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***

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|---|---|
| 22-0732GC | *Intermountain Healthcare FFY 2022 IPPS Section 401 Hospitals Rural Floor CIRP Group* |
| 22-0733GC | *Ardent Health FFY 2022 IPPS Section 401 Hospitals Rural Floor CIRP Group* |
| 22-0735GC | *CHS FFY 2022 IPPS Section 401 Hospitals Rural Floor CIRP Group* |
| 22-0740GC | *CHRISTUS Health FFY 2022 IPPS Section 401 Hospitals Rural Floor CIRP Group* |
| 23-1393G | *King & Spalding FFY 2022 IPPS Section 401 Hospitals Rural Floor Group* |

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Consolidated[1] Request for Expedited Judicial Review ("EJR") filed on **January 5, 2026** concerning the above referenced common issue related party ("CIRP") and optional group appeals. The Board's decision on jurisdiction and EJR for these five (5) cases are set forth below.

**Issue:**

The Petition for EJR describes the issue as follows:

> The Medicare statute provides that "Section 401" hospitals must be treated as being located in a rural area for all purposes under the IPPS system, *see* 42 U.S.C. § 1395ww(d)(8)(E), and that no urban hospital can be assigned a wage index that is lower than the wage index assigned to rural hospitals in the same state, *see* 42 U.S.C. § 1395ww note. In its rulemaking for the Inpatient Prospective Payment System for fiscal year 2020, and carried forward to FFY 2022, however, CMS announced a new rule that violates both of these statutory directives. Specifically, under CMS's new policy, Section 401 hospitals would not be treated as rural in calculating the rural floor, and urban hospitals will be assigned a lower wage index than the one applicable to rural hospitals in the state. The issue presented in these

[1] The Request for EJR also included Case No. 22-0734GC, which will be addressed under separate cover.

> appeals is whether CMS's new wage index rule is unlawful because it conflicts with the unambiguous requirements of the Medicare statute.[2]

The Providers are requesting "that the Board grant EJR of the Providers appeals challenging the validity of CMS's rule excluding Section 401 hospitals from the calculation of the rural floor."[3]

**Statutory and Regulatory Background:**

*1. Wage Index; Rural and Urban Classification*

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[4] known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs"). The base payment rate is comprised of a standardized amount[5] for all subsection (d) hospitals located in an "urban" or "rural" area.[6]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[7] adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).[8]

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix

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[2] Case Nos. 22-0732GC *et al.*, Consolidated Petition for Expedited Judicial Review at 1 (Jan. 5, 2026).
[3] *Id.* at 10.
[4] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).
[5] The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27708, 27765-27766 (May 27, 1994). Section 1395ww(d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).
[6] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[7] of the Department of Health and Human Services.
[8] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index (last visited January 30, 2026).

Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives an "average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts."[9]

In 1999, Congress recognized that in some cases, a hospital in one geographical area may compete for the same labor pool as hospitals in a nearby, larger urban area but receive lower reimbursement because they are geographically located in a lower wage index area. This resulted in some hospitals being underpaid for their labor costs. As a result, "Congress amended the Medicare Act in order to allow a hospital to seek reclassification from its geographically-based wage area to a nearby area for payment purposes if it met certain criteria"[10] and established the Medicare Geographic Review Board (MGCRB) to administer the reclassification process.[11,12]

Ten years after the MGCRB was established, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106-113).[13] This legislation instructed the Secretary that urban hospitals that applied to the MGCRB for redesignation as rural were to be treated as such. Hospitals that receive these redesignations are sometimes known as "Section 401" hospitals. Codified at 42 U.S.C. § 1395ww(d)(8)(E), the statute states that:

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

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[9] *Id.*
[10] *Robert Wood Johnson University Hosp. v. Thompson*, 297 F. 3d. 273, 276 (3d Cir. 2002).
[11] *Id.*
[12] 42 U.S.C. § 1395ww(d)(10)(D)(v).
[13] *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Public L. 106-113, app. F. § 401, 113, Stat. 1501, 1501A-321 (Nov. 29, 1999). Codified as 42 U.S.C. § 1395ww(d)(8).

> (III) The hospital would qualify as a rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.
> (IV) The hospital meets such other criteria as the Secretary may specify.[14]

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

> Hospitals qualifying under this section shall be eligible to qualify for all categories and designations available to rural hospitals, including sole community, Medicare dependent, critical access, and referral centers. Additionally, qualifying hospitals shall be eligible to apply to the [MGCRB] for geographic reclassification to another area. The [MGCRB] shall regard such hospitals as rural and as entitled to the exceptions extended to referral centers and sole community hospitals, if such hospitals are so designated.[15]

### *2. Rural Floor Adjustment*

In 1997, Congress observed that the calculation of the wage index for all regions of a state can sometimes result in "some urban hospitals being paid less than the average rural hospital in their state."[16] To correct this problem, in the Balanced Budget Act of 1997, Congress provided that the wage index assigned to a hospital in an urban area must be at least as great as the wage index assigned to rural hospitals within the same state. The statute provides that:

> For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)) may not be less than the area wage index applicable under such section to hospitals located in rural areas in the State in which the hospital is located.[17]

This provision is commonly referred to as the "rural floor."

### *3. Changes to the Wage Index Calculation*

In the FFY 2019 IPPS proposed rule,[18] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information ("RFI") as part of the FFY 2020 IPPS proposed rule.[19] Therein, the Secretary noted that many

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[14] *Id.* (emphasis added).
[15] H.R. Conf. Rep. No. 106-479, 512 (1999).
[16] H.R. Rep. No. 105-149, at 1305 (1997).
[17] 42 U.S.C. § 1395ww note (Floor on Area Wage Index).
[18] 83 Fed. Reg. 20164 (May 7, 2018).
[19] 84 Fed Reg 19158, 19393-94 (May 3, 2019).

respondents expressed: (1) "a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[20] In the FFY 2020 IPPS Final Rule, the Secretary proposed several policies to address wage index disparities.[21] Relevant to the issue under appeal here are the Secretary's proposals to prevent allegedly inappropriate payment increases due to rural reclassifications made under the provisions of 42 C.F.R. § 412.103.[22,23] The Secretary finalized without modification the proposals

- to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103); and
- for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . .(as implemented at § 412.103) from the calculation of "the wage index for rural areas in the State in which the county is located" referred to in section [1395ww](d)(8)(C)(iii). . . .[24]

The Secretary contends that this policy "is necessary and appropriate to address the unanticipated effects of rural reclassification on the rural floor and resulting wage index disparities, including the effects of the manipulation of the rural floor by certain hospitals."[25] The Secretary concludes that "the inclusion of reclassified hospitals in the rural floor calculation has had the unforeseen

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[20] *Id.*
[21] *See generally* 84 Fed. Reg. 42044, 42336-42339 (Aug. 16, 2019).
[22] 84 Fed. Reg. at 42332. 42 C.F.R. § 412.103 states in relevant part that:

> (a) General criteria. A prospective payment hospital that is located in an urban area (as defined in subpart D of this part) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
> (1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification, the Rural–Urban Commuting Area codes, . . . .
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.
> *****
> (7) For a hospital with a main campus and one or more remote locations under a single provider agreement where services are provided and billed under the inpatient hospital prospective payment system and that meets the provider-based criteria at § 413.65 of this chapter as a main campus and a remote location of a hospital, the hospital is required to demonstrate that the main campus and its remote location(s) each independently satisfy the location conditions specified in paragraphs (a)(1) and (2) of this section.

[23] 84 Fed. Reg. at 42332.
[24] *Id.* at 42336.
[25] *Id.* at 42333.

effect of exacerbating the wage index disparities between low and high wage index hospitals."[26]

Under the 2020 IPPS Final Rule, the Secretary "would continue to calculate the rural floor based on the physical non-MSA area of a state, which is the same rural area to which a hospital is reclassified under section [1395ww](d)(8)(E). However, for purposes of calculating the rural floor wage index for a state, [the Secretary] would not include in the rural area the data of hospitals that have reclassified as rural under section [1395ww](d)(8)(E)."[27] The Secretary pointed out that the "legislative intent of the rural floor was to correct the 'anomaly' of 'some urban hospitals being paid less than the average rural hospital in their States.'"[28]

The Secretary found that "[u]nder the current rural floor wage index calculation, rather than raising the payment of some urban hospitals to the level of the average rural hospital in their State, urban hospitals may have their payments raised to the relatively high level of one or more geographically urban hospitals reclassified as rural."[29] The Secretary explained that "[w]hile urban hospitals in mostly rural states may benefit from an increase in the rural floor due to urban to rural reclassification . . . other states with high wage urban hospitals using [42 C.F.R.] § 412.103 reclassifications to raise the rural floor can mitigate those gains for mostly rural states, due to budget neutrality."[30] The Secretary believes that "excluding the data of hospitals that reclassify as rural under section [1395ww](d)(8)(E) from the rural floor wage index is necessary and appropriate to address these unanticipated effects of rural reclassifications on the rural floor and the resulting wage index disparities."[31]

The Secretary contends that his reimbursement calculation "is permissible under [42 U.S.C. § 1395ww](d)(8)(E) (as implemented by [42 C.F.R.] § 412.103) and the rural floor statute [42 U.S.C. § 1395ww(d) note]" and notes that the statute "does not specify where the wage data of reclassified hospitals must be included."[32] Therefore, the Secretary believes that he has the "discretion to exclude the wage index data of such hospitals from the calculation of the rural floor. Furthermore, the rural floor statute does not specify how the rural floor wage index is to be calculated or what data are to be included in the calculation."[33] Consequently, the Secretary believes that he has the "discretion under the rural floor statute to exclude the wage data of hospitals reclassified under section [1395ww](d)(8)(E) from the calculation of the rural floor."[34]

CMS has adopted the FY 2020 IPPS Final Rule's policy in its FY 2022 IPPS Final Rule, meaning for FFY 2022 it will calculate the rural floor in a state without reference to the wage index that applies for any hospitals in that state which were reclassified as rural pursuant to Section 401.[35]

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[26] *Id.*
[27] *Id.* at 42334.
[28] *Id.*
[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] *Id.*
[34] *Id.*
[35] 86 Fed. Reg. 44774, 45175 (Aug. 13, 2021).

**Positions of the Parties:**

***1. Providers' Appeal Requests***

The Providers describe the appealed issue as follows:

> The Providers in this group appeal challenge the Secretary's calculation of the rural floor for federal fiscal year (FFY) 2022. The Secretary's calculation violates the plain meaning of the rural floor provision of the statute and the requirement to treat reclassified rural hospitals as rural hospitals for all purposes of the prospective payment system.
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> For wage index purposes, there are two types of geographic areas: urban and rural.
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> When a hospital reclassifies as rural, its wage and hour data is included in the calculation of the state rural wage index adjustment in the next federal fiscal year.
> The Medicare statute contains a provision requiring that no urban hospital can be assigned a wage index adjustment that is lower than the wage index assigned to rural hospitals in the state.
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> In the Inpatient Prospective Payment System Rulemaking for FFY 2020, the . . . . rural wage index will continue to be calculated based on the average hourly wage of all rural hospitals and all urban hospitals that have reclassified as rural. The rural floor, however, will not include the wage and hour data of reclassified rural hospitals; it will be based solely on the wage data of naturally rural hospitals. The Secretary continued this policy in FFYs 2021 and 2022. 86 Fed. Reg. 44774, 45175-76 (Aug. 13, 2021). As a direct result of this policy, in FFY 2022, urban hospitals in some states have been assigned a wage index that is lower than the wage index assigned to rural hospitals in those states.
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> This result violates the rural floor, which expressly prohibits the Secretary from assigning a wage index to urban hospitals that is lower than the wage index of rural hospitals in the same state. *See* 42 U.S.C. § 1395ww note. Even if this result did not violate the rural floor (it does), the Secretary's policy would separately violate 42 U.S.C. § 1395ww(d)(8)(E)(i), which requires the Secretary to treat a hospital that has elected to reclassify as rural as rural for the purposes of the prospective payment system.

> For the forging reasons, the Providers in this group appeal are seeking reversal of CMS's policy of divorcing the rural floor from the rural wage index.[36]

### *2. Providers' Request for EJR*

The Providers filed their Petition for EJR to challenge CMS' new wage index rules as unlawful because it conflicts with the Medicare statute.[37] They argue that the FY 2020 rulemaking (1) does not treat reclassified "Section 401" hospitals as being located in a rural are as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[38]

They seek to have their wage indices recalculated in compliance with the requirements of the Medicare statute.[39] The Providers are specifically seeking the Board hold that:

> CMS's calculation of the FFY 2022 rural floor is unlawful because CMS does not have statutory authority to exclude data of Section 401 hospitals from the calculation of the rural floor and CMS cannot assign a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state, and to compel CMS to pay the Providers reimbursement that was withheld as a result of that regulation during the years under appeal.[40]

The Providers insist they have met the criteria set forth in 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), namely that the Board has jurisdiction over the appeal but lacks the authority to grant the relief the Provider seeks.[41]

### *3. Medicare Contractor's Position*

On **January 12, 2026**, the Medicare Contractor's designated representative, Federal Specialized Services, filed a response to the Consolidated Request for Expedited Judicial Review. It took no position on the Request for EJR but noted "that the MAC will file substantive claim challenges for 22-0733GC, 22-0740GC and 23-1393G."[42]

Substantive Claim Challenges were filed in those three (3) Cases on **January 22, 2026**. A Substantive Claim Challenge was also filed in Case 22-0732GC on **January 19, 2026**. The Substantive Claim Challenges are addressed below.

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[36] *E.g.*, Case No. 22-0732GC, Statement of the Issue at 1-2 (Feb. 9, 2022).
[37] Consolidated Petition for Expedited Judicial Review at 5-6 (Jan. 5, 2026).
[38] *Id.* at 1, 5-6.
[39] *Id.* at 1-2.
[40] *Id.* at 7.
[41] *Id.* at 6-10.
[42] *E.g.*, Case No. 22-0732GC, Response to Provider's Request for Expedited Judicial Review at 1 (Jan. 12, 2026).

**Decision of the Board:**

The Providers participating in the group appeals included in this EJR request have filed their appeals from policies established in the FFY 2022 IPPS Final Rule published in the Federal Register.

