1986 and later years. Further, in prior decisions, the Board found that 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations[82]) prohibit administrative and judicial review of those BNAs. Based on those findings, the Board concluded that it did not have substantive jurisdiction over the issue in those group cases and denied the providers' requests for EJR, and further, dismissed the cases.

As previously mentioned, based on the ruling in *St. Mary's*, Board review of the matter in this appeal ***is not precluded by statute or regulation***, and thus, the Board has subject matter jurisdiction over such appeals.[83] However, *St. Mary's* holding is "'confin[ed]' to reviewing the 'validity of

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[78] The CMS Administrator confirmed that, consistent with the D.C. Circuit's decision in *Washington Hosp. Ctr. v. Bowen*, 795 F.3d 139 (D.C. Cir. 1986, a wage index notice published in the Federal Register is a final determination from which a provider may appeal to the Board within the meaning of 42 U.S.C. § 1395oo(a)(1)(A)(ii). *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993*)*, *rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015); 42 C.F.R. § 405.1837.
[79] *See* 42 C.F.R. § 405.1837.
[80] Request for EJR at 10.
[81] *See Infinity Care of Tulsa v. Sebelius*, 2011 WL 778111, *3 (N.D. OK 2011). *Compare Beacon Healthcare Svcs., Inc. v. Leavitt*, 629 F.3d 981, 984 (9th Cir. 2010) (distinguishing the amount in controversy, which is typically determined from the face of the pleadings, with the remedy sought).
[82] *See, e.g.*, 42 C.F.R. §§ 405.1804, 405.1840(b)(2).
[83] *See St. Mary's* at 17.

th[at] ground[]'"[84] and does not make a dispositive determination regarding the appropriateness of EJR for the instant matter or the like.

Based on the foregoing, the Board Majority acknowledges that it has jurisdiction over the Providers' above-captioned appeals.

b. 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. §§ 405.1873 and 413.24(j) are applicable. Particularly, the regulation at 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. . . .
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> ***
>
> (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***

[84] *See* Providers' Exhibit 3 to the Supplement to EJR, Memorandum and Order on Motion for Clarification, p. 5 (quoting *SEC v. Chenery Corp.*, 318 U.S. 80, 88 (1943)).

> ***findings of fact and conclusions of law*** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, ***must be included in such EJR decision*** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> (1) Board jurisdictional dismissal decision. ***If the Board issues a jurisdictional dismissal decision*** regarding the specific item under appeal (pursuant to § 405.1840(c)), ***the Board's specific findings of fact and conclusions of law*** (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, ***must not be included in such jurisdictional dismissal decision***.[85]

The substantive claim regulations are applicable to the cost reporting periods under appeal for all the participants in the instant cases, which all have cost reporting periods ending on or after December 31, 2016. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board restates its findings of fact and conclusions of law outlined above with regard to the three Substantive Claim Challenges filed in the instant cases.

For the Case 19-1735GC Challenged Providers, the Board finds that none of them made an appropriate claim on their cost reports for the specific item under appeal ***except for*** Wilson Medical Center (Provider No. 34-0126, FYE 2/28/2020) and Saline Memorial Hospital (Provider No. 04-0084, FYE 6/30/2020).

The Board finds that none of the Case 19-1763GC Challenged Providers made an appropriate claim on their cost reports for the specific item under appeal.

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[85] (Bold italics emphasis added.)

The Board rejects the Medicare Contractor's arguments in the Substantive Claim Challenge for Case 19-0223GC. Based on the documentation submitted by the Providers, the Board finds that any challenged providers in that case ***did*** make an appropriate claim on their cost reports for the specific item under appeal.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to ***only*** require the Board to review a provider's "compliance"[86] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made. [87]

For the Providers in Cases 19-1723GC and 19-1628GC (where no Substantive Claim Challenges were filed), and any non-challenged Providers in Cases 19-1735GC, 19-1763GC, and 10-0233GC, Pursuant to § 405.1873(a) and in compliance with the Board's Rules, since no party to the appeal has questioned whether an appropriate claim was made,[88] 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 for those providers. The Board will now proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d) for the participants in these five CIRP groups.

BOARD DECISION:

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the IPPS.[89] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[90]

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services."[91] The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain base period cost data be developed and modified in several specified ways (*i.e.*, inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[92] Section 1395ww(d)(2)(A) requires that the

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[86] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[87] *See* 42 C.F.R. § 405.1873(a).
[88] 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."
[89] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[90] *Id.*
[91] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[92] *Id*.

Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available:

> (A) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

Consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the "base period" operating cost per discharge.[93] The Secretary then *updated* the per discharge amount by an inflationary factor.[94]

The Providers dispute how the Secretary determined "discharges" and allege that the Secretary improperly treated transfers as discharges for purposes of this calculation. In doing so, they point to the 1984 IPPS Final Rule and the discussion therein, arguing CMS acknowledged the distinction between transfers and discharges but incorrectly claimed the effect was insignificant:

> With respect to the data used in computing prospective payment rates, we recognize that transfers were previously considered as discharges. Under the interim final rule, the transfer of a patient between two hospitals, each of which is subject to the prospective payment system, will not be considered a discharge for the transferring hospital. This type of a transfer would have been a discharge under the reasonable cost reimbursement system. However, no data were presented to indicate the actual effect, if any that this difference between the definitions of discharge under the old and new payment system might have on the DRG rates.
>
> With respect to the Federal rates, we would expect any discrepancy between the "old" and "new" definitions of discharge to have no significant effect on the rates. This is because patients transferred to another hospital constitute only a small fraction of the total number of discharges. It should also be noted that certain transfers under the prospective payment system will still be considered discharges, namely, transfers between a hospital subject to prospective payment and an excluded hospital. This would reduce even further the already small discrepancy between the definition of discharges under the old system and the definition under the new system.