***1. Jurisdiction and Request for EJR***

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

As previously noted, all of the participants in this group case appealed from the FFY 2022 IPPS Final Rule.[43] The Board has determined that (1) the participants' documentation in the group appeal shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal;[44] (2) the appeals were timely filed; and (3) Board review of the matter in this appeal is not precluded by statute or regulation. In finding that the group meets the $50,000 amount in controversy, the Board recognizes that amounts in controversy illustrate the difference between the "current rural floor calculation" and "if [the] rural floor were calculated correctly."[45] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractors for the actual final amounts in each case.

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

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

> (1) *General Requirement*. In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in

[43] 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.
[44] *See* 42 C.F.R. § 405.1837.
[45] *E.g.*, Case No. 22-0732, Impact Calculation, Alta View Hospital (Prov. No. 46-0044).

> paragraph (j)(3) of this section), **must include an appropriate claim for the specific item**, by either—
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> (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
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> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
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> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
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> (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
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> (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.[46]

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.

[46] (Bold and underline emphasis added.)

> (b) *Summary of Procedures*.
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> (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-*
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> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
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> (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-*
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> (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**.[47]

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

> give the parties an adequate opportunity to submit factual evidence and legal argument regarding the question of whether the provider's cost report included an appropriate claim for the specific item under

[47] (Bold and underline emphasis added.)

> 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.

Board Rule 44.5.2 (2021) governs the timing for filing substantive claim challenges pursuant to 42 C.F.R. § 405.1873(a) and reads:

> A party that questions whether the one or more participants in a group case (CIRP or optional) included an appropriate claim *on the cost report at issue* for the common issue being appealed in the group ***must file a Substantive Claim Challenge sixty (60) days after the group files its final Schedule of Providers (SOP) unless the moving party's filing demonstrates good cause***.[48] The moving party must summarize in its Substantive Claim Challenge the efforts that it made to contact the opposing party to discuss the merits of the Substantive Claim Challenge. If the moving party has attempted to confer but has been unsuccessful, briefly describe the attempts made. *See* sample language in Rule 44.2. The opposing party(ies) has thirty (30) days to respond (including in the context of an EJR filing).
> - *Expedited Challenge Filing Deadline When an EJR Request Is Filed per Board Rule 42.---If the final SOP is filed concurrent with an EJR request or 60 days has not yet transpired between the filing of the final SOP and the EJR request, then refer to Rule 44.6 for special instructions on deadlines for filing Substantive Claim Challenges and any response thereto.*

For group cases where an EJR Request is filed within 60 days of the Final Schedule of Providers, Board Rule 44.6 (2021) governs. In those instances:

> . . . the Medicare Contractor (or any other moving party) has five (5) business days to either:
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> 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).

[48] (Emphasis added.)

> 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***.

In Case 22-0732GC, the Providers certified that the group was complete and fully populated in OH CDMS pursuant to Board Rule 20, effectively finalizing its Schedule of Providers, on **February 8, 2023**. A Substantive Claim Challenge was not filed until **January 19, 2026**, well beyond the sixty (60) day timeframe for filing the challenge mandated by Board Rule 44.5.2 (2021). Since this challenge was not timely, the Board declines to consider it.

In Case 22-0733GC, the Providers certified that the group was complete and fully populated in OH CDMS pursuant to Board Rule 20, effectively finalizing its Schedule of Providers, on **February 8, 2023**. A Substantive Claim Challenge was not filed until **January 22, 2026**, well beyond the sixty (60) day timeframe for filing the challenge mandated by Board Rule 44.5.2 (2021). Since this challenge was not timely, the Board declines to consider it.

In Case 22-0740GC, the Providers certified that the group was complete and fully populated in OH CDMS pursuant to Board Rule 20, effectively finalizing its Schedule of Providers, on **February 8, 2023**. A Substantive Claim Challenge was not filed until **January 22, 2026**, well beyond the sixty (60) day timeframe for filing the challenge mandated by Board Rule 44.5.2 (2021). Since this challenge was not timely, the Board declines to consider it.

In Case 23-1393G, the Providers certified that the group was complete and fully populated in OH CDMS pursuant to Board Rule 20, effectively finalizing its Schedule of Providers, on **July 19, 2024**. A Substantive Claim Challenge was not filed until **January 22, 2026**, well beyond the sixty (60) day timeframe for filing the challenge mandated by Board Rule 44.5.2 (2021). Since this challenge was not timely, the Board declines to consider it.

In Case 22-0735GC, the Providers certified that the group was complete and fully populated in OH CDMS pursuant to Board Rule 20, effectively finalizing its Schedule of Providers, on **February 8, 2023.** A Substantive Claim Challenge was not filed until April 4, 2024, well beyond the sixty (60) day timeframe for filing the challenge mandated by Board Rule 44.5.2 (2021). Since this challenge was not timely, the Board declines to consider it.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[49] 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.[50] In these group cases, the Medicare Contractor has failed to file a Substantive Claim Challenge[51] in accordance

[49] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[50] *See* 42 C.F.R. § 405.1873(a).
[51] Board Rule 44.5 (2023) 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."

with Board Rules 44.5.2 and 44.6 (2021) for any of the Providers with FYEs December 31, 2016.

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[52] 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).

### *3. Analysis Regarding Appealed Issue*

As set forth below, the Board finds that the Secretary's determination to (1) "calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103)"; and (2) "for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . . (as implemented at § 412.103) from the calculation of 'the wage index for rural areas in the State in which the county is located' referred to in section [1395ww](d)(8)(C)(iii). . . ."[53] was made through notice and comment in the form of an uncodified regulation.[54]

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

> After consideration of the public comments we received, for the reasons discussed in this final rule and in the proposed rule, we are finalizing without modification our proposal to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103). Additionally, we are finalizing without modification our proposal, for purposes of applying the provisions of section 1886(d)(8)(C)(iii) of the Act, to remove the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103) from the calculation of "the wage index for rural areas in the State in which the county is located" referred to in section 1886(d)(8)(C)(iii) of the Act.[55]

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[52] The Board notes that Board Rule 10.2 (2023) 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."
[53] 84 Fed. Reg. 42044 at 42336.
[54] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals."
[55] 84 Fed. Reg. at 42336.

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as the "Uncodified Regulations on Rural Floor Calculation and Wage Index." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation.[56]

While this appeal involves the FFY 2022 IPPS Final Rule, the continuation of this policy was implemented in the same way as it was initially for FFY 2020.[57] The FY 2022 IPPS Final Rule did not make any changes to this policy. Therefore, the Board finds that this policy continues to be a binding but uncodified regulation for FFY 2022.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2022 IPPS Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulations on Rural Floor Calculation and Wage Index which they allege (1) does not treat reclassified "Section 401" hospitals as being located in a rural are as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[58] As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in Cases 22-0732GC, 22-0733GC, 22-0735GC, 22-0740GC, and 23-1393G.

***D. Board's Decision Regarding the EJR Request***

The Board finds that:

1) It has jurisdiction over the Uncodified Regulations on Rural Floor Calculation and Wage Index Issue for the subject year in Cases 22-0732GC, 22-0733GC, 22-0735GC, 22-0740GC, and 23-1393G and that the Providers in these group appeals are entitled to a hearing before the Board;

2) While the Providers appealed cost reporting periods beginning after January 1, 2016, no substantive claim challenges[59] have been filed pursuant to 42 C.F.R. § 405.1873(a) and in accordance with the Board's Rules to trigger either Board review under § 405.1873(b) or reporting under § 405.1873(d)(2);

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[56] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

[57] 86 Fed. Reg. 44774, 45175 (Aug. 12, 2021).

[58] Consolidated Petition for Expedited Judicial Review at 1, 5-6.

[59] As the Board explained in Board Rule 44.5 (2023), "[t]he Board adoption of the term "Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

3) Based upon the Providers' assertions regarding the FFY 2022 IPPS 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 codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2022 IPPS Final Rule is valid.

Accordingly, the Board finds that the question of the validity of the codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2022 IPPS Final Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject 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 Cases 22-0732GC, 22-0733GC, 22-0735GC, 22-0740GC, and 23-1393G and removes them from its docket.

Board Members Participating:

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

FOR THE BOARD:

2/2/2026

X Kevin D. Smith, CPA

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

Enclosure: Schedules of Providers

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Dean Wolfe, Noridian Healthcare Solutions (J-F)
Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Scott Berends, Esq., Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**Via Electronic Delivery**

Daniel Hettich, Esq.
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RE: ***Expedited Judicial Review Determination***

| | |
|---|---|
| 20-1659GC | *HonorHealth CY 2020 OPPS Section 401 Hospitals Rural Floor CIRP Group* |
| 20-1660GC | *Cleveland Clinic Fdn. CY 2020 OPPS Section 401 Hospitals Rural Floor CIRP Group* |
| 20-1661GC | *Trinity Health CY 2020 OPPS Section 401 Hospitals Rural Floor CIRP Group* |
| 20-1663GC | *BayCare Health CY 2020 OPPS Section 401 Hospitals Rural Floor CIRP Group* |
| 20-1664GC | *CHS CY 2020 OPPS Section 401 Hospitals Rural Floor CIRP Group* |
| 20-1665G | *King & Spalding CY 2020 OPPS Section 401 Hospitals Rural Floor Group* |

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Consolidated[1] Request for Expedited Judicial Review ("EJR") filed on **January 5, 2026** concerning the above referenced common issue related party ("CIRP") and optional group appeals. The Board's decision on jurisdiction and EJR for these six (6) cases are set forth below.

**Issue:**

The Petition for EJR describes the issue as follows:

> The Medicare statute provides that "Section 401" hospitals must be treated as being located in a rural area for all purposes under the IPPS system, *see* 42 U.S.C. § 1395ww(d)(8)(E), and that no urban hospital can be assigned a wage index that is lower than the wage index assigned to rural hospitals in the same state, *see* 42 U.S.C. § 1395ww note. CMS has also established that it uses the IPPS wage index for purposes of OPPS payments. 42 C.F.R. § 419.43(c)(1). In its rulemaking for the Inpatient Prospective Payment System and the Outpatient Prospective Payment System for fiscal year 2020, however, CMS announced a new rule that violates both of these statutory directives. Specifically, under CMS's new policy, Section 401 hospitals would not be treated as rural in calculating the rural floor, and urban hospitals will be assigned a lower wage index than the one applicable to rural hospitals in the state. The issue presented

[1] The Petition also included Case 20-1662GC, which will be addressed under separate cover.

> in these appeals is whether CMS's new wage index rule is unlawful because it conflicts with the unambiguous requirements of the Medicare statute.[2]

The Providers are requesting "that the Board grant EJR of the Providers appeals challenging the validity of CMS's rule excluding Section 401 hospitals from the calculation of the rural floor."[3]

**Statutory and Regulatory Background:**

***1. Wage Index; Rural and Urban Classification***

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[4] known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs"). The base payment rate is comprised of a standardized amount[5] for all subsection (d) hospitals located in an "urban" or "rural" area.[6]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[7] adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).[8]

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage

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[2] Case Nos. 20-1659GC *et al.*, Consolidated Petition for Expedited Judicial Review at 1-2 (Jan. 5, 2026).
[3] *Id.* at 10.
[4] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).
[5] The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27708, 27765-27766 (May 27, 1994). Section 1395ww(d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).
[6] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[7] of the Department of Health and Human Services.
[8] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index (last visited January 30, 2026).

index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives "an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts."[9]

In 1999, Congress recognized that in some cases, a hospital in one geographical area may compete for the same labor pool as hospitals in a nearby, larger urban area but receive lower reimbursement because they are geographically located in a lower wage index area. This resulted in some hospitals being underpaid for their labor costs. As a result, "Congress amended the Medicare Act in order to allow a hospital to seek reclassification from its geographically-based wage area to a nearby wage area for payment purposes if it met certain criteria"[10] and established the Medicare Geographic Review Board (MGCRB) to administer the reclassification process.[11,12]

Ten years after the MGCRB was established, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106-113).[13] This legislation instructed the Secretary that urban hospitals that applied to the MGCRB for redesignation as rural were to be treated as such. Hospitals that receive these redesignations are sometimes known as "Section 401," hospitals. Codified at 42 U.S.C. § 1395ww(d)(8)(E), the statute states that:

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

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[9] *Id.*
[10] *Robert Wood Johnson University Hosp. v. Thompson*, 297 F. 3d. 273, 276 (3d Cir. 2002).
[11] *Id.*
[12] 42 U.S.C. § 1395ww(d)(10)(D)(v).
[13] *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Public L. 106-113, app. F. § 401, 113, Stat. 1501, 1501A-321 (Nov. 29, 1999). Codified as 42 U.S.C. § 1395ww(d)(8).

> (III) The hospital would qualify as a rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.
> (IV) The hospital meets such other criteria as the Secretary may specify.[14]

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

> Hospitals qualifying under this section shall be eligible to qualify for all categories and designations available to rural hospitals, including sole community, Medicare dependent, critical access, and referral centers. Additionally, qualifying hospitals shall be eligible to apply to the [MGCRB] for geographic reclassification to another area. The [MGCRB] shall regard such hospitals as rural and as entitled to the exceptions extended to referral centers and sole community hospitals, if such hospitals are so designated.[15]

### *2. Rural Floor Adjustment*

In 1997, Congress observed that the calculation of the wage index for all regions of a state can sometimes result in "some urban hospitals being paid less than the average rural hospital in their state."[16] To correct this problem, in the Balanced Budget Act of 1997, Congress provided that the wage index assigned to a hospital in an urban area must be at least as great as the wage index assigned to rural hospitals within the same state. The statute provides that:

> For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)) may not be less than the area wage index applicable under such section to hospitals located in rural areas in the State in which the hospital is located.[17]

This provision is commonly referred to as the "rural floor."

### *3. Changes to the Wage Index Calculation*

In the FFY 2019 IPPS proposed rule,[18] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information ("RFI") as part of the FFY 2020 IPPS proposed rule.[19] Therein, the Secretary noted that many

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[14] *Id.* (emphasis added).
[15] H.R. Conf. Rep. No. 106-479, 512 (1999).
[16] H.R. Rep. No. 105-149, at 1305 (1997).
[17] 42 U.S.C. § 1395ww note (Floor on Area Wage Index).
[18] 83 Fed. Reg. 20164 (May 7, 2018).
[19] 84 Fed Reg 19158, 19393-94 (May 3, 2019).

respondents expressed: (1) "a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[20] In the FFY 2020 IPPS Final Rule, the Secretary proposed several policies to address wage index disparities.[21] Relevant to the issue under appeal here are the Secretary's proposals to prevent allegedly inappropriate payment increases due to rural reclassifications made under the provisions of 42 C.F.R. § 412.103.[22,23] The Secretary finalized without modification the proposals

- to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103); and
- for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . .(as implemented at § 412.103) from the calculation of ''the wage index for rural areas in the State in which the county is located'' referred to in section [1395ww](d)(8)(C)(iii). . . .[24]

The Secretary contends that this policy "is necessary and appropriate to address the unanticipated effects of rural reclassifications on the rural floor and resulting wage index disparities, including the effects of the manipulation of the rural floor by certain hospitals."[25] The Secretary concludes that "the inclusion of reclassified hospitals in the rural floor calculation has had the unforeseen

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[20] *Id.*
[21] *See generally* 84 Fed. Reg. 42044, 42336-42339 (Aug. 16, 2019).
[22] 42 C.F.R. § 412.103 states in relevant part that:

> (a) General criteria. A prospective payment hospital that is located in an urban area (as defined in subpart D of this part) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
> (1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification, the Rural–Urban Commuting Area codes, . . . .
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.
> *****
> (7) For a hospital with a main campus and one or more remote locations under a single provider agreement where services are provided and billed under the inpatient hospital prospective payment system and that meets the provider-based criteria at § 413.65 of this chapter as a main campus and a remote location of a hospital, the hospital is required to demonstrate that the main campus and its remote location(s) each independently satisfy the location conditions specified in paragraphs (a)(1) and (2) of this section.

[23] 84 Fed. Reg. at 42332.
[24] *Id.* at 42336.
[25] *Id.* at 42333.

effect of exacerbating the wage index disparities between low and high wage index hospitals."[26]

Under the 2020 IPPS Final Rule, the Secretary "would continue to calculate the rural floor based on the physical non-MSA area of the state, which is the same rural area to which a hospital is reclassified under section [1395ww](d)(8)(E). However, for purposes of calculating the rural floor wage index for a state, [the Secretary] would not include in the rural area the data of hospitals that have reclassified as rural under section [1395ww](d)(8)(E)."[27] The Secretary pointed out that the "legislative intent of the rural floor was to correct the 'anomaly' of 'some urban hospitals being paid less than the average rural hospital in their States.'"[28]

The Secretary found that "[u]nder the current rural floor wage index calculation, rather than raising the payment of some urban hospitals to the level of the average rural hospital in their State, urban hospitals may have their payments raised to the relatively high level of one or more geographically urban hospitals reclassified as rural."[29] The Secretary explained that "[w]hile urban hospitals in mostly rural states may benefit from an increase in the rural floor due to urban to rural reclassification . . . other states with high wage urban hospitals using [42 C.F.R.] § 412.103 reclassifications to raise the rural floor can mitigate those gains for mostly rural states, due to budget neutrality."[30] The Secretary believes that "excluding the data of hospitals that reclassify as rural under section [1395ww](d)(8)(E) from the rural floor wage index is necessary and appropriate to address these unanticipated effects of rural reclassifications on the rural floor and the resulting wage index disparities."[31]

The Secretary contends that his reimbursement calculation "is permissible under [42 U.S.C. § 1395ww](d)(8)(E) (as implemented by [42 C.F.R.] § 412.103) and the rural floor statute [42 U.S.C. § 1395ww(d) note]" and notes that the statute "does not specify where the wage data of reclassified hospitals must be included."[32] Therefore, the Secretary believes that he has the "discretion to exclude the wage index data of such hospitals from the calculation of the rural floor. Furthermore, the rural floor statute does not specify how the rural floor wage index is to be calculated or what data are to be included in the calculation."[33] Consequently, the Secretary believes that he has the "discretion under the rural floor statute to exclude the wage data of hospitals reclassified under section [1395ww](d)(8)(E) from the calculation of the rural floor.[34]

CMS has adopted the FY 2020 IPPS Final Rule's policy in its FY 2020 OPPS Final Rule, meaning for FFY 2020 it will calculate the rural floor in a state without reference to the wage

[26] *Id.*
[27] *Id.* at 42334.
[28] *Id.*
[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] *Id.*
[34] *Id.*

index that applies for any hospitals in that state which were reclassified as rural pursuant to Section 401.[35]

**Positions of the Parties:**

***1. Providers' Appeal Requests***

The Providers describe the appealed issue as follows:

> The Providers in this group appeal challenge the Secretary's calculation of the rural floor in the inpatient prospective payment system (IPPS) final rule for federal fiscal year (FY) 2020 to the extent that it has affected the calculation of the wage indices in the outpatient prospective payment system (OPPS) final rule for calendar year (CY) 2020.
>
> The methodology that the Secretary adopted to calculate the rural floor in the IPPS final rule for FY 2020 violates the plain meaning of the rural floor provision of the statute and the requirement to treat reclassified rural hospitals as rural hospitals for all purposes of the prospective payment system. In addition to understating the Providers' IPPS payments, the Secretary's errors in calculating the rural floor also affected the Providers' OPPS payments. This is because the Secretary's own regulations require him to use the IPPS wage index adjustment factors in calculating OPPS payments. 42 C.F.R. § 419.43(c).
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> ***
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> For wage index purposes, there are two types of geographic areas: urban and rural.
>
> ***
>
> When a hospital reclassifies as rural, its wage and hour data is included in the calculation of the state rural wage index adjustment in the next federal fiscal year.
> The Medicare statute contains a provision requiring that no urban hospital can be assigned a wage index adjustment that is lower than the wage index assigned to rural hospitals in the state.
>
> ***
>
> In the IPPS final rule for FY 2020, . . . [t]he rural wage index will continue to be calculated based on the average hourly wage of all rural hospitals and all urban hospitals that have reclassified as rural. The rural floor, however, will not include the wage and hour data of reclassified rural hospitals; it will be based solely on the wage data of naturally rural hospitals.

[35] 84 Fed. Reg. 61142, 61187-61188 (Nov. 12, 2019) (stating "as proposed, we are using the FY 2020 hospital IPPS post-reclassified wage index for urban and rural areas as the wage index under the OPPS to determine the wage adjustments for both the OPPS payment rate and the copayment standardized amount for CY 2020.").

> As a direct result of this policy, in FFY 2020, urban hospitals in some states have been assigned a wage index that is lower than the wage index assigned to rural hospitals in those states.
> This result violates the rural floor, which expressly prohibits the Secretary from assigning a wage index to urban hospitals that is lower than the wage index of rural hospitals in the same state. *See* 42 U.S.C. § 1395ww note. Even if this result did not violate the rural floor (it does), the Secretary's policy would separately violate 42 U.S.C. § 1395ww(d)(8)(E)(i), which requires the Secretary to treat a hospital that has elected to reclassify as rural as rural for the purposes of the prospective payment system.
>
> ***
>
> For the forging reasons, the Providers in this group appeal request that the Board reverse the Secretary's calculation of the rural floor for FY 2020 to the extent it calculated OPPS payments in CY 2020 and direct the Secretary to recalculate the OPPS wage index for CY 2020 in the manner required by the statute. [36]

### *2. Providers' Request for EJR*

The Providers filed their Petition for EJR to challenge CMS' new wage index rules as unlawful because it conflicts with the Medicare statute.[37] They argue that the FY 2020 rulemaking (1) does not treat reclassified "Section 401" hospitals as being located in a rural are as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[38]

They seek to have their wage indices recalculated in compliance with the requirements of the Medicare statute.[39] The Providers are specifically seeking the Board hold that:

> CMS's calculation of the FFY 2020 rural floor is unlawful because CMS does not have statutory authority to exclude data of Section 401 hospitals from the calculation of the rural floor and CMS cannot assign a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state, and to compel CMS to pay the Providers reimbursement that was withheld as a result of that regulation during the years under appeal.[40]

The Providers insist they have met the criteria set forth in 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), namely that the Board has jurisdiction over the appeal but lacks the authority to grant the relief the Providers seek.[41]

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[36] *E.g.*, Case No. 20-1659GC, Statement of the Issue at 1-2 (May 11, 2020).
[37] Consolidated Petition for Expedited Judicial Review at 5-6 (Jan. 5, 2026).
[38] *Id.* at 1, 5-6.
[39] *Id.* at 2.
[40] *Id.* at 7.
[41] *Id.* at 6-10.

### *3. Medicare Contractor's Position*

On **January 12, 2026**, the Medicare Contractor's designated representative, Federal Specialized Services, filed a response to the Consolidated Request for Expedited Judicial Review. It took no position on the Request for EJR but noted "that the MAC will file a substantive claim challenge in 20-1662GC . . . ."[42]

Therefore, Substantive Claim Challenges were not filed in the six (6) cases subject to this decision (Case No. 20-1662GC is being handled separately).

**Decision of the Board:**

The Providers participating in the group appeals included in this EJR request have filed their appeals from policies established in the FFY 2020 OPPS Final Rule published in the Federal Register.

### *1. Jurisdiction and Request for EJR*

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

As previously noted, all of the participants in these group cases appealed from the FFY 2020 OPPS Final Rule.[43] The Board has determined that (1) the participants' documentation in the group appeals show that the estimated amounts in controversy exceeds $50,000, as required for a group appeal;[44] (2) the appeals were timely filed; and (3) Board review of the matter in this appeal is not precluded by statute or regulation. In finding that the groups meet the $50,000 amount in controversy, the Board recognizes that the filed amounts in controversy illustrate the difference between the "Actual Wage Index FY '20" and the "Wage Index Required by Statute."[45] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractors for the actual final amounts in each case.

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[42] Response to Provider's Request for Expedited Judicial Review at 1 (Jan. 12, 2026).
[43] 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.
[44] *See* 42 C.F.R. § 405.1837.
[45] *E.g.*, Case No. 20-1659GC, Reimbursement Impact, HonorHealth Deer Valley Medical Center (Prov. No. 03-0092).

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

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

> (1) *General Requirement*. In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), **must include an appropriate claim for the specific item**, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **and describing** how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[46]

[46] (Bold and underline emphasis added.)

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

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider **must include in its cost report an appropriate claim for the specific item** (as prescribed in § 413.24(j) of this chapter). If the provider files an appeal to the Board seeking reimbursement for the specific item and any party to such appeal questions whether the provider's cost report included an appropriate claim for the specific item, the Board must address such question in accordance with the procedures set forth in this section.
>
> (b) *Summary of Procedures*.
>
> ***
>
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ***
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ***
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> (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**.[47]

These 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 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.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[48] 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.[49] In these cases, the Medicare Contractor has failed to file a Substantive Claim Challenge[50] within the time frame specified by Board Rule 44.5.1 (2023).

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[51] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d) for the participants in these cases.

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[47] (Bold and underline emphasis added.)
[48] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[49] *See* 42 C.F.R. § 405.1873(a).
[50] 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."
[51] 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."

### *3. Analysis Regarding Appealed Issue*

As set forth below, the Board finds that the Secretary's determination to (1) "calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103)"; and (2) "for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . . (as implemented at § 412.103) from the calculation of 'the wage index for rural areas in the State in which the county is located' referred to in section [1395ww](d)(8)(C)(iii). . . ."[52] was made through notice and comment in the form of an uncodified regulation.[53]

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

> After consideration of the public comments we received, for the reasons discussed in this final rule and in the proposed rule, we are finalizing without modification our proposal to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103). Additionally, we are finalizing without modification our proposal, for purposes of applying the provisions of section 1886(d)(8)(C)(iii) of the Act, to remove the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103) from the calculation of "the wage index for rural areas in the State in which the county is located" referred to in section 1886(d)(8)(C)(iii) of the Act.[54]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as the "Uncodified Regulations on Rural Floor Calculation and Wage Index." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation.[55]

While this appeal involves the FFY 2020 OPPS Final Rule, CMS has adopted the FY 2020 IPPS Final Rule's policy in its FY 2020 OPPS Final Rule, meaning for FFY 2020 it will calculate the rural floor in a state without reference to the wage index that applies for any hospitals in that

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[52] 84 Fed. Reg. 42044 at 42336.
[53] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals."
[54] 84 Fed. Reg. at 42336.
[55] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

state which were reclassified as rural pursuant to Section 401.[56] Therefore, the Board finds that this policy is a binding but uncodified regulation for FFY 2020 for the purposes of the OPPS.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2020 OPPS Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulations on Rural Floor Calculation and Wage Index which they allege (1) does not treat reclassified "Section 401" hospitals as being located in a rural are as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[57] As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in Cases 20-1659GC, 20-1660GC, 20-1661GC, 20-1663GC, 20-1664GC, and 20-1665G.

***D. Board's Decision Regarding the EJR Request***

The Board finds that:

1) It has jurisdiction over the Uncodified Regulations on Rural Floor Calculation and Wage Index Issue for the subject year in Cases 20-1659GC, 20-1660GC, 20-1661GC, 20-1663GC, 20-1664GC, and 20-1665G and that the Providers in these group appeals are entitled to a hearing before the Board;

2) While the Providers appealed cost reporting periods beginning after January 1, 2016, no substantive claim challenges[58] have been filed pursuant to 42 C.F.R. § 405.1873(a) to trigger either Board review under § 405.1873(b) or reporting under § 405.1873(d)(2);

3) Based upon the Providers' assertions regarding the FFY 2020 OPPS 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 codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2020 OPPS Final Rule is valid.

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[56] 84 Fed. Reg. 61187-61188 (Nov. 12, 2019) (stating "as proposed, we are using the FY 2020 hospital IPPS post-reclassified wage index for urban and rural areas as the wage index under the OPPS to determine the wage adjustments for both the OPPS payment rate and the copayment standardized amount for CY 2020.").
[57] Consolidated Petition for Expedited Judicial Review at 1, 5-6.
[58] As the Board explained in Board Rule 44.5, "[t]he Board adoption of the term "Substantive Claim Challenge' simply refers to any question raised by a party concerning whether *the cost report at issue* included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

Accordingly, the Board finds that the question of the validity of the codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2020 OPPS 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 Cases 20-1659GC, 20-1660GC, 20-1661GC, 20-1663GC, 20-1664GC, and 20-1665G and removes them from its docket.