[93] 48 Fed. Reg. 39752, at 39763 (Sept. 1, 1983).
[94] *Id*. at 39763-64.

> In discussing the transfer policy with respect to the difference in the definition of "discharge", a distinction must be made between the computation of the Federal rates, and the payments made to a particular hospital under the prospective payment system. While we would expect, as stated above, that there would be little effect of the difference in definitions on the rates, individual providers could receive a significant amount of unjustified payments, if they had a large number of transfers and we paid for each transfer at the full prospective payment rate as if it were a discharge.
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> ***
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> Finally, we wish to reiterate that the transfer policy contained in the interim final rule was intended as an interim policy. As we stated in the preamble to the interim final rule (48 FR 39759), our ultimate goal, which we expect to implement within the next few years, is to pay a single rate to one hospital for a given course of treatment to a given patient. Therefore, we believe that hospital managers should begin to anticipate our final transfer policy and to incorporate this eventual change into their financial and management planning.[95]

B. Board Majority's Decision Regarding the EJR Request

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1), the Board must grant a request for EJR if it has jurisdiction over the appealed issue and 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. Having already found that it has jurisdiction over these appeals, the Board must determine whether it has the authority to decide the legal question relevant to the matter at issue.

1. Factual Disputes and Board Record Development

At the outset of this of our analysis, the Board Majority acknowledges that Board Rule 42.3 requires a Request for EJR to demonstrate that there are "no factual issues in dispute." Here, it is important to note that the duty to establish whether there are factual disputes first lies with the parties to the appeal. Although Board Rule 42.3 requires a demonstration that there are "no factual issues in dispute," such is not to be interpreted as any and all facts must be resolved to pursue expedited review of a ***legal question*** outside of the Board's authority, which is distinguished from a question of fact. Moreover, from a purely legal perspective, a Request for EJR is akin to a motion for summary judgment in trial court where to prevail, the moving party must show there are no

[95] 49 Fed. Reg. 234, 245-246 (Jan. 3, 1984).

genuine disputes of ***material fact.***[96] The Board Majority recognizes that "material" is not used as an adjective that modifies the noun "fact" to specify the significance of the facts to be discerned versus trivial ones.[97] However, in its prior dismissals of the issue presented herein, even the Board acknowledged that "no factual issues in dispute" in Board Rule 42.3 is with reference to "material" facts, not merely any facts that have no dispositive impact on the matter.[98]

Additionally, in accordance with 42 C.F.R. § 405.1865, *et. seq*., the Board Majority recognizes the importance of developing a sufficient record for review by the CMS Administrator or the district courts.[99] However, here too, the initial responsibility to develop the record lies with the parties in either the pursuit or defense of the appeal. For instance, 42 C.F.R. § 1865(a)(2) states, "For proceedings before the Board, ***the administrative record consists of all evidence, documents and***

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[96] *See e.g.* Federal Rule of Civil Procedure 56.

[97] Even if the reference to "no factual issues in dispute" in Board Rule 42.3 is taken at face value, a historical review of 42 C.F.R. § 405.1842 reveals that prior to 2008, versions of regulation specified that:

> If there are factual or legal issues in dispute on an issue ***within the authority of the Board to decide***, the Board will not make an expedited review determination on the particular issue but will proceed with a hearing. The Board has the authority to decide when two or more issues are sufficiently related to preclude separation for purposes of an expedited review determination on one or more of them and a hearing on the other or others.

See 48 Fed. Reg. 22920, 22922-22925 (May 23, 1983). However, by May 23, 2008, 405.1842 had been overhauled and all references to the words "factual" or "fact" were removed from the regulation in an effort to clarify that EJRs were specific to legal questions over which the Board had no authority to resolve. *See* 73 Fed. Reg. 30190, 30214-30215:

> Under section 1878(f)(1) of the Act, a provider in certain situations may immediately seek judicial review of an action of the intermediary involving a question of the statute or regulations whenever the Board determines that it is without authority to decide the issue. If the Board determines that it has jurisdiction over the issue, but it lacks the authority to decide the issue, the provider may obtain expedited judicial review (EJR). The intent of this provision is to eliminate undue delays resulting from a requirement that providers pursue time-consuming and unproductive administrative reviews before they could obtain judicial review of a Board determination. We proposed several changes to § 405.1842 to clarify any confusion surrounding the procedures and the types of cases to which EJR applies.

[98] *See* PRRB Case 19-1723GC at 10-11 ("Similarly, the Board notes that consideration of expedited judicial review is not appropriate if there are ***material*** facts in dispute. Accordingly, the Board's RFI was designed to further develop the record regarding both the highly complex nature of the Providers' dispute as it relates to whether the Board has jurisdiction to hear the Providers' dispute and whether EJR is appropriate (including whether there are ***material*** factual disputes)."); *see id* at 3 (where the Board discusses a prior denial of EJR and requested additional information "to allow the Board to determine whether…(3) there are ***material*** factual disputes,"); *see id* at 30, Fn. 63 (where the Board pondered that additional input from the parties could lead to a determination "that ***material*** factual disputes exist").

[99] *See also* 42 C.F.R. § 405.1875 and § 405.1877.

any other tangible materials ***submitted by the parties to the appeal and by any nonparty*** (as described in §§ 405.1853(e)(4) and 405.1857(c)(3) of this subpart), along with all Board correspondence, rulings, subpoenas, orders, and decisions." Although the trier-of-fact in matters before it, the Board must remain impartial and balanced in developing the record (that is, finding out what the facts are) based on the documentary and testimonial evidence presented by the parties, and even some pertinent public factual information of which it may take notice. That is to say, "[t]he administrative [tribunal] must not go so far in developing the record so as to take on the aspects of a litigant with a decided point of view."[100] Furthermore, with respect to EJR requests, the record is based on the documentary evidence produced by the parties in support of or opposition to ***the legal question or challenge*** posed by the appellant.[101]

2. Providers' legal challenge and whether EJR is appropriate.

Courts have unequivocally held that the Board lacks the power to adjudicate direct challenges to IPPS rules.[102] Moreover, pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program.