Board Members Participating:

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

FOR THE BOARD:

2/2/2026

X Kevin D. Smith, CPA

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

Enclosure: Schedule of Providers

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Dean Wolfe, Noridian Healthcare Solutions (J-F)
Goeff Pike, First Coast Services Options, Inc. c/o GuideWell Source (J-N)
Danelle Decker, National Government Services, Inc. (J-K)
Scott Berends, Esq., Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**Via Electronic Delivery**

Daniel Hettich, Esq.
King & Spalding, LLP
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Washington, DC 20006

RE: ***Expedited Judicial Review Determination***
21-1089GC *CHS FFY 2021 IPPS Section 401 Hospitals Rural Floor CIRP Group*

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Consolidated Request for Expedited Judicial Review ("EJR") filed on **January 5, 2026** concerning the above referenced common issue related party ("CIRP") group appeal. The Board's decision on jurisdiction and EJR for this case are set forth below.[1]

**Issue:**

The Petition for EJR describes the issue as follows:

> The Medicare statute provides that "Section 401" hospitals must be treated as being located in a rural area for all purposes under the IPPS system, *see* 42 U.S.C. § 1395ww(d)(8)(E), and that no urban hospital can be assigned a wage index that is lower than the wage index assigned to rural hospitals in the same state, *see* 42 U.S.C. § 1395ww note. In its rulemaking for the Inpatient Prospective Payment System for fiscal year 2020, and carried forward to FFY 2021, however, CMS announced a new rule that violates both of these statutory directives. Specifically, under CMS's new policy, Section 401 hospitals would not be treated as rural in calculating the rural floor, and urban hospitals will be assigned a lower wage index than the one applicable to rural hospitals in the state. The issue presented in these appeals is whether CMS's new wage index rule is unlawful because it conflicts with the unambiguous requirements of the Medicare statute.[2]

[1] The Consolidated Request also included Case Nos. 21-1088GC, 21-1090GC, 21-1106GC, and 21-1107GC. Those four (4) cases sit in a different procedural posture with regard to Substantive Claim Challenges and are being addressed under separate cover.
[2] Case Nos. 21-1088GC *et al.*, Consolidated Petition for Expedited Judicial Review at 1 (Jan. 5, 2026).

The Providers are requesting "that the Board grant EJR of the Providers appeals challenging the validity of CMS's rule excluding Section 401 hospitals from the calculation of the rural floor."[3]

**Statutory and Regulatory Background:**

*1. Wage Index; Rural and Urban Classification*

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[4] known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs"). The base payment rate is comprised of a standardized amount[5] for all subsection (d) hospitals located in an "urban" or "rural" area.[6]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[7] adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).[8]

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives an "average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the

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[3] *Id.* at 10.
[4] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).
[5] The standardized amount is based on per discharge averages from a base period which are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27708, 27765-27766 (May 27, 1994). Section 1395ww(d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).
[6] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[7] of the Department of Health and Human Services.
[8] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index (last visited January 30, 2026).

nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts."[9]

In 1999, Congress recognized that in some cases, a hospital in one geographical area may compete for the same labor pool as hospitals in a nearby, larger urban area but receive lower reimbursement because they are geographically located in a lower wage index area. This resulted in some hospitals being underpaid for their labor costs. As a result, "Congress amended the Medicare Act in order to allow a hospital to seek reclassification from its geographically-based wage area to a nearby wage area for payment purposes if it meets certain criteria"[10] and established the Medicare Geographic Review Board (MGCRB) to administer the reclassification process.[11,12]

Ten years after the MGCRB was established, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106-113).[13] This legislation instructed the Secretary that urban hospitals that applied to the MGCRB for redesignation as rural were to be treated as such. Hospitals that receive these redesignations are sometimes known as "Section 401" hospitals. Codified at 42 U.S.C. § 1395ww(d)(8)(E), the statute states that:

> (E)(i) For purposes of this subsection, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital described in clause (ii), the Secretary ***shall treat the hospital as being located in the rural area*** (as defined in paragraph (2)(D)) of the State in which the hospital is located.
> (ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban area (as defined in paragraph (2)(D)) and satisfies any of the following criteria:
> (I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).
> (II) The hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).
> (III) The hospital would qualify as a rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.
> (IV) The hospital meets such other criteria as the Secretary may specify.[14]

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[9] *Id.*
[10] *Robert Wood Johnson University Hosp. v. Thompson*, 297 F. 3d. 273, 276 (3d Cir. 2002)
[11] *Id.*
[12] 42 U.S.C. § 1395ww(d)(10)(D)(v).
[13] *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Public L. 106-113, app. F. § 401, 113, Stat. 1501, 1501A-321 (Nov. 29, 1999). Codified as 42 U.S.C. § 1395ww(d)(8).
[14] *Id.* (emphasis added).

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

> Hospitals qualifying under this section shall be eligible to qualify for all categories and designations available to rural hospitals, including sole community, Medicare dependent, critical access, and referral centers. Additionally, qualifying hospitals shall be eligible to apply to the [MGCRB] for geographic reclassification to another area. The [MGCRB] shall regard such hospitals as rural and as entitled to the exceptions extended to referral centers and sole community hospitals, if such hospitals are so designated.[15]

### *2. Rural Floor Adjustment*

In 1997, Congress observed that the calculation of the wage index for all regions of a state can sometimes result in "some urban hospitals being paid less than the average rural hospital in their state."[16] To correct this problem, in the Balanced Budget Act of 1997, Congress provided that the wage index assigned to a hospital in an urban area must be at least as great as the wage index assigned to rural hospitals within the same state. The statute provides that:

> For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)) may not be less than the area wage index applicable under such section to hospitals located in rural areas in the State in which the hospital is located.[17]

This provision is commonly referred to as the "rural floor."

### *3. Changes to the Wage Index Calculation*

In the FFY 2019 IPPS proposed rule,[18] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information ("RFI") as part of the FFY 2020 IPPS proposed rule.[19] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[20] In the

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[15] H.R. Conf. Rep. No. 106-479, 512 (1999).
[16] H.R. Rep. No. 105-149, at 1305 (1997).
[17] 42 U.S.C. § 1395ww note (Floor on Area Wage Index).
[18] 83 Fed. Reg. 20164 (May 7, 2018).
[19] 84 Fed Reg 19158, 19393-94 (May 3, 2019).
[20] *Id.*

FFY 2020 IPPS Final Rule, the Secretary proposed several policies to address wage index disparities.[21] Relevant to the issue under appeal here are the Secretary's proposals to prevent allegedly inappropriate payment increases due to rural reclassifications made under the provisions of 42 C.F.R. § 412.103.[22,23] The Secretary finalized without modification the proposals

- to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103); and
- for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . .(as implemented at § 412.103) from the calculation of ''the wage index for rural areas in the State in which the county is located'' referred to in section [1395ww](d)(8)(C)(iii). . . .[24]

The Secretary contends that this policy "is necessary and appropriate to address the unanticipated effects of rural reclassifications on the rural floor and resulting wage index disparities, including the effects of the manipulation of the rural floor by certain hospitals."[25] The Secretary concludes that "the inclusion of reclassified hospitals in the rural floor calculation has had the unforeseen effect of exacerbating the wage index disparities between low and high wage index hospitals."[26]

Under the 2020 IPPS Final Rule, the Secretary "would continue to calculate the rural floor based on the physical non-MSA area of a state, which is the same rural area to which a hospital is reclassified under section [1395ww](d)(8)(E). However, for purposes of calculating the rural

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[21] *See generally* 84 Fed. Reg. 42044, 42336-42339 (Aug. 16, 2019).
[22] 42 C.F.R. § 412.103 states in relevant part that:

> (a) General criteria. A prospective payment hospital that is located in an urban area (as defined in subpart D of this part) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
> (1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification, the Rural–Urban Commuting Area codes, . . . .
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.
> *****
> (7) For a hospital with a main campus and one or more remote locations under a single provider agreement where services are provided and billed under the inpatient hospital prospective payment system and that meets the provider-based criteria at § 413.65 of this chapter as a main campus and a remote location of a hospital, the hospital is required to demonstrate that the main campus and its remote location(s) each independently satisfy the location conditions specified in paragraphs (a)(1) and (2) of this section.

[23] *Id.* 84 Fed. Reg. at 42332.
[24] *Id.* at 42336.
[25] *Id.* at 42333.
[26] *Id.*

floor wage index for a state, [the Secretary] would not include in the rural area the data of hospitals that have reclassified as rural under section [1395]ww(d)(8)(E)."[27] The Secretary pointed out that the "legislative intent of the rural floor was to correct the 'anomaly' of 'some urban hospitals being paid less than the average rural hospital in their States.'"[28]

The Secretary found that "[u]nder the current rural floor wage index calculation, rather than raising the payment of some urban hospitals to the level of the average rural hospital in their State, urban hospitals may have their payments raised to the relatively high level of one or more geographically urban hospitals reclassified as rural."[29] The Secretary explained that "[w]hile urban hospitals in mostly rural states may benefit from an increase in the rural floor due to urban to rural reclassification . . . other states with high wage urban hospitals using [42 C.F.R.] § 412.103 reclassifications to raise the rural floor can mitigate those gains for mostly rural states, due to budget neutrality."[30] The Secretary believes that "excluding the data of hospitals that reclassify as rural under section [1395ww](d)(8)(E) from the rural floor wage index is necessary and appropriate to address these unanticipated effects of rural reclassifications on the rural floor and the resulting wage index disparities."[31]

The Secretary contends that his reimbursement calculation "is permissible under [42 U.S.C. § 1395ww](d)(8)(E) (as implemented by [42 C.F.R.] § 412.103) and the rural floor statute [42 U.S.C. § 1395ww(d) note]" and notes that the statute "does not specify where the wage data of reclassified hospitals must be included."[32] Therefore, the Secretary believes that he has the "discretion to exclude the wage index data of such hospitals from the calculation of the rural floor. Furthermore, the rural floor statute does not specify how the rural floor wage index is to be calculated or what data are to be included in the calculation."[33] Consequently, the Secretary believes that he has the "discretion under the rural floor statute to exclude the wage data of hospitals reclassified under section [1395ww](d)(8)(E) from the calculation of the rural floor."[34]

CMS has adopted the FY 2020 IPPS Final Rule's policy in its FY 2021 IPPS Final Rule, meaning for FFY 2021 it will calculate the rural floor in a state without reference to the wage index that applies for any hospitals in that state which were reclassified as rural pursuant to Section 401.[35]

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[27] *Id.* at 42334.
[28] *Id.*
[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] *Id.*
[34] *Id.*
[35] 85 Fed. Reg. 58432, 58766 (Sept. 18, 2020).

**Positions of the Parties:**

***1. Providers' Appeal Requests***

The Providers describe the appealed issue as follows:

> The Providers in this group appeal challenge the Secretary's calculation of the rural floor for federal fiscal year (FFY) 2021. The Secretary's calculation violates the plain meaning of the rural floor provision of the statute and the requirement to treat reclassified rural hospitals as rural hospitals for all purposes of the prospective payment system.
>
> ***
>
> For wage index purposes, there are two types of geographic areas: urban and rural.
>
> ***
>
> When a hospital reclassifies as rural, its wage and hour data is included in the calculation of the state rural wage index adjustment in the next federal fiscal year.
> The Medicare statute contains a provision requiring that no urban hospital can be assigned a wage index adjustment that is lower than the wage index assigned to rural hospitals in the state.
>
> ***
>
> In the Inpatient Prospective Payment System Rulemaking for FFY 2020, the . . . . rural wage index will continue to be calculated based on the average hourly wage of all rural hospitals and all urban hospitals that have reclassified as rural. The rural floor, however, will not include the wage and hour data of reclassified rural hospitals; it will be based solely on the wage data of naturally rural hospitals. The Secretary continued this policy in FFY 2021. As a direct result of this policy, in FFY 2021, urban hospitals in some states have been assigned a wage index that is lower than the wage index assigned to rural hospitals in those states.
>
> ***
>
> This result violates the rural floor, which expressly prohibits the Secretary from assigning a wage index to urban hospitals that is lower than the wage index of rural hospitals in the same state. *See* 42 U.S.C. § 1395ww note. Even if this result did not violate the rural floor (it does), the Secretary's policy would separately violate 42 U.S.C. § 1395ww(d)(8)(E)(i), which requires the Secretary to treat a hospital that has elected to reclassify as rural as rural for the purposes of the prospective payment system.
>
> ***

> For the forging reasons, the Providers in this group appeal are seeking reversal of CMS's policy of divorcing the rural floor from the rural wage index.[36]

### *2. Providers' Request for EJR*

The Providers filed their Petition for EJR to challenge CMS' new wage index rules as unlawful because it conflicts with the Medicare statute.[37] They argue that the FY 2020 rulemaking (1) does not treat reclassified "Section 401" hospitals as being located in a rural area, as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[38]

They seek to have their wage indices recalculated in compliance with the requirements of the Medicare statute.[39] The Providers are specifically seeking the Board hold that:

> CMS's calculation of the FFY 2021 rural floor is unlawful because CMS does not have statutory authority to exclude data of Section 401 hospitals from the calculation of the rural floor and CMS cannot assign a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state, and to compel CMS to pay the Providers reimbursement that was withheld as a result of that regulation during the years under appeal.[40]

The Providers insist they have met the criteria set forth in 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), namely that the Board has jurisdiction over the appeal but lacks the authority to grant the relief the Provider seeks.[41]

### *3. Medicare Contractor's Position*

On **January 12, 2026**, the Medicare Contractor's designated representative, Federal Specialized Services, filed a response to the Consolidated Request for Expedited Judicial Review. It took no position on the Request for EJR but noted that a Substantive Claim Challenge had been previously filed in this case on **December 28, 2022**.[42] The Substantive Claim Challenge is addressed below.

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[36] Statement of the Issue at 1-2 (Mar. 16, 2021).
[37] Consolidated Petition for Expedited Judicial Review at 5-6 (Jan. 5, 2026).
[38] *Id.* at 1, 5-6.
[39] *Id.* at 1-2.
[40] *Id.* at 7.
[41] *Id.* at 6-10.
[42] Response to Provider's Request for Expedited Judicial Review at 1 (Jan. 12, 2026).

**Decision of the Board:**

The Providers participating in this group appeal included in this EJR request have filed their appeals from policies established in the FFY 2021 IPPS Final Rule published in the Federal Register.

***1. Jurisdiction and Request for EJR***

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

As previously noted, all of the participants in this group case appealed from the FFY 2021 IPPS Final Rule.[43] The Board has determined that (1) the participants' documentation in the group appeal shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal;[44] (2) the appeals were timely filed; and (3) Board review of the matter in this appeal is not precluded by statute or regulation. In finding that the group meets the $50,000 amount in controversy, the Board recognizes that the filed amounts in controversy illustrate the difference between the "current rural floor calculation" and "if [the] rural floor were calculated correctly."[45] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractors for the actual final amounts in each case.

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

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

> (1) *General Requirement*. In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in

[43] 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.
[44] *See* 42 C.F.R. § 405.1837.
[45] *E.g.*, Impact Calculation, Northwest Medical Center (Prov. No. 03-0085).

> paragraph (j)(3) of this section), **must include an appropriate claim for the specific item**, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **and describing** how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[46]

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.

[46] (Bold and underline emphasis added.)

> (b) *Summary of Procedures*.
>
> ***
>
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ***
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ***
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> (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**.[47]

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

> give the parties an adequate opportunity to submit factual evidence and legal argument regarding the question of whether the provider's cost report included an appropriate claim for the specific item under

[47] (Bold and underline emphasis added.)

> 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.

Board Rule 44.5.2 (2021) requires that a party which questions whether any participants in a group case included an appropriate claim on the cost report at issue must file a Substantive Claim Challenge within sixty (60) days of the final Schedule of Providers being filed. In this case, the Providers' representative acknowledged that the group was complete and fully populated in OH CDMS pursuant to Board Rule 20, effectively finalizing the Schedule of Providers, on **March 16, 2022**. FSS filed a Substantive Claim Challenge on **December 28, 2022**, and a Response was filed on **January 27, 2023**.

Pursuant to Board Rule Board Rule 44.5.2 (2021), any Substantive Claim Challenges would have typically been due no later than **May 16, 2022**. The deadline to file the challenge, however, was indefinitely stayed via Board Alert 19 due to the public health emergency created by the COVID-19 pandemic. (*Available at* https://www.cms.gov/files/document/prrb-alerts.pdf). This indefinite stay was lifted effective December 7, 2022 via Board Alert 23, 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.***" (*Available at* https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/current-prrb-alerts) (emphasis in original). There was no correspondence in Case 21-1089GC, or any general notice applicable to this case, which re-established deadlines for Substantive Claim Challenges. As such, the stay for the deadline for a Substantive Claim Challenge was never lifted and FSS' filing was not untimely.

*A.* Medicare Contractor's Argument

The Medicare Contractor claims that neither participant in this case made an appropriate claim on its cost report for the issue under appeal.

For Northwest Medical Center (03-0085) FYE 09/30/2021, the Medicare Contractor notes that the cost report identified $5,058,207 in Part A protested amounts with a Summary of Protested Amounts, but that this did not identify any amount for the IPPS Section 401 Hospital Rural Floor issue on appeal as a protested item.[48]

For Oro Valley Hospital (03-0114) FYE 09/30/2021, the Medicare Contractor notes that the cost report identified $928,352 in Part A protested amounts with a Summary of Protested Amounts, but that this did not identify any amount for the IPPS Section 401 Hospital Rural Floor issue on appeal as a protested item.[49]

[48] Substantive Claim Letter at 3-4 (Dec. 28, 2022).
[49] *Id.* at 4.

B. Group Representative's Argument

The Providers do not dispute that they failed to include an appropriate cost report claim for the issue under appeal. Instead, they argue that consideration of the Substantive Claim Challenge is premature because they could file amended cost reports which include additional self-disallowed items.[50] They acknowledge, however, that the Medicare Contractor may exercise its discretion to deny any amended cost reports submitted.[51] The remainder of the response argues that the regulations requiring an appropriate cost report claim are unlawful and unenforceable. They cite *Bethesda Hosp. Ass'n v. Bowen*[52] and *Banner Heart Hospital v. Burwell*[53] in support of their position that these regulations are unlawful.[54]

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

The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[55] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

The Providers do not dispute that they failed to include an appropriate cost report claim for the IPPS Section 401 Hospital Rural Floor issue under appeal, and the Board finds that they did not.

### *3. Analysis Regarding Appealed Issue*

As set forth below, the Board finds that the Secretary's determination to (1) "calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103)"; and (2) "for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . . (as implemented at § 412.103) from the calculation of 'the wage index for rural areas in the State in which the county is located' referred to in section [1395ww](d)(8)(C)(iii). . . ."[56] was made through notice and comment in the form of an uncodified regulation.[57]

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[50] Response to MAC's Substantive Claim Letter at 1, 4 (Jan. 27, 2023).
[51] *Id.* at 4.
[52] 485 U.S. 399 (1988).
[53] 201 F.Supp.3d 131 (D.D.C. 2016)
[54] Response to MAC's Substantive Claim Letter at 4-6.
[55] (Emphasis added.)
[56] 84 Fed. Reg. 42044 at 42336.
[57] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals."

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

> After consideration of the public comments we received, for the reasons discussed in this final rule and in the proposed rule, we are finalizing without modification our proposal to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103). Additionally, we are finalizing without modification our proposal, for purposes of applying the provisions of section 1886(d)(8)(C)(iii) of the Act, to remove the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103) from the calculation of "the wage index for rural areas in the State in which the county is located" referred to in section 1886(d)(8)(C)(iii) of the Act.[58]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as the "Uncodified Regulations on Rural Floor Calculation and Wage Index." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation.[59]

While this appeal involves the FFY 2021 IPPS Final Rule, the continuation of this policy was implemented in the same way as it was initially for FFY 2020.[60] The FY 2021 IPPS Final Rule did not make any changes to this policy. Therefore, the Board finds that this policy continues to be a binding but uncodified regulation for FFY 2021.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2021 IPPS Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulations on Rural Floor Calculation and Wage Index which they allege (1) does not treat reclassified "Section 401" hospitals as being located in a rural are as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[61] As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in the Case 21-1089GC.

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[58] 84 Fed. Reg. at 42336.
[59] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."
[60] 85 Fed. Reg. 58,432, 58,766 (Sept. 18, 2020).
[61] Consolidated Petition for Expedited Judicial Review at 1, 5-6.

***D. Board's Decision Regarding the EJR Request***

The Board finds that:

1) It has jurisdiction over the Uncodified Regulations on Rural Floor Calculation and Wage Index Issue for the subject year in Case 21-1089GC and that the Providers in this group appeal are entitled to a hearing before the Board;

2) The review process in 42 C.F.R. § 405.1873(a)-(b) has been triggered for both Providers in this case and the Board specifically finds that both 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);

3) Based upon the Providers' assertions regarding the FFY 2021 IPPS 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 codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2021 IPPS Final Rule is valid.

Accordingly, the Board finds that the question of the validity of the codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2021 IPPS Final Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject year.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this group case, the Board hereby closes Case 21-1089GC 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:

2/2/2026

X Kevin D. Smith, CPA

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

Enclosure: Schedule of Providers

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Scott Berends, Esq., Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**Via Electronic Delivery**

Daniel Hettich, Esq.
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Washington, DC 20006

RE: ***Expedited Judicial Review Determination***
Case Number: 21-1108
University of Utah Hospitals and Clinics (Provider Number 46-0009)
Federal Fiscal Year 2021

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's Request for Expedited Judicial Review ("EJR") filed on **January 5, 2026** concerning the above referenced individual appeal. The Board's decision on jurisdiction and EJR for this case are set forth below.

**Issue:**

The Petition for EJR describes the issue as follows:

> The Medicare statute provides that "Section 401" hospitals must be treated as being located in a rural area for all purposes under the IPPS system, *see* 42 U.S.C. § 1395ww(d)(8)(E), and that no urban hospital can be assigned a wage index that is lower than the wage index assigned to rural hospitals in the same state, *see* 42 U.S.C. § 1395ww note. In its rulemaking for the Inpatient Prospective Payment System for fiscal year 2020, and carried forward to FFY 2021, however, CMS announced a new rule that violates both of these statutory directives. Specifically, under CMS's new policy, Section 401 hospitals would not be treated as rural in calculating the rural floor, and urban hospitals will be assigned a lower wage index than the one applicable to rural hospitals in the state. The issue presented in these appeals is whether CMS's new wage index rule is unlawful because it conflicts with the unambiguous requirements of the Medicare statute.[1]

The Provider is requesting "that the Board grant EJR of the Provider's appeal challenging the validity of CMS's rule excluding Section 401 hospitals from the calculation of the rural floor."[2]

[1] Petition for Expedited Judicial Review at 1 (Jan. 5, 2026).
[2] *Id.* at 9.

**Statutory and Regulatory Background:**

***1. Wage Index; Rural and Urban Classification***

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[3] known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs"). The base payment rate is comprised of a standardized amount[4] for all subsection (d) hospitals located in an "urban" or "rural" area.[5]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[6] adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).[7]

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

[3] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).
[4] The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27708, 27765-27766 (May 27, 1994). Section 1395ww(d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).
[5] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[6] of the Department of Health and Human Services.
[7] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index (last visited January 30, 2026).

the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts."[8]

In 1999, Congress recognized that in some cases, a hospital in one geographical area may compete for the same labor pool as hospitals in a nearby, larger urban area but receive lower reimbursement because they are geographically located in a lower wage index area. This resulted in some hospitals being underpaid for their labor costs. As a result, "Congress amended the Medicare Act in order to allow a hospital to seek reclassification from its geographically-based wage area to a nearby wage area for payment purposes if it meets certain criteria"[9] and established the Medicare Geographic Review Board (MGCRB) to administer the reclassification process.[10,11]

Ten years after the MGCRB was established, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106-113).[12] This legislation instructed the Secretary that urban hospitals that applied to the MGCRB for redesignation as rural were to be treated as such. Hospitals that receive these redesignations are sometimes known as "Section 401" hospitals. Codified at 42 U.S.C. § 1395ww(d)(8)(E), the statute states that:

> (E)(i) For purposes of this subsection, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital described in clause (ii), the Secretary ***shall treat the hospital as being located in the rural area*** (as defined in paragraph (2)(D)) of the State in which the hospital is located.
> (ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban area (as defined in paragraph (2)(D)) and satisfies any of the following criteria:
> (I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).
> (II) The hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).
> (III) The hospital would qualify as a rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.
> (IV) The hospital meets such other criteria as the Secretary may specify.[13]

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[8] *Id.*
[9] *Robert Wood Johnson University Hosp. v. Thompson*, 297 F. 3d. 273, 276 (3d Cir. 2002)
[10] *Id.*
[11] 42 U.S.C. § 1395ww(d)(10)(D)(v).
[12] *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Public L. 106-113, app. F. § 401, 113, Stat. 1501, 1501A-321 (Nov. 29, 1999). Codified as 42 U.S.C. § 1395ww(d)(8).
[13] *Id.* (emphasis added).

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

> Hospitals qualifying under this section shall be eligible to qualify for all categories and designations available to rural hospitals, including sole community, Medicare dependent, critical access, and referral centers. Additionally, qualifying hospitals shall be eligible to apply to the [MGCRB] for geographic reclassification to another area. The [MGCRB] shall regard such hospital as rural and as entitled to the exceptions extended to referral centers and sole community hospitals, if such hospitals are so designated.[14]

### *2. Rural Floor Adjustment*

In 1997, Congress observed that the calculation of the wage index for all regions of a state can sometimes result in "some urban hospitals being paid less than the average rural hospital in their state."[15] To correct this problem, in the Balanced Budget Act of 1997, Congress provided that the wage index assigned to a hospital in an urban area must be at least as great as the wage index assigned to rural hospitals within the same state. The statute provides that:

> For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)) may not be less than the area wage index applicable under such section to hospitals located in rural areas in the State in which the hospital is located.[16]

This provision is commonly referred to as the "rural floor."

### *3. Changes to the Wage Index Calculation*

In the FFY 2019 IPPS proposed rule,[17] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information

[14] H.R. Conf. Rep. No. 106-479, 512 (1999).
[15] H.R. Rep. No. 105-149, at 1305 (1997).
[16] 42 U.S.C. § 1395ww note (Floor on Area Wage Index).
[17] 83 Fed. Reg. 20164 (May 7, 2018).

("RFI") as part of the FFY 2020 IPPS proposed rule.[18] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[19] In the FFY 2020 IPPS Final Rule, the Secretary proposed several policies to address wage index disparities.[20] Relevant to the issue under appeal here are the Secretary's proposals to prevent allegedly inappropriate payment increases due to rural reclassifications made under the provisions of 42 C.F.R. § 412.103.[21,22] The Secretary finalized without modification the proposals

- to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103); and
- for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . .(as implemented at § 412.103) from the calculation of 'the wage index for rural areas in the State in which the county is located' referred to in section [1395ww](d)(8)(C)(iii). . . .[23]

The Secretary contends that this policy "is necessary and appropriate to address the unanticipated effects of rural reclassification on the rural floor and resulting wage index disparities, including

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[18] 84 Fed Reg 19158, 19393-94 (May 3, 2019).
[19] *Id.*
[20] *See generally* 84 Fed. Reg. 42044, 42336-42339 (Aug. 16, 2019).
[21] 42 C.F.R. § 412.103 states in relevant part that:

> (a) General criteria. A prospective payment hospital that is located in an urban area (as defined in subpart D of this part) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
> (1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification, the Rural–Urban Commuting Area codes, . . . .
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.
> *****
> (7) For a hospital with a main campus and one or more remote locations under a single provider agreement where services are provided and billed under the inpatient hospital prospective payment system and that meets the provider-based criteria at § 413.65 of this chapter as a main campus and a remote location of a hospital, the hospital is required to demonstrate that the main campus and its remote location(s) each independently satisfy the location conditions specified in paragraphs (a)(1) and (2) of this section.