In these cases, the Providers challenge their IPPS underpayments resulting from the alleged understatement of the standardized amount and payment rates published in the FFY 2019 IPPS Final Rule.[103] As set forth above, to support its challenge of the validity of the FY 2019 IPPS rates based on a perpetually embedded Transfer/Discharge Error, Providers argue the Secretary acknowledged the inclusion of transfers.

In these cases, it is undisputed that 42 U.S.C. § 1395ww(d)(2)(A) required the Secretary to "determine the allowable operating ***costs per discharge*** of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available."[104] Providers' "claim that the Secretary lumped discharges and transfers together is uncontroverted. 49 Fed. Reg. 234, 245–46 (Jan. 3, 1984)."[105] The record is clear that the Secretary used 1981 data to make this determination, and acknowledged that certain transfers, namely transfers between hospitals subject to IPPS, counted as discharges in 1981 would no longer be considered discharges starting in 1984 under the new IPPS. However, the Secretary believed that these certain types of transfers would not significantly impact the calculation of the 1984 standardized amounts and did not adjust for them.[106] *Whether 42 U.S.C. § 1395ww(d)(2)(A) required the removal of these transfers from the calculation of the 1984 standardized amount is* ***a purely legal question.*** Stated differently, the

[100] Richard Murphy & Charles H. Koch, Jr., *Administrative Law And Practice* § 5:25 (3d ed. 2021).
[101] *See e.g.*, 42 C.F.R. § 405.1842(d)(2) and (e)(2)(ii).
[102] *See St. Mary's Regional Medical Center v. Becerra*, 2024 WL 5186641, *5 (D.D.C. Dec. 20, 2024) (citing *Bayshore Cmty. Hosp. v. Azar*, 325 F. Supp. 3d 18, 21 (D.D.C. 2018)); *Cape Cod Hosp.*, 630 F.3d 203, 205 (D.C. Cir. 2011).
[103] EJR Request at 2.
[104] Emphasis added.
[105] St. Mary's at 7; Notably, in the instant and similar matters, the Medicare Contractor neither counters nor denies Providers' claims that the Secretary failed to distinguish transfers from discharges in the calculation of the inaugural standardized amounts and payment rates.
[106] 49 Fed. Reg. 234, 245-246 (Jan. 3, 1984).

legal challenge presented in Providers' EJR Request is whether the Secretary's inclusion of transfers without distinction from discharges was proper, which can only be determined by the court—not the Board as it must follow the proper procedural progression for questions of law outside of its authority.[107] Even if the Board had the authority to find that the transfers should have been removed, the Board lacks the authority to order the removal or to order the invalidation and recalculation of IPPS rates based on such a finding.[108] As the Providers point out, noteworthy is the Medicare Contractor's prior concession in its pleadings:

> ***The MACs believe that there are no factual matters that need resolution or further development before the Board reaches a decision on whether to grant EJR.*** At the same time, the MACs acknowledge the existence of the "Expert Report". The presence of such a report might suggest a factual matter that needs resolution. ***However, as the controversy has developed, any factual evaluation is premature.***[109]
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> ***
>
> The issue is whether there is a legal basis for changing in FFYs 35+ years after the amounts were put into use. Can the laws, regulations, and other authorities in place when the amounts were established be read in a way that would allow any modification today? That is the heart of the legal question before the Board in the EJR request. ***Any attempt to quantify what the alleged correction should be is a secondary and future question.***[110]
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> ***
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> ***Should the Board determine that it has jurisdiction, the MAC agrees that expedited judicial review is appropriate***.[111]

Based on the foregoing, the Board Majority finds that EJR is appropriate.

The Board Majority acknowledges that if the Providers prevail in this legal challenge of the Secretary's actions at the district court level, with the presentation of evidence, they must then prove the impact of any alleged errors in setting the inaugural IPPS standardized amounts on present day rates to prove actual damages. But at this juncture, a case on the merits is premature where an overarching legal question remains unresolved.

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[107] *See* 42 C.F.R. § 405.1840(a)(2)(i); *see also* 42 C.F.R. § 405.1842.
[108] 42 C.F.R. § 405.1867.
[109] Medicare Contractor's Response to the Board's Denial of EJR & Request for Information at 10 (February 4, 2022).
[110] *Id.* at 11 – 12.
[111] *Id.* at 14.

Moreover, in *St. Mary's,* the Court signaled that EJR is appropriate as to the legal question presented and that the Board's lack of authority to resolve the matter:

> If the plaintiffs cannot establish *ultra vires* jurisdiction, the appropriate next step is to remand the case to the agency, *which will likely result in certification for expedited judicial review*. *See Bayshore Cmty. Hosp*, 325 F. Supp. 3d at 21 (citing 42 C.F.R. § 405.1867). Remanding for this purpose may seem like a pointless formality, but as another court in this District has concluded, the statutory scheme appears to condition the district court's jurisdiction on the plaintiffs' receipt of expedited judicial review certification. *[citations omitted]*.
>
> ***Additionally, if and when the case returns to federal court, the parties' briefs will be focused on the merits of the dispute, rather than the jurisdictional questions addressed herein***.
>
> ***
> As for the second element [of the *ultra vires* review], the Court has already clarified that the PRRB has subject matter jurisdiction to entertain the plaintiffs' challenge and ***certify it for judicial review***, affording an "alternative procedure for review of the [plaintiffs'] statutory claim ...." [citation omitted].[112]

Based on the foregoing, the Board Majority finds that:

1) It has jurisdiction over the challenges to the calculation of the standardized amounts used in federal rates for the IPPS during FFY 1984 as it allegedly impacts the Providers' FFY 2019 IPPS rates and that the Providers in these group appeals are entitled to a hearing before the Board;

2) For the Case 19-1735GC Challenged Providers, the review process in 42 C.F.R. § 405.1873(a)-(b) has been triggered and the Board specifically finds that, ***except for*** Wilson Medical Center (Provider No. 34-0126, FYE 2/28/2020) and Saline Memorial Hospital (Provider No. 04-0084, FYE 6/30/2020), the Case 19-1735GC 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);

[112] *St. Mary's* at 17-18 (emphasis added).