[22] *Id.* 84 Fed. Reg. at 42332.
[23] *Id.* at 42336.

the effects of the manipulation of the rural floor by certain hospitals."[24] The Secretary concludes that "the inclusion of reclassified hospitals in the rural floor calculation has had the unforeseen effect of exacerbating the wage index disparities between low and high wage index hospitals.[25]

Under the 2020 IPPS Final Rule, the Secretary "would continue to calculate the rural floor based on the physical non-MSA area of the state, which is the same rural area to which a hospital is reclassified under section [1395ww](d)(8)(E). However, for purposes of calculating the rural floor wage index for a state, [the Secretary] would not include in the rural area the data of hospitals that have been reclassified as rural under section [1395ww](d)(8)(E)."[26] The Secretary pointed out that the "legislative intent of the rural floor was to correct the 'anomaly' of 'some urban hospitals being paid less than the average rural hospital in their States.'"[27]

The Secretary found that "[u]nder the current rural floor wage index calculation, rather than raising the payment of some urban hospitals to the level of the average rural hospital in their State, urban hospitals may have their payments raised to the relatively high level of one or more geographically urban hospitals reclassified as rural."[28] The Secretary explained that "[w]hile urban hospitals in mostly rural states may benefit from an increase in the rural floor due to urban to rural reclassification . . . other states with high wage urban hospitals using [42 C.F.R.] § 412.103 reclassifications to raise the rural floor can mitigate those gains for mostly rural states, due to budget neutrality."[29] The Secretary believes that "excluding the data of hospitals that reclassify as rural under section [1395ww](d)(8)(E) from the rural floor wage index is necessary and appropriate to address these unanticipated effects of the rural reclassifications on the rural floor and the resulting wage index disparities."[30]

The Secretary contends that his reimbursement calculation "is permissible under [42 U.S.C. § 1395ww](d)(8)(E) (as implemented by [42 C.F.R.] § 412.103) and the rural floor statute [42 U.S.C. § 1395ww(d) note]" and notes that the statute "does not specify where the wage data of reclassified hospitals must be included."[31] Therefore, the Secretary believes that he has the "discretion to exclude the wage index data of such hospitals from the calculation of the rural floor. Furthermore, the rural floor statute does not specify how the rural floor wage index is to be calculated or what data are to be included in the calculation."[32] Consequently, the Secretary believes that he has the "discretion under the rural floor statute to exclude the wage data of hospitals reclassified under section [1395ww](d)(8)(E) from the calculation of the rural floor."[33]

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[24] *Id.* at 42333.
[25] *Id.*
[26] *Id.* at 42334.
[27] *Id.*
[28] *Id.*
[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] *Id.*

CMS has adopted the FY 2020 IPPS Final Rule's policy in its FY 2021 IPPS Final Rule, meaning for FFY 2021 it will calculate the rural floor in a state without reference to the wage index that applies for any hospitals in that state which were reclassified as rural pursuant to Section 401.[34]

**Positions of the Parties:**

***1. Provider's Appeal Request***

The Provider describes the appealed issue as follows:

> The Provider challenges the Secretary's calculation of the rural floor for federal fiscal year (FFY) 2021. The Secretary's calculation violates the plain meaning of the rural floor provision of the statute and the requirement to treat reclassified rural hospitals as rural hospitals for all purposes of the prospective payment system.
>
> ****
>
> For wage index purposes, there are two types of geographic areas: urban and rural.
>
> ***
>
> When a hospital reclassifies as rural, its wage and hour data is included in the calculation of the state rural wage index adjustment in the next federal fiscal year.
>
> The Medicare statute contains a provision requiring that no urban hospital can be assigned a wage index adjustment that is lower than the wage index assigned to rural hospitals in the state.
>
> ***
>
> In the Inpatient Prospective Payment System Rulemaking for FFY 2020, the . . . . rural wage index will continue to be calculated based on the average hourly wage of all rural hospitals and all urban hospitals that have reclassified as rural. The rural floor, however, will not include the wage and hour data of reclassified rural hospitals; it will be based solely on the wage data of naturally rural hospitals. The Secretary continued this policy in FFY 2021.
>
> As a direct result of this policy, in FFY 2021, urban hospitals in some states have been assigned a wage index that is lower than the wage index assigned to rural hospitals in those states.
>
> ***
>
> This result violates the rural floor, which expressly prohibits the Secretary from assigning a wage index to urban hospitals that is lower than the wage index of rural hospitals in the same state. *See* 42 U.S.C. § 1395ww note. Even if this result did not violate the rural floor (it does), the Secretary's

[34] 85 Fed. Reg. 58432, 58766 (Sept. 18, 2020).

> policy would separately violate 42 U.S.C. § 1395ww(d)(8)(E)(i), which requires the Secretary to treat a hospital that has elected to reclassify as rural as rural for the purposes of the prospective payment system.
>
> For the forging reasons, the Provider is seeking reversal of CMS's policy of divorcing the rural floor from the rural wage index.[35]

### *2. Provider's Request for EJR*

The Provider filed its Petition for EJR to challenge CMS' new wage index rules as unlawful because it conflicts with the Medicare statute.[36] It argues that the FY 2020 rulemaking (1) does not treat reclassified "Section 401" hospitals as being located in a rural area, as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[37]

It seeks to have its wage index recalculated in compliance with the requirements of the Medicare statute.[38] The Provider is specifically seeking the Board hold that:

> CMS's calculation of the FFY 2021 rural floor is unlawful because CMS does not have statutory authority to exclude data of Section 401 hospitals from the calculation of the rural floor and CMS cannot assign a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state, and to compel CMS to pay the Provider reimbursement that was withheld as a result of that regulation during the year under appeal.[39]

The Provider insists it has met the criteria set forth in 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), namely that the Board has jurisdiction over the appeal but lacks the authority to grant the relief the Provider seeks.[40]

### *3. Medicare Contractor's Position*

On **January 12, 2026**, the Medicare Contractor's designated representative, Federal Specialized Services ("FSS"), filed a response to the Request for Expedited Judicial Review. It took no position on the Request for EJR but noted "that the MAC will file a substantive claim challenge in this case."[41] A challenge was filed on **January 26, 2026**, which is addressed below.

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[35] Statement of the Issue at 1-2 (Mar. 17, 2021).
[36] Petition for Expedited Judicial Review at 5-6 (Jan. 5, 2026).
[37] *Id.* at 1, 5-6.
[38] *Id.* at 1.
[39] *Id.* at 7.
[40] *Id.* at 6-9.
[41] Response to Provider's Request for Expedited Judicial Review at 1 (Jan. 12, 2026).

**Decision of the Board:**

The Provider which filed this Request for EJR has filed its appeal from policies established in the FFY 2021 IPPS Final Rule published in the Federal Register.

***1. Jurisdiction and Request for EJR***

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

As previously noted, the Provider filed an individual appeal from the FFY 2021 IPPS Final Rule.[42] The Board has determined that (1) the Provider's documentation in shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal;[43] (2) the appeal was timely filed; and (3) Board review of the matter in this appeal is not precluded by statute or regulation. In finding that the Provider meets the $10,000 amount in controversy, the Board recognizes that amount in controversy illustrates the difference between the "current rural floor calculation" and "if [the] rural floor were calculated correctly" though the calculation erroneously refers to both FY 2021 and 2022 in separate locations.[44] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying Provider. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

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

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

> (1) *General Requirement*. In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in

[42] 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.
[43] *See* 42 C.F.R. § 405.1835(a)(2).
[44] Individual Appeal request, Impact Calculation.

> paragraph (j)(3) of this section), **must include an appropriate claim for the <u>specific</u> item**, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **<u>and</u> describing** how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[45]

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 <u>specific</u> 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.

[45] (Bold and underline emphasis added.)

> (b) *Summary of Procedures*.
>
> ***
>
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ***
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ***
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> (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**.[46]

These regulations are applicable to the cost reporting period under appeal for the Provider in the instant case, which has a cost reporting period 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 argument regarding the question of whether the provider's

[46] (Bold and underline emphasis added.)

> 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.

Board Rule 44.5.1 governs the timing of Substantive Claim Challenges filed pursuant 42 C.F.R. § 405.1873(a) in an individual appeal, and requires:

> A party that questions whether *the cost report at issue* included an appropriate reimbursement claim for one or more issues being appealed must file a Substantive Claim Challenge no later than the filing deadline for the Medicare contractor's preliminary position paper, unless the moving party's filing demonstrates good cause. The moving party must summarize in its Substantive Claim Challenge the efforts that it made to contact the opposing party to discuss the merits of the challenge. If the moving party has attempted to confer but has been unsuccessful, briefly describe the attempts made. *See* Rule 44.2 for sample language. The opposing party(ies) has thirty (30) days to respond (including in the context of an EJR filing).
>
> - *Expedited Challenge Filing Deadline When an EJR Request Is Filed Per Board Rule 42*.---If the provider files an EJR request prior to the Medicare contractor filing its preliminary position paper, then any Substantive Claim Challenge *on the issue that is the subject of the EJR request* must be filed within five (5) business days of the EJR request (to the extent it has not already been filed or unless the moving party demonstrates good cause). In this situation (and consistent with 42 C.F.R. §§ 405.1842(e)(3), (3)(ii) and 405.1873(b)(1), (d)(2) and Board Rule 42.1), the Board will then 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.

In the instant case, the Medicare Contractor has not filed its Preliminary Position Paper and the current deadline for doing so is **March 16, 2026,** so the expedited challenge filing deadline for any Substantive Claim Challenges was within five (5) business days of the Request for EJR. The Request for EJR was filed on **January 5, 2026**, so the deadline for filing a Substantive Claim Challenge was **January 12, 2026**. The Medicare Contractor's designated representative, Federal Specialized Services ("FSS") filed a Response to the Request for EJR on **January 12, 2026**,

which stated "that the MAC will file a substantive claim challenge in this case."[47] The challenge was filed on **January 26, 2026**, which was untimely pursuant to Board Rule 44.5.1 and, thus, the Board declines to consider the challenge.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[48] 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.[49] In this case, the Medicare Contractor has failed to file a Substantive Claim Challenge[50] within the time frame specified by Board Rule 44.5.1 (2023).

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a) and in compliance with the Board's Rules, whether an appropriate claim was made,[51] 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).

### *3. Analysis Regarding Appealed Issue*

As set forth below, the Board finds that the Secretary's determination to (1) "calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103)"; and (2) "for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . . (as implemented at § 412.103) from the calculation of 'the wage index for rural areas in the State in which the county is located' referred to in section [1395ww](d)(8)(C)(iii). . . ."[52] was made through notice and comment in the form of an uncodified regulation.[53]

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

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[47] Response to Provider's request for expedited judicial review at 1 (Jan. 12, 2026).
[48] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[49] *See* 42 C.F.R. § 405.1873(a).
[50] 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."
[51] 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."
[52] 84 Fed. Reg. 42044 at 42336.
[53] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals."

> After consideration of the public comments we received, for the reasons discussed in this final rule and in the proposed rule, we are finalizing without modification our proposal to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103). Additionally, we are finalizing without modification our proposal, for purposes of applying the provisions of section 1886(d)(8)(C)(iii) of the Act, to remove the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103) from the calculation of "the wage index for rural areas in the State in which the county is located" referred to in section 1886(d)(8)(C)(iii) of the Act.[54]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as the "Uncodified Regulations on Rural Floor Calculation and Wage Index." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation.[55]

While this appeal involves the FFY 2021 IPPS Final Rule, the continuation of this policy was implemented in the same way as it was initially for FFY 2020.[56] The FY 2021 IPPS Final Rule did not make any changes to this policy. Therefore, the Board finds that this policy continues to be a binding but uncodified regulation for FFY 2021.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2021 IPPS Final Rule and the Board does not have the authority to grant the relief sought by the Provider, namely invalidating the Uncodified Regulations on Rural Floor Calculation and Wage Index which it alleges (1) does not treat reclassified "Section 401" hospitals as being located in a rural are as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[57] As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in Case 21-1108.

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[54] 84 Fed. Reg. at 42336.
[55] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."
[56] 85 Fed. Reg. 58,432, 58,766 (Sept. 18, 2020).
[57] Consolidated Petition for Expedited Judicial Review at 1, 5-6.

***D. Board's Decision Regarding the EJR Request***

The Board finds that:

1) It has jurisdiction over the Uncodified Regulations on Rural Floor Calculation and Wage Index Issue for the subject year in Case 21-1108 and that the Provider in this appeal is entitled to a hearing before the Board;

2) While the Provider appealed a cost reporting period beginning after January 1, 2016, no substantive claim challenges[58] have been filed pursuant to 42 C.F.R. § 405.1873(a) and in accordance with the Board's Rules to trigger either Board review under § 405.1873(b) or reporting under § 405.1873(d)(2);

3) Based upon the Provider's assertions regarding the FFY 2021 IPPS 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 codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2021 IPPS Final Rule is valid.

Accordingly, the Board finds that the question of the validity of the codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2021 IPPS 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.

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 this case, the Board hereby closes Case 21-1108 and removes it from its docket.

[58] As the Board explained in Board Rule 44.5, "[t]he Board adoption of the term "Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

Board Members Participating:

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

FOR THE BOARD:

2/2/2026

X Kevin D. Smith, CPA

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

cc: Dean Wolfe, Noridian Healthcare Solutions (J-F)
Scott Berends, Esq., Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**Via Electronic Delivery**

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RE: ***Expedited Judicial Review Determination***
21-1088GC *Hartford Health FFY 2021 IPPS Section 401 Hospitals Rural Floor CIRP Group*
21-1090GC *Trinity New England FFY 2021 IPPS Section 401 Hospitals Rural Floor CIRP Group*

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Consolidated Request for Expedited Judicial Review ("EJR") filed on **January 5, 2026** concerning the above referenced common issue related party ("CIRP") group appeals. The Board's decision on jurisdiction and EJR for these two (2) cases are set forth below.[1]

**Issue:**

The Petition for EJR describes the issue as follows:

> The Medicare statute provides that "Section 401" hospitals must be treated as being located in a rural area for all purposes under the IPPS system, *see* 42 U.S.C. § 1395ww(d)(8)(E), and that no urban hospital can be assigned a wage index that is lower than the wage index assigned to rural hospitals in the same state, *see* 42 U.S.C. § 1395ww note. In its rulemaking for the Inpatient Prospective Payment System for fiscal year 2020, and carried forward to FFY 2021, however, CMS announced a new rule that violates both of these statutory directives. Specifically, under CMS's new policy, Section 401 hospitals would not be treated as rural in calculating the rural floor, and urban hospitals will be assigned a lower wage index than the one applicable to rural hospitals in the state. The issue presented in these appeals is whether CMS's new wage index rule is unlawful because it conflicts with the unambiguous requirements of the Medicare statute.[2]

[1] The Consolidated Request for EJR also included Case Nos. 21-1089GC, 21-1106GC, and 21-1107GC. Those three (3) cases had previously filed or forthcoming Substantive Claim Challenges and will be addressed under separate cover.
[2] Case Nos. 21-1088GC *et al.*, Consolidated Petition for Expedited Judicial Review at 1 (Jan. 5, 2026).