3) For the Case 19-1763GC Challenged Providers, the review process in 42 C.F.R. § 405.1873(a)-(b) has been triggered and the Board specifically finds that the Case 19-1763GC 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);

4) For all the Providers in Case 19-0223GC, the review process in 42 C.F.R. § 405.1873(a)-(b) has been triggered and the Board specifically finds they all did 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);

5) The review process in 42 C.F.R. § 405.1873(a)-(b) has not been triggered for the remaining Providers and, therefore, there are no findings regarding whether their cost reports included appropriate claims for the specific item at issue in these appeals;

6) Based upon the Providers' uncontested assertions regarding the calculation of the standardized amounts used in federal rates for the IPPS during FFY 1984 (i.e., the inclusion of transfers indistinct from discharges) and its alleged impact on the Providers' FFY 2019 IPPS rates, there are no findings of fact for resolution by the Board at this juncture;

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

8) It lacks the authority to decide the legal question of whether the Providers' FFY 2019 IPPS rates are understated because transfers were erroneously included in the calculation of the standardized amounts used in federal rates for the IPPS during FFY 1984.

Accordingly, the Board concludes that the question of whether the Providers' FFY 2019 IPPS rates are understated falls within the provisions of 42 U.S.C. § 1395oo(f)(1), and in accordance with 42 C.F.R. §405.1842(f)(1), hereby grants the Providers' requests for EJR for the issue and the subject years.

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 five Cases, the Board hereby closes them and removes them from its docket.

Board Members Participating:

Kevin D. Smith, CPA (dissenting in part and concurring in part)
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

4/30/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Byron Lamprecht, WPS Government Health Administrators (J-5)
Cecile Huggins, Palmetto GBA (J-J)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Scott Berends, FSS

Dissenting in part, concurring in part, Kevin D. Smith, CPA

I find myself having to dissent with the Board Majority regarding the Provider's Request for Expedited Judicial Review ("EJR"). Historically, the Board denied EJR in these types of cases as it determined it lacked substantive jurisdiction, however, the District Court for the District of Columbia rejected that argument in *St. Mary's Regional Medical Center v. Becerra*.[113] CMS did not appeal that decision. CMS did, however, seek clarification of the scope of the Court's ruling on summary judgement. In the Memorandum & Order resulting from that Motion for Clarification, the D.C. District Court made clear that its decision addressed only the single determination of the Board that it did not have jurisdiction for the reasons it had cited in its EJR denial. The Court stated:

> The Court appreciates that aspects of the Court's extensive analysis on standing could be read as portending a ruling on the justiciability of the plaintiffs' claims on the merits. But to the extent they do so, that discussion should be understood only as dicta. The plaintiffs present thin justifications for why it could and should be construed otherwise. For example, they contend that '[t]he Court had an obligation to satisfy itself that Plaintiffs were entitled to be in federal court.' But that obligation . . . was limited to determining Article III standing only to the extent necessary for resolving the jurisdictional question before it. The plaintiffs also contend that a broader reading of the ruling would promote judicial economy. But a litigant's perspective on efficiency cannot justify sidestepping the exhaustion procedures set out by Congress. 'Though Congress implemented the EJR provision to avoid unnecessary delays, those necessary to and inherent in the legal process are often unavoidable.' *Cape Cod Hosp.*, 565 F. Supp. 2d at 141. 'The proper procedures' still 'must be followed.' *Id.*[114]

Additionally, in its original decision, the D.C. District Court addressed "issue exhaustion," stating:

> Issue exhaustion in the administrative context is 'an analogy to the rule that appellate courts will not consider arguments not raised before trial courts. . . .the plaintiffs had no genuine opportunity 'to

[113] No. 1:23-cv-1594-RCL, 2024 WL 5186641 (D.D.C. Dec. 20, 2024).
[114] No. 1:23-cv-1594-RCL, Memorandum and Order, 6 (Sep. 26, 2025).

> develop the issue[] in an adversarial administrative proceeding' before they arrived in this court.[115]

In that same December 20, 2024 decision, the D.C. District Court further stated:

> As the case proceeds from here to a determination on the merits, the agency should be given an opportunity to examine the administrative record and determine whether it is adequately developed. . . . the Court will order the parties to submit periodic status reports updating the Court on the parties' progress toward finalizing the administrative record (if any supplementation is necessary). . . .[116]

It is clear that the Court expects the agency, and by extension of remand, the Board, to ensure that the record is "adequately developed," expecting "periodic status reports" (both "periodic" and the plural term "reports" implies a potential length of time). In the *St. Mary's* case, five group cases before the Board were requesting EJR. In all five cases, both parties had filed a preliminary position paper, the Board had issued a Request for Information ("RFI") on certain issues, and the parties had responded. Yet, the Court still was aware of the possibility that the record may not have been fully developed and might require supplementation. These cases have now been remanded back to the Board by the Administrator for analysis of the record.

The Code of Federal Regulations at 42 C.F.R. § 405.1842(f) addresses the Board's decision on EJR. Section 405.1842(f)(2), and states:

> (2) The Board's decision must deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if any of the following conditions are satisfied:
>
> > (i) The Board determines that it does not have jurisdiction to conduct a hearing on the specific matter at issue in accordance with § 405.1840 of this subpart.
> >
> > (ii) The Board determines it has the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is neither a challenge to the constitutionality of a provision of a statute, nor a challenge to the substantive or procedural validity of a regulation or CMS Ruling.