The Providers are requesting "that the Board grant EJR of the Providers appeals challenging the validity of CMS's rule excluding Section 401 hospitals from the calculation of the rural floor."[3]

**Statutory and Regulatory Background:**

***1. Wage Index; Rural and Urban Classification***

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[4] known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs"). The base payment rate is comprised of a standardized amount[5] for all subsection (d) hospitals located in an "urban" or "rural" area.[6]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[7] adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).[8]

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives "an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the

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[3] *Id.* at 10.
[4] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).
[5] The standardized amount is based on per discharge averages from a base period which are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27708, 27765-27766 (May 27, 1994). Section 1395ww(d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).
[6] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[7] of the Department of Health and Human Services.
[8] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index (last visited January 30, 2026).

nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts."[9]

In 1999, Congress recognized that in some cases, a hospital in one geographical area may compete for the same labor pool as hospitals in a nearby, larger urban area but receive lower reimbursement because they are geographically located in a lower wage index area. This resulted in some hospitals being underpaid for their labor costs. As a result, "Congress amended the Medicare Act in order to allow a hospital to seek reclassification from its geographically-based wage area to a nearby wage area for payment purposes if it meets certain criteria"[10] and established the Medicare Geographic Review Board (MGCRB) to administer the reclassification process.[11,12]

Ten years after the MGCRB was established, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106-113).[13] This legislation instructed the Secretary that urban hospitals that applied to the MGCRB for redesignation as rural were to be treated as such. Hospitals that receive these redesignations are sometimes known as "Section 401" hospitals. Codified at 42 U.S.C. § 1395ww(d)(8)(E), the statute states that:

> (E)(i) For purposes of this subsection, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital described in clause (ii), the Secretary ***shall treat the hospital as being located in the rural area*** (as defined in paragraph (2)(D)) of the State in which the hospital is located.
> (ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban area (as defined in paragraph (2)(D)) and satisfies any of the following criteria:
> (I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).
> (II) The hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).
> (III) The hospital would qualify as a rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.
> (IV) The hospital meets such other criteria as the Secretary may specify.[14]

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[9] *Id.*
[10] *Robert Wood Johnson University Hosp. v. Thompson*, 297 F. 3d. 273, 276 (3d Cir. 2002).
[11] *Id.*
[12] 42 U.S.C. § 1395ww(d)(10)(D)(v).
[13] *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. 106-113, app. F. § 401, 113, Stat. 1501, 1501A-321 (Nov. 29, 1999). Codified as 42 U.S.C. § 1395ww(d)(8).
[14] *Id.* (emphasis added).

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

> Hospitals qualifying under this section shall be eligible to qualify for all categories and designations available to rural hospitals, including sole community, Medicare dependent, critical access, and referral centers. Additionally, qualifying hospitals shall be eligible to apply to the [MGCRB] for geographic reclassification to another area. The [MGCRB] shall regard such hospitals as rural and as entitled to the exceptions extended to referral centers and sole community hospitals, if such hospitals are so designated.[15]

### *2. Rural Floor Adjustment*

In 1997, Congress observed that the calculation of the wage index for all regions of a state can sometimes result in "some urban hospitals being paid less than the average rural hospital in their states."[16] To correct this problem, in the Balanced Budget Act of 1997, Congress provided that the wage index assigned to a hospital in an urban area must be at least as great as the wage index assigned to rural hospitals within the same state. The statute provides that:

> For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)) may not be less than the area wage index applicable under such section to hospitals located in rural areas in the State in which the hospital is located.[17]

This provision is commonly referred to as the "rural floor."

### *3. Changes to the Wage Index Calculation*

In the FFY 2019 IPPS proposed rule,[18] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information ("RFI") as part of the FFY 2020 IPPS proposed rule.[19] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of States to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[20] In the

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[15] H.R. Conf. Rep. No. 106-479, 512 (1999).
[16] H.R. Rep. No. 105-149, at 1305 (1997).
[17] 42 U.S.C. § 1395ww note (Floor on Area Wage Index).
[18] 83 Fed. Reg. 20164 (May 7, 2018).
[19] 84 Fed Reg 19158, 19393-94 (May 3, 2019).
[20] *Id.*

FFY 2020 IPPS Final Rule, the Secretary proposed several policies to address wage index disparities.[21] Relevant to the issue under appeal here are the Secretary's proposals to prevent allegedly inappropriate payment increases due to rural reclassifications made under the provisions of 42 C.F.R. § 412.103.[22,23] The Secretary finalized without modification the proposals

- to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103); and
- for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . .(as implemented at § 412.103) from the calculation of ''the wage index for rural areas in the State in which the county is located'' referred to in section [1395ww](d)(8)(C)(iii). . . .[24]

The Secretary contends that this policy "is necessary and appropriate to address the unanticipated effects of rural reclassifications on the rural floor and resulting wage index disparities, including the effects of the manipulation of the rural floor by certain hospitals."[25] The Secretary concludes that "the inclusion of reclassified hospitals in the rural floor calculation has had the unforeseen effect of exacerbating the wage index disparities between low and high wage index hospitals."[26]

Under the 2020 IPPS Final Rule, the Secretary "would continue to calculate the rural floor based on the physical non-MSA area of a state, which is the same rural area to which a hospital is reclassified under section [1395ww](d)(8)(E). However, for purposes of calculating the rural

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[21] *See generally* 84 Fed. Reg. 42044, 42336-42339 (Aug. 16, 2019).
[22] 42 C.F.R. § 412.103 states in relevant part that:

> (a) General criteria. A prospective payment hospital that is located in an urban area (as defined in subpart D of this part) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
> (1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification, the Rural–Urban Commuting Area codes, . . . .
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.
> *****
> (7) For a hospital with a main campus and one or more remote locations under a single provider agreement where services are provided and billed under the inpatient hospital prospective payment system and that meets the provider-based criteria at § 413.65 of this chapter as a main campus and a remote location of a hospital, the hospital is required to demonstrate that the main campus and its remote location(s) each independently satisfy the location conditions specified in paragraphs (a)(1) and (2) of this section.

[23] *Id.* 84 Fed. Reg. at 42332.
[24] *Id.* at 42336.
[25] *Id.* at 42333.
[26] *Id.*

floor wage index for a state, [the Secretary] would not include in the rural area the data of hospitals that have reclassified as rural under section [1395ww](d)(8)(E)."[27] The Secretary pointed out that the "legislative intent of the rural floor was to correct the 'anomaly' of 'some urban hospitals being paid less than the average rural hospital in their States.'"[28]

The Secretary found that "[u]nder the current rural floor wage index calculation, rather than raising the payment of some urban hospitals to the level of the average rural hospital in their State, urban hospitals may have their payments raised to the relatively high level of one or more geographically urban hospitals reclassified as rural."[29] The Secretary explained that "[w]hile urban hospitals in mostly rural states may benefit from an increase in the rural floor due to urban to rural reclassification . . . other states with high wage urban hospitals using [42 C.F.R.] § 412.103 reclassifications to raise the rural floor can mitigate those gains for mostly rural states, due to budget neutrality."[30] The Secretary believes that "excluding the data of hospitals that reclassify as rural under section [1395ww](d)(8)(E) from the rural floor wage index is necessary and appropriate to address these unanticipated effects of rural reclassifications on the rural floor and the resulting wage index disparities."[31]

The Secretary contends that his reimbursement calculation "is permissible under [42 U.S.C. § 1395ww](d)(8)(E) (as implemented by [42 C.F.R.] § 412.103) and the rural floor statute [42 U.S.C. § 1395ww(d) note]" and notes that the statute "does not specify where the wage data of reclassified hospitals must be included."[32] Therefore, the Secretary believes that he has the "discretion to exclude the wage index data of such hospitals from the calculation of the rural floor. Furthermore, the rural floor statute does not specify how the rural floor wage index is to be calculated or what data are to be included in the calculation."[33] Consequently, the Secretary believes that he has the "discretion under the rural floor statute to exclude the wage data of hospitals reclassified under section [1395ww](d)(8)(E) from the calculation of the rural floor."[34]

CMS has adopted the FY 2020 IPPS Final Rule's policy in its FY 2021 IPPS Final Rule, meaning for FFY 2021 it will calculate the rural floor in a state without reference to the wage index that applies for any hospitals in that state which were reclassified as rural pursuant to Section 401.[35]

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[27] *Id.* at 42334.
[28] *Id.*
[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] *Id.*
[34] *Id.*
[35] 85 Fed. Reg. 58432, 58766 (Sept. 18, 2020).

**Positions of the Parties:**

***1. Providers' Appeal Requests***

The Providers describe the appealed issue as follows:

> The Providers in this group appeal challenge the Secretary's calculation of the rural floor for federal fiscal year (FFY) 2021. The Secretary's calculation violates the plain meaning of the rural floor provision of the statute and the requirement to treat reclassified rural hospitals as rural hospitals for all purposes of the prospective payment system.
>
> ****
>
> For wage index purposes, there are two types of geographic areas: urban and rural.
>
> ***
>
> When a hospital reclassifies as rural, its wage and hour data is included in the calculation of the state rural wage index adjustment in the next federal fiscal year.
>
> The Medicare statute contains a provision requiring that no urban hospital can be assigned a wage index adjustment that is lower than the wage index assigned to rural hospitals in the state.
>
> ***
>
> In the Inpatient Prospective Payment System Rulemaking for FFY 2020, the . . . . rural wage index will continue to be calculated based on the average hourly wage of all rural hospitals and all urban hospitals that have reclassified as rural. The rural floor, however, will not include the wage and hour data of reclassified rural hospitals; it will be based solely on the wage data of naturally rural hospitals. The Secretary continued this policy in FFY 2021.
>
> As a direct result of this policy, in FFY 2021, urban hospitals in some states have been assigned a wage index that is lower than the wage index assigned to rural hospitals in those states.
>
> ***
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> This result violates the rural floor, which expressly prohibits the Secretary from assigning a wage index to urban hospitals that is lower than the wage index of rural hospitals in the same state. *See* 42 U.S.C. § 1395ww note. Even if this result did not violate the rural floor (it does), the Secretary's policy would separately violate 42 U.S.C. § 1395ww(d)(8)(E)(i), which requires the Secretary to treat a hospital that has elected to reclassify as rural as rural for the purposes of the prospective payment system.

> For the forging reasons, the Providers in this group appeal are seeking reversal of CMS's policy of divorcing the rural floor from the rural wage index.[36]

### *2. Providers' Request for EJR*

The Providers filed their Petition for EJR to challenge CMS' new wage index rules as unlawful because it conflicts with the Medicare statute.[37] They argue that the FY 2020 rulemaking (1) does not treat reclassified "Section 401" hospitals as being located in a rural area, as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[38]

They seek to have their wage indices recalculated in compliance with the requirements of the Medicare statute.[39] The Providers are specifically seeking the Board hold that:

> CMS's calculation of the FFY 2021 rural floor is unlawful because CMS does not have statutory authority to exclude data of Section 401 hospitals from the calculation of the rural floor and CMS cannot assign a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state, and to compel CMS to pay the Providers reimbursement that was withheld as a result of that regulation during the years under appeal.[40]

The Providers insist they have met the criteria set forth in 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), namely that the Board has jurisdiction over the appeal but lacks the authority to grant the relief the Provider seeks.[41]

### *3. Medicare Contractor's Position*

On **January 12, 2026**, the Medicare Contractor's designated representative, Federal Specialized Services, filed a response to the Consolidated Request for Expedited Judicial Review. It noted it has filed, or would be filing, Substantive Claim Challenges in Cases 21-1089GC, 21-1106GC, and 21-1107GC. It made no mention of Cases 21-1088GC and 21-1090GC. Therefore, the time for filing any challenge has elapsed.[42]

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[36] *E.g.*, Case No. 21-1088GC, Statement of the Issue at 1-2 (Mar. 16, 2021).
[37] Consolidated Petition for Expedited Judicial Review at 5-6 (Jan. 5, 2026).
[38] *Id.* at 1, 5-6.
[39] *Id.* at 1-2.
[40] *Id.* at 7.
[41] *Id.* at 6-10.
[42] *See* Board Rule 44.5.2 (2023); Board Rule 10.2 ("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.").

**Decision of the Board:**

The Providers participating in the group appeals included in this EJR request have filed their appeals from policies established in the FFY 2021 IPPS Final Rule published in the Federal Register.

***1. Jurisdiction and Request for EJR***

As previously noted, all of the participants in both group cases at issue appealed from the FFY 2021 IPPS Final Rule.[43] The Board has determined that (1) the participants' documentation in both group appeals shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal;[44] (2) the appeals were timely filed; and (3) Board review of the matter in these appeals is not precluded by statute or regulation. In finding that the groups meet the $50,000 amount in controversy, the Board recognizes that the filed amounts in controversy illustrate the difference between the "current rural floor calculation" and "if [the] rural floor were calculated correctly."[45] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractors for the actual final amounts in each case.

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

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

> (1) *General Requirement*. In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), **must include an appropriate claim for the specific item**, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or

[43] 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.
[44] *See* 42 C.F.R. § 405.1837.
[45] *E.g.*, Case No. 21-1088GC, Impact Calculation, Hartford Hospital (Prov. No. 07-0025).

> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **and describing** how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[46]

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

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider **must include in its cost report an appropriate claim for the specific item** (as prescribed in § 413.24(j) of this chapter). If the provider files an appeal to the Board seeking reimbursement for the specific item and any party to such appeal questions whether the provider's cost report included an appropriate claim for the specific item, the Board must address such question in accordance with the procedures set forth in this section.
>
> (b) *Summary of Procedures*.
>
> ***
>
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ***

[46] (Bold and underline emphasis added.)

> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ***
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> (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**.[47]

These regulations are applicable to the cost reporting periods under appeal for all the participants in the instant cases, which both 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 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.

[47] (Bold and underline emphasis added.)

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[48] 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.[49]

Since no party to the appeal has questioned, pursuant to § 405.1873(a), and in compliance with the Board's Rules, whether an appropriate claim was made,[50] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request, pursuant to 42 C.F.R. § 405.1873(d) for the participants in these CIRP groups.

### *C. Analysis Regarding Appealed Issue*

As set forth below, the Board finds that the Secretary's determination to (1) "calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103)"; and (2) "for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . . (as implemented at § 412.103) from the calculation of 'the wage index for rural areas in the State in which the county is located' referred to in section [1395ww](d)(8)(C)(iii). . . ."[51] was made through notice and comment in the form of an uncodified regulation.[52]

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

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

[48] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[49] *See* 42 C.F.R. § 405.1873(a).
[50] 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."
[51] 84 Fed. Reg. 42044 at 42336.
[52] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals."