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[115] No. 1:23-cv-1594-RCL, 2024 WL 5186641 (D.D.C. Dec. 20, 2024).
[116] *Id.*

> (iii) The Board does not have sufficient information to determine whether the criteria specified in paragraph (f)(1)(i) or (f)(1)(ii) of this section are met.[117]

Similarly, in the Board's own Rules, Rule 42.3 addresses the Content of the EJR Request, and states:

> A provider or a group of providers must file a written request for EJR with a *fully developed narrative* that:
>
> - Identifies the issue for which EJR is requested;
> - Demonstrates that there are no factual issues in dispute;
> - Demonstrates that the Board has jurisdiction;
> - Identifies the controlling law, regulation, Federal Register notice, or CMS ruling that is being challenged; and
> - Explains why the Board does not have authority to decide the legal question posed by the appeal.[118]

I have doubts that the facts are as clear as the Providers attempt to suggest in these five (5) cases, which reflects upon the requirement in Board Rule 42.3 to "[d]emonstrate[] that there are no factual issues in dispute." Indeed, in its discussion of the Providers' *ultra vires* argument in the *St. Mary's* case, the D.C. District noted that:

> the plaintiffs do not contend that § 1395ww explicitly defines 'discharge' at all, let alone so as to unambiguously exclude transfers. . . . Thus, the Court cannot say that the Secretary's decision to include transfers in his count of discharges runs 'contrary to a specific prohibition in the statute.' This is not to prejudge the plaintiffs' likelihood of success on the merits; it is merely to say that the plain language of the statute does not compel their victory so obviously as to sustain a claim for *ultra vires* jurisdiction.[119]

In four (4) of these cases, the Providers' single sentence issue statement is as follows:

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[117] 42 C.F.R. § 405.1842(f)(2). The Board notes that the references to (f)(1)(i) and (f)(1)(ii) reflect the same criteria which are reiterated in (f)(2)(i) and (f)(2)(ii).
[118] Board Rules v. 3.2 (Dec. 15, 2023).
[119] No. 1:23-cv-1594-RCL, 2024 WL 5186641 (D.D.C. Dec. 20, 2024) (Citations omitted).

> The common issue before the PRRB is whether the hospitals have been underpaid for the periods covered by the 2019 federal fiscal year because the inpatient hospital prospective payment system (PPS) standardized amounts are understated for the 2019 federal year due to the Secretary's failure to properly distinguish between patient transfers and discharges in establishing the PPS 1983 base year amounts.[120]

In their EJR request, the Providers have expanded the issue statement somewhat, now arguing that 42 U.S.C. § 1395ww(d)(2)(A) mandates the Secretary determine the allowable operating *costs per discharge* of inpatient hospital services but that when implementing IPPS the Secretary in fact calculated the average *costs per discharge or transfer* because the Secretary did not remove or adjust for transfers that were included in the 1981 base year data.[121]

As discussed above, the D.C. Circuit Court noted that the Providers in *St. Mary's* stopped short of stating that "§ 1395ww explicitly defines 'discharge' at all, let alone so as to unambiguously exclude transfers." But, the regulation only refers to "allowable operating costs per discharge." No suggestion that "transfers" must be excluded is made in the statute. In the Final 1984 IPPS Rule[122] published on January 3, 1984, the Secretary stated:

> With respect to the data used in computing prospective payment rates, we recognize that transfers were previously considered as discharges. Under the interim final rule, the transfer of a patient between two hospitals, each of which is subject to the prospective payment system, will not be considered a discharge for the transferring hospital. This type of a transfer **would have been a discharge under the reasonable cost reimbursement system**. However, no data were presented [in the comments to the Rule] to indicate the actual effect, if any, that this difference between the definitions of discharge under the old and new payment system might have on the DRG rates.[123]

It is important to note that the Providers' EJR request states, "Congress required CMS to calculate the 'allowable operating costs per discharge of inpatient hospital services for . . . the most recent cost reporting period for which data are available."[124] Yet, as the quote from the

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[120] *E.g.*, Case 19-1763GC, Statement of Issue Under Appeal at 1 (Feb. 1, 2019). In the case of Case No. 19-0233GC, the statement has been slightly expanded but makes the same arguments.
[121] Request for EJR at 3-5 (citing 48 Fed. Reg. 39751, 39763-39764 (Sept. 1, 1983).
[122] 49 Fed. Reg. 234 (Jan. 3, 1984).
[123] *Id.* at 245-46 (Bold emphasis added).
[124] Request for EJR at 4 (citing 42 U.S.C. § 1395ww(d)(2)(A)).

Final 1984 Rule states above, transfers between two hospitals "would have been a discharge under the reasonable cost reimbursement system."[125] The cost reporting periods used to develop the standardized rates were from 1981 and, thus, were cost-reimbursed cost reporting periods. For such periods, transfers "would have been a discharge."[126] The Providers in these cases suggest that "CMS "assumed" that the difference between 'transfers' and 'discharges' was not 'significant.'"[127]

The 1984 Interim Final Notice With Comment Period was issued as 48 Fed. Reg. 39746 on September 1, 1983. The Final Rule was then issued as 49 Fed. Reg. 234 on January 3, 1984. Both refer to 42 C.F.R. 405.470, as follows. In the Interim Final Notice, the purpose of § 405.470 is given as:

> Sections 405.470 through 405.477 of this subpart implement section 1886(d) of the Act by establishing *a prospective payment system for inpatient hospital services furnished to beneficiaries in cost reporting periods beginning on or after October 1, 1983.*[128]

The Final Rule revises § 405.470(c) as follows:

> (c) Discharges and transfers.
>
> (c)(1) Discharges. A hospital inpatient is discharged when –
>
> (c)(1)(i) The patient is formally released from the hospital (release of the patient to another hospital as described in paragraph (c)(2) of this section, or a leave of absence from the hospital, will not be recognized as a discharge for the purpose of determining payment under the prospective payment system);
>
> (c)(1)(ii) The patient dies in the hospital; or
>
> (c)(1)(iii) The patient is transferred to a hospital or unit that is excluded from the prospective payment system under § 405.471.
>
> (c)(2) Transfers. Except as provided in paragraph (c)(1)(iii) of this section, a discharge of a hospital inpatient is not counted *for purposes of the prospective payment system* when the patient is transferred –

[125] 49 Fed. Reg. 246.
[126] *Id.*
[127] Request for EJR at 5 (citing 49 Fed. Reg. 245-246).
[128] 48 C.F.R. 39746, 39817 (Sept. 1, 1983) (italics emphasis added).

> (c)(2)(i) From one inpatient area or unit of the hospital to another area or unit of the hospital;
>
> (c)(2)(ii) From the care of a hospital *paid under this section* to the care of another such hospital;
>
> (c)(2)(iii) From the care of a hospital *paid under this section* to the care of another hospital –
>
> (c)(2)(iii)(A) Excluded from the prospective payment system only because of its participation in an approved statewide cost control program or demonstration; or
>
> (c)(2)(iii)(B) That would be paid under this section except that its first cost reporting period under the prospective payment system has not yet begun; or
>
> (c)(2)(iv) From the care of a hospital paid under this section to the care of another hospital or hospital unit not officially determined to be excluded from the prospective payment system under § 405.471.[129]

These sections, which were new in 1983/1984 (as they implemented section 1886(d) of the Act), address how discharges/transfers will be handled for purposes of payment under the IPPS system, "for hospital services furnished to beneficiaries in cost reporting periods beginning **on or after October 1, 1983**."[130] The regulation states that "a discharge of a hospital inpatient is not counted *for purposes of the prospective payment system* when the patient is transferred…."[131] The regulation goes on to identify "from the care of a hospital paid under this section to the care of another such hospital."[132] The Providers would like to apply these definitions to the data from the **1981** cost reports used in the development of the standardized rates, but those services were furnished before October 1, 1983, and further, at that time, no hospital was "paid under this [inpatient prospective payment system] section." The 1984 Final Rule was clear that "[t]his type of a transfer would have been a discharge under the reasonable cost reimbursement system."[133] In these cases, the Providers would like to apply retroactive definitions that were published in 1983/1984 to data from 1981. Any prior definitions of

[129] 49 Fed. Reg. 314 (emphasis added).
[130] 48 Fed. Reg. 39817 (emphasis added).
[131] 49 Fed. Reg. 314 (emphasis added).
[132] *Id.*
[133] 49 Fed. Reg. 246.

transfers as being different than discharges, prior to the implementation of IPPS in 1983/1984, have not been substantiated in the records before the Board.

The Providers' EJR Requests also quote the *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"),[134] case, saying "[t]o this day. . . Medicare payments for inpatient services depend in part on *factual determinations* derived from 1981 data and embedded in 1983 calculations, including the calculation of 'allowable operating costs per discharge.'"[135] The argument that these are factual determinations would suggest that the Board should ensure that no facts are in dispute (such as the data or definitions used in the calculation). Again, the record is not fully developed. The Providers make assumptions that the level of transfer data they are seeking was available and/or reported in the 1981 records,[136] even though it is clear that such transfers were discharges in the reasonable cost reimbursement system, and that the definition of excludable transfers was from 1983 and only applied to services furnished on or after October 1, 1983. The Providers further contend in the Supplement to the EJR Request that "the Secretary knew - . . . that the inaugural FFY 1984 standardized amounts had been improperly calculated without excluding or applying any adjustment for the impact of transfers."[137] This is an over-reach. The Secretary knew that no adjustments had been made to reflect the exclusion of transfers (as defined in 1983) from the 1981 data, but the statute required a calculation of allowable cost per discharge, from a time when transfers were considered to be discharges prior to 1983. That is not the same thing.

The Providers' EJR Request identifies more than one potential "understatement" amount, suggesting the use of the Capital PPS correction factor from 1991 (10 years after the IPPS data) of 0.9%. It is important to note that Capital PPS rates and Operating PPS rates are not the same, nor were the calculations to develop them and, thus, it does not follow that the correction factor, if any, would be the same. The Providers use that Capital PPS correction factor to develop their amount in controversy, according to the EJR Request.[138] Later, the Providers cite Exhibit D of the EJR Request (the "Panis Report") "which analyzes available alternative National Hospital Discharge Survey ("NHDS") data [for 1981] and calculates an estimated correction factor of 0.65%."[139] Finally, the Panis Report also evaluated MedPAR data from 1997 through 2017, resulting in a "transfer correction factor" that "ranges from 0.62% to 0.71%."[140] The Panis Report also shows a Table of "Inpatient Stay Destinations" in the 1981 NHDS alternative data it

[134] 894 F.3d 290, 291 (D.C. Cir. 2011).
[135] *Saint Francis Medical Center v. Azar*, 894 F.3d 290, 291 (D.C. Cir. 2018) (italics emphasis added).
[136] Request for EJR, Exhibit D, ⁋ 43 (Aug. 10, 2020).
[137] EJR Supplement at 4.
[138] *Id*. at 9-10.
[139] *Id*. at 6.
[140] *Id.* Exhibit D at ¶ 56.

used to calculate the 0.65% correction factor.[141] The Report indicates that "[t]ransfers to another short-term facility, which I have interpreted to mean another hospital as an inpatient, account for 2.0% of all inpatient stays."[142] However, this reasoning is flawed, as there are short-term facilities, such as Rehab Hospitals, Psych Hospitals, and Cancer Hospitals which are exempt from IPPS. Even in the 1984 IPPS Final Rule, transfers to these hospitals were still deemed discharges, not excluded as transfers (see 42 C.F.R. 405.470(c)(1)(iii) (1984), *supra*). Thus, this data is not sufficient for the purpose for which it is being used and, thus, could be factually disputed. Per the table included in Exhibit 5, no information is provided to identify the discharges to non-IPPS hospitals, which should remain discharges, as distinct from the discharges to IPPS hospitals, which would be considered as transfers, ***after*** October 1, 1983. The viability of the data to be able to imply the Providers' desired retroactive definitions is definitely questionable.