> index for rural areas in the State in which the county is located" referred to in section 1886(d)(8)(C)(iii) of the Act.[53]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as the "Uncodified Regulations on Rural Floor Calculation and Wage Index." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment for services" as a regulation.[54]

While this appeal involves the FFY 2021 IPPS Final Rule, the continuation of this policy was implemented in the same way as it was initially for FFY 2020.[55] The FY 2021 IPPS Final Rule did not make any changes to this policy. Therefore, the Board finds that this policy continues to be a binding but uncodified regulation for FFY 2021.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2021 IPPS Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulations on Rural Floor Calculation and Wage Index which they allege (1) does not treat reclassified "Section 401" hospitals as being located in a rural are as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[56] As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in the Cases 21-1088GC and 21-1090GC.

***D. Board's Decision Regarding the EJR Request***

The Board finds that:

1) It has jurisdiction over the Uncodified Regulations on Rural Floor Calculation and Wage Index Issue for the subject year in Cases 21-1088GC and 21-1090GC and that the Providers in these group appeals are entitled to a hearing before the Board;

2) While the Providers appealed cost reporting periods beginning after January 1, 2016, no substantive claim challenges[57] have been filed pursuant to 42 C.F.R. § 405.1873(a) to trigger either Board review under § 405.1873(b) or reporting under § 405.1873(d)(2);

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[53] 84 Fed. Reg. at 42336.
[54] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment for services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."
[55] 85 Fed. Reg. 58,432, 58,766 (Sept. 18, 2020).
[56] Consolidated Petition for Expedited Judicial Review at 1, 5-6.
[57] As the Board explained in Board Rule 44.5, "[t]he Board adoption of the term "Substantive Claim Challenge' simply refers to any question raised by a party concerning whether *the cost report at issu*e included an appropriate

3) Based upon the Providers' assertions regarding the FFY 2021 IPPS 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 codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2021 IPPS Final Rule is valid.

Accordingly, the Board finds that the question of the validity of the codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2021 IPPS Final Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject year.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes Cases 21-1088GC and 21-1090GC and removes them from its docket.

Board Members Participating:

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

FOR THE BOARD:

2/2/2026

X Kevin D. Smith, CPA

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

Enclosure: Schedules of Providers

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

claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

**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***
Lake Norman Regional Medical Center, Prov. No. 34-0129, FYE 09/30/2018
Case No. 22-1237

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-1237. 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. 22-1237*

On **February 17, 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 **August 3, 2022**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

[1] On February 1, 2023, this issue was transferred to Case No. 21-1206GC.
[2] On February 1, 2023, this issue was transferred to Case No. 20-2149GC.
[3] On February 1, 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 **February 1, 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 Payment – Medicaid Eligible Days).

On **August 4, 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]

On **February 8, 2023**, the Medicare Contractor filed its 2nd and Final Request for DSH Package in connection with Issue 3. In this filing, the Medicare Contractor noted that, on August 4, 2022 (1st request), it had previously requested that the Provider send it a DSH package to resolve Issue 3. As no response was received, the Medicare Contractor formally filed the 2nd and Final Request for DSH Package to formally request that a listing of the Medicaid eligible days at issue plus supporting documentation be provided to the Medicare Contractor on or before March 10, 2023 (*i.e.*, within 30 days). Notwithstanding the formal request, the Provider failed to file any response to the Medicare Contractor.

On **March 21, 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 $71,394 based on an *estimated* 100 days.

[4] (Emphasis added.)

On **June 7, 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 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider did not file a response until **August 4, 2023**, which was after the deadline for a timely response.

On **June 28, 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 failed to respond to any of the Medicare Contractor's requests for that Medicaid eligible days listing.

On **July 19, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **November 24, 2023**, more than 4 months after the deadline for responding to the Jurisdictional Challenge, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the *caveat* that the "Listing [is] *pending finalization* upon receipt of State eligibility data."[6] The Listing was 4 pages with roughly 516 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 516 days) was being submitted at this late date or why it was not final (*i.e.*, why it was "pending finalization") at this late date, ***more than 5 years after the fiscal year at issue had closed***. NOTE—the roughly 516 included in this belated listing is larger than the original *estimated* impact of 100 days included with the appeal request.

### *B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 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:

---

[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).

[6] (Emphasis added.)

> 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).[7]

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 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,

[7] Issue Statement at 1 (Aug. 3, 2022).

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 March 21, 2023, the Board received the Provider's preliminary position paper in 22-1237. 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 care of Advocate Christ Medical Center, et al, v Xavier Becerra (Apellants' reply brief included as Exhibit P-3).[9]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $29,002.

**MAC's Contentions**

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

[8] Group Appeal Issue Statement in Case No. 21-1206GC.
[9] Provider's Preliminary Position Paper at 10 (Mar. 21, 2023).

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:

> The MAC contends that the Provider has abandoned the issue of SSI realignment and, therefore, it should be considered withdrawn. The Provider did not brief this issue within its preliminary position paper PRRB Rule 25.3 addresses issues that are not briefed in a provider's position paper. In relevant part, this rule states:
>
> > Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.[10]

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. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[11]

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.[12]

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."[13] The MAC posits that the Provider "failed to sufficiently develop and set forth the relevant facts and regarding the merits of its claim in its Preliminary Position Paper."[14] Specifically the MAC avers:

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[10] Jurisdictional Challenge at 6 (Jun. 7, 2023).
[11] *Id*. at 7.
[12] *Id*. at 4-6.
[13] *Id*. at 7.
[14] *Id*. at 9.

> Within its Provider's Preliminary Position Paper, the Provider makes the broad allegation that 'The Provider contends that its' [sic] SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation' yet offers no evidence or analysis to demonstrate that CMS calculated its SSI percentage inaccurately. The Providers failed to include any evidence to establish the material facts in this case relating to inaccuracies in the SSI Percentage calculation at issue or any evidence pertaining to the alleged systemic SSI ratio data match errors like those referenced in the *Baystate* case. The Provider merely repeats their appeal request which itself is a verbatim recitation of the deficiencies that the Board found in the *Baystate* case.[15]

*Issue 3 – DSH Payment – Medicaid Eligible Days*

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

> The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.
>
> Within its Provider's preliminary position paper, the Provider makes the broad allegation, ". . . the Provider contends that the total number of days reflected in its' [sic] 2018 cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats their appeal request.[16]

**Provider's Jurisdictional Response**

[15] *Id*. at 9-10.
[16] *Id*. at 11-12.

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.[17] The Provider did not file a response to the Jurisdictional Challenge until the time for doing had 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." The Jurisdictional Challenge was filed on June 7, 2023. Therefore, the deadline to file a response was July 7, 2023. The Provider's Response was filed on August 4, 2023. That filing was untimely and the Board will not consider it.

## 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 Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[18] 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.

[17] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[18] Issue Statement at 1.

§ 1395ww(d)(5)(F)(i)."[19] 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."[20]

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 Case No. 22-1237 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, 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.[21] 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" 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 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.[22] 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

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[19] *Id.*
[20] *Id.*
[21] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[22] 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.

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.[23]

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.[24]

[23] (Italics and underline emphasis added.)
[24] Last accessed Oct. 15, 2024.

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[25]

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.

Accordingly, *based on the record before it*,[26] the Board finds that the SSI Provider Specific issue in Case No. 22-1237 and the group issue from the CHS CIRP group under Case No. 21-1206GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

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.

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.

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[25] (Emphasis added).
[26] Again, the Board notes that the Provider failed to timely respond to the Jurisdictional Challenge and the Board must make its determination based on the record before it.
[27] (Emphasis added).

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.

***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:

> 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.

[28] (Bold emphasis added.)

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

**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. Even though it will not be addressed in the Board's notice, the provider may file an *optional* response no later than ninety days following the due date for the Medicare contractor's preliminary position paper. Therefore, the Board requires preliminary position papers to present the ***fully***-developed positions of the parties and expects that parties will be diligent in planning and conducting any required investigation, discovery, and analysis well in advance of the filing deadline.

**25.1 Content of Position Paper Narrative**

The text of the position papers must include the elements addressed in the applicable sub-section.

**25.1.1 Provider's Position Paper**

The provider's preliminary position paper must:

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

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

- 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**

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

**COMMENTARY**:
Note that the change to require filing of the ***complete*** preliminary position paper was effective on August 19, 2018. Accordingly, failure to file a ***complete*** preliminary position paper with the Board will result in the Board dismissing your appeal or taking other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on August 4, 2022 included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

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

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

[30] (Emphasis added.)

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 March 21, 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.[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 continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $71,394 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

[31] Provider's Preliminary Position Paper at 9.

> state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's [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 requested 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.

Notably, the Medicare Contractor sent two (2) separate requests for the Provider's list of Medicaid Eligible days (and also discussed the lack of the listing in the Medicare Contractor's own position paper filing). The first notice was sent to the Provider on August 4, 2022 and the second request was sent to the Provider on February 8, 2023. The second, final request was filed *more than four years after the end of the Provider's cost reporting period*. The Medicare Contractor also informed the Provider in its final request for information that the deadline to respond was March 10, 2023. The Provider failed to file any response to the 2nd and final request.

Due to the non-responsiveness of the Provider, on **June 7, 2023**, the Medicare Contractor filed Jurisdictional Challenge, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish the list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2 (or when request by the Medicare Contractor 3 separate times after that). The Medicare Contractor thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to

explain why it failed to produce those documents, as required by the regulations and the Board Rules.[32]

Pursuant to Board Rule 44.4.3, the Provider had 30 days to respond to the Jurisdictional. However, the Provider ***failed*** to timely respond to that Motion by the July 7, 2023 filing deadline (*i.e.*, 30 days after June 7, 2023).

However, on November 24, 2023 (over 4 months after the deadline to respond to the Motion), QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the caveat that the "Listing [is] pending finalization upon receipt of State eligibility data." The Listing was 4 pages with roughly 516 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 516 days) was being submitted at this late date or why it was not final (*i.e.*, why it was "pending finalization") at this late date, ***more than 5 years after the fiscal year at issue had closed***. NOTE—the roughly 516 included in this belated listing is larger than the original estimate of 100 days included with the appeal request. Regardless, this filing was more than 4 months past the deadline for responding to the Jurisdictional Challenge *and, more importantly,* ***was roughly nearly 8 months past the deadline for including it with its preliminary position paper*** since the position paper deadline was March 31, 2023.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

The fact that the Listing was filed 4 months after the Provider changed its designated representative to QRS does not excuse the Provider for its failure to include the information with its preliminary position paper or its failure to timely respond to the Jurisdictional Challenge. Board Rule 5.2 makes clear that "the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings." Moreover, the Board rejects the Provider's attempt to label the November 24, 2023 filing as a "Supplement to Position Paper" and does not accept that filing because:

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[32] *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.

1. The alleged "Supplement" was filed ***nearly 8 months*** *after the deadline* for that exhibit to be included with its preliminary position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)). Indeed, the Provider failed to timely reply to the Medicare Contractor's Jurisdictional Challenge and the alleged "Supplement" was filed ***more than 4 months*** *after the deadline* for filing a response to the Jurisdictional Challenge.

2. The alleged "Supplement" fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the roughly 516 days was not previously available, *in whole or in part* (*i.e*., it is not clear why the Provider failed to identify a single day at issue until more than a year after this appeal was filed and more than 5 years after the fiscal year at issue had closed); and (c) why the listing still was ***not*** a "*final*" listing at this late date.

3. Neither the Board Rules nor the August 4, 2022 Case Acknowledgment and Critical Due Dates permit the Provider to file a "Supplement" to its preliminary position paper (nor did the Provider allege in the "Supplement" filing that they do).

4. Given the fact that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the position paper filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its preliminary position paper or a supplement of documents that were identified in the preliminary position paper as being unavailable consistent with Board Rule 25.2.2. However, neither the preliminary position paper nor the alleged "Supplement" identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the alleged "Supplement" cannot be considered a refinement of the position paper since no specific days or listing were included with the preliminary position paper (indeed the *tentative* 516 days listed in the alleged "Supplement" is, without explanation, larger than the original estimated 100 days included with the appeal request).[33]

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"[34] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provider the § 412.106(b)(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,

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

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.[35]

### *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 August of 2022 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[36]

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[35] *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.

[36] 42 C.F.R. § 405.1835(b).

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

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>   - the relevant adjustment(s), including the adjustment number(s),
>   - the controlling authority (*e.g.*, specific regulation, Federal Register issuance, manual provision or Ruling),
>   - why the adjustment(s) is incorrect,
>   - how the payment should be determined differently,
>   - the reimbursement effect, and
>   - the basis for jurisdiction before the Board.

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

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include, but are not limited to: . . . ***Section 1115 waiver days (program/waiver specific). . .***[37]

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.[38]

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.

[37] (Bold and italic emphasis added).
[38] *See* 73 Fed. Reg. 30190 (May 23, 2008).

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider 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.[39] 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) 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.

[39] 65 FR 47054, 47087 (Aug. 1, 2000).

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

Finally, even in the Provider's preliminary position paper, the Provider fails to identify what § 1115 waiver program(s) are involved and whether or not the § 1115 waive days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the preliminary position paper is perfunctory in that it only makes perfunctory conclusions.[40] 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 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*.[41] 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 . . ."[42] 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."[43] 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.[44] Here, the Board makes the same finding based on similarly *overly generalized language*.

* * * * *

[40] 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."
[41] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[42] *Id*. at *11.
[43] *Id.*
[44] *Id.*

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. 22-1237 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:

2/2/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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**Via Electronic Delivery**

Daniel Hettich, Esq.
King & Spalding, LLP
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Washington, DC 20006

RE: ***Expedited Judicial Review Determination***
Case Number: 21-1091
Middlesex Hospital (Provider Number 07-0020)
Federal Fiscal Year 2021

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's Request for Expedited Judicial Review ("EJR") filed on **January 5, 2026** concerning the above referenced individual appeal. The Board's decision on jurisdiction and EJR for this case are set forth below.

**Issue:**

The Petition for EJR describes the issue as follows:

> The Medicare statute provides that "Section 401" hospitals must be treated as being located in a rural area for all purposes under the IPPS system, *see* 42 U.S.C. § 1395ww(d)(8)(E), and that no urban hospital can be assigned a wage index that is lower than the wage index assigned to rural hospitals in the same state, *see* 42 U.S.C. § 1395ww note. In its rulemaking for the Inpatient Prospective Payment System for fiscal year 2020, and