In prior dismissals of this issue, where the Board found it did not have substantive jurisdiction, it also brought attention to the numerous adjustments made since the inception of IPPS that may or may not have affected the calculation of the standardized amount through the requirement of budget neutrality. When evaluating the impact of any alleged mistreatment of transfers in the base period data, it is important to note that the initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis*, the standardized amount is not adjusted each year simply for inflation.[143] Significantly, some of these annual adjustments were required to be *budget neutral*. In particular, 42 U.S.C. § 1395ww(c)(1)(B) provides the budget neutrality adjustment for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

> **(e) Proportional adjustments in *applicable percentage increases***
>
> (II) . . . .
>
> (B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—

[141] *Id*. at ¶ 50.
[142] *Id*. at ¶ 51.
[143] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

> (II) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),
>
> *are not greater or less than*—
>
> (ii) the DRG percentage (as defined in subsection (d)(1)(C)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).[144]

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 rate year and 1985 rate year respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

> (II) *Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c) through (h) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of **the payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1984 **under the Social Security Act as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[145]

[144] (Bold emphasis in original and italics and underline emphasis added.) The budget neutrality adjustment at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).
[145] (Italics emphasis in original and bold and underline emphasis added.)

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

> (v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of the reduced standardized amounts determined under paragraph (c) of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is **not greater or less** than 50 percent of the **payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[146]

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than **or** less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e*., reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average payment per case, is prescribed by law to be *no more **and** no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget neutrality for 1984 and 1985 are ***external*** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.[147] Since these points are ***fixed,*** it also means that it is capped (*i.e*.,

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

[147] 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board's pie concept:

> Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.
>
> Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are

cannot be increased subsequently outside of the budget neutrality adjustment). Additionally, the Board included in those decisions an Appendix (included here as Appendix A) which iterated the numerous adjustments made outside of the budget neutrality adjustments of 1984 and 1985. The records in these cases do not address how these may or may not affect the final outcome of the standardized amount as it is developed for FFY 2019, should the Providers' argument prevail.

While I recognize that this issue may eventually require EJR, as the Providers in these cases are attempting to challenge the regulation, for all of the reasons I have expanded upon above, I find that these cases, at this time, are not ripe for EJR, as the record is not fully developed, and there are facts presumed that I find to be in question. I would therefore deny EJR and require the parties to fully brief the issue before I determined if EJR was appropriate.

With regard to the Substantive Claim Challenges made by the Medicare Contractor in Case Nos. 19-1735GC, 19-1763GC, and 19-0233GC, I concur with the Board Majority's opinion, as follows:

> Case No. 19-1735GC – for the Challenged Providers, I find that none of them made an appropriate claim on their cost reports for the specific item under appeal ***except for*** Wilson Medical Center (Provider No. 34-0126, FYE 2/28/2020) and Saline Memorial Hospital (Provider No. 04-0084, FYE 6/30/2020).
>
> Case No. 19-1763GC – I find that none of the Challenged Providers made an appropriate claim on their cost reports for the specific item under appeal.
>
> Case No. 19-0223GC - With the Board Majority, I reject the Medicare Contractor's arguments in the Substantive Claim Challenge for this case. Based on the documentation submitted by the Providers, I find that any challenged providers in that case ***did*** make an appropriate claim on their cost reports for the specific item under appeal.

4/30/2026

X Kevin D. Smith, CPA

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

required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

APPENDIX A

The following are examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments and the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i):

a. "Restandardization of base year costs per case used in [the] calculation of Federal rates" for both the labor and non-labor portions to reflect the survey-based wage index as discussed in the FY 1986 IPP Final Rule. 50 Fed. Reg. 35646, 35692 (Sept. 3, 1985).

b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.[148] An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.[149]

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[148] The Secretary confirmed that, beginning in 1991, these adjustments are to be made in a budget neutral manner:

> Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

59 Fed. Reg. 45330, 45348 (Sept. 1, 1994).

[149] 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

> *Comment:* A commenter was concerned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.
>
> *Response:* This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs, inclusion of transfer cases tends to ***increase*** the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.
>
> Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

Id. at 35655-56.

c. Budget neutrality adjustments made to the standardized amount designated for urban hospitals and the one designated for rural hospitals when certain urban hospitals were deemed to be urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).[150]

d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)[151] and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).[152]

e. Budget neutrality provision at 42 U.S.C. § 1395ww(d)(3)(A)(vi) that allows Secretary to adjust standardized amount to eliminate the effect of "changes in coding or classification of discharges that do not reflect real changes in case mix."

f. The discretion of the Secretary in 42 U.S.C. § 1395ww(d)(3)(I)(i) to "provide by regulation for such other exceptions and adjustments to such payments amounts under this subsection as the Secretary deems appropriate."

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[150] *See also* 56 Fed. Reg. 43358, 43373 (Aug. 30, 1991) (stating "Consistent with the prospective payment system for operating costs, the September 1, 1987 capital final rule provided for separate standardized amounts for hospitals located in urban and rural areas. Subsequently, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) provided for a higher update factor for hospitals located in large urban areas than in other urban areas and thereby established three standardized amounts under the prospective payment system for operating costs. Large urban areas are defined as those metropolitan statistical areas (MSAs) with a population of more than 1 million (or New England County metropolitan statistical areas (NECMAs) with a population of more than 970,000). Beginning with discharges on or after April 1,1988 and continuing to F Y 1995, the Congress has also established higher update factors for rural hospitals than for urban hospitals. The differential updates have had the effect of substantially reducing the differential between the rural and other urban standardized amounts. Section 4002(c) of Public Law 101-508 provides for the elimination of the separate standardized amounts for rural and other urban hospitals in FY 1995 by equating the rural standardized amount to the other urban standardized amount. The separate standardized amount for large urban hospitals would continue. Currently, the large urban standardized amount under the prospective payment system for operating costs is 1.6 percent higher than the standardized amount for hospitals located in other urban areas.").
[151] *See* 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A); *supra* note 18.
[152] Omnibus Reconciliation Act of 1990, Pub. L. 101-508, § 4002(c), 104 Stat. 1388, 1388-33 – 1388-35 (1990).

g. The subsequent amendments that Congress made in 1994[153] and 1997[154] to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. The Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS.[155]

To illustrate the complex nature of these issues, Board points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,[156] the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).[157] The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

> Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that developed since they were published. *We believe that it is necessary, **each year**, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries*. Further, we think this review must include assessment of whether the previous

[153] Social Security Act Amendments of 1994, § 109, Pub. L. 103-432, 108 Stat. 4398, 4408 (1994) placed the then-existing language of 42 U.S.C. § 1395ww(d)(5)(I) into clause (i) and added the following clause (ii): "(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater than or lesser than those that would have otherwise been made in such fiscal year."
[154] Balanced Budget Act of 1997, Pub. L. 105-33, § 4407, 111 Stat. 251, 401 (1997), further revised 42 U.S.C. § 1395ww(d)(5)(I) and added § 1395ww(d)(5)(J).
[155] *See* 60 Fed. Reg. 45778, 45854 (Sept. 1, 1995) ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional payments for transfer cases of $159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.").
[156] 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).
[157] U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.

In addition to this general consideration, *the FY 1985 adjusted average standardized amounts* (***Federal rates***) *were required by law* ***to be adjusted to achieve budget neutrality***; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more* ***nor*** *less than* we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years*.

Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were ***higher*** *than necessary to achieve budget neutrality*. Therefore, *we have updated the FY 1985 standardized amounts using a factor that takes into account the* ***overstatement*** *of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts*. To this end, we have identified several factors, ***discussed in section II.A.3.c.***, below, that contributed to the overstatement of the FY 1985 standardized amounts. *We have determined an appropriate percent value for each of them, and have combined them into* ***a proposed composite correction factor*** *for FY 1986 that equals –7.5 percent*.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. **We have combined these values into a composite policy target adjustment factor**, **as discussed in section III.3.e., below**. For FY 1986, this factor equals —1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." *Establishing FY 1986 prospective payment rates based on FY 1985 rates* ***that have been demonstrated to be overstated****, clearly would not comport*

with the statutory requirement that the rates represent payment for efficiently delivered care.

Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes is +.31 percent, it is clear that there is a potential justification of a –4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:

	Percent
Forecasted market basket increase..	+4.27
Part B costs and FICA taxes.....	+.31
Composite correction factor.....	–7.5
Composite policy target adjustment factor.....	–1.5

However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.[158]

****

(3) *Additional causes for the overstatement of FY 1985 Federal rates.* In addition to the factors above, which we believe we must correct, **other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts**.

When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for

[158] 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

1985. After application of the revised market basket, discussed previously, use of these actuarial estimates would reduce the standardized amounts by an additional 1.2 percent.

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates. The hospital specific rates were set using later (1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. **Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount**. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals" total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.

We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we**

> **have decided <u>at this time not</u> to correct the standardized amounts for these factors.**
>
> We received no comments on this issue.
>
> (4) ***Composite Correction Factor.*** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:
>
> | | *Percent* |
> |---|---|
> | Case mix..... ..... | –6.3 |
> | Market basket..... | –1.2 |
> | Composite correction factor..... | –7.5[159] |

Congress did immediately act on the Secretary's September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 ("EEA-85") to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates (*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).[160] Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

> - Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
>
> - Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
>
> - Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
>
> - Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.[161]

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.[162]

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[159] *Id.* at 35703-04 (bold and underline emphasis added).
[160] Pub. L. 99-107, § 5(a), 99 Stat. 479, 479 (1985). In July 1984, Congress had *already* reduced the 1 percent update factor planned for FFY 1986 to ¼ of a percentage point. Deficit Reduction Act of 1984, Pub. L. 98-369, § 2310(a), 98 Stat. 494, 1075 (1984). As part of the Emergency Extension Act of 1985, Congress further reduced the update factor for FFY 1986, presumably in response to the Secretary's recommendation.
[161] 51 Fed. Reg. 16772, 16772 (May 6, 1986).
[162] *See id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).

The examples highlight concerns about how certain future actions and decisions by the Secretary and Congress build upon prior decisions. Here, the Secretary's recommendation to Congress regard the FFY 1986 update factor were based on its analysis of the FFY 1984 and 1985 standardized amounts that had already been adjusted for budget neutrality. To the extent the 1984 standardized amounts had been *further* adjusted (*as **now** proposed by the Providers*), it could have potentially impacted the Secretary's recommendation to Congress for the FFY 1986 update factor as well as Congress' subsequent revisions to the updated factor. Accordingly, this highlights how revisiting and otherwise adjusting the FY 1984 standardized amounts can have ripple effects with the update factor and other adjustments that were made for subsequent years *based on analysis of the prior year(s) and other information*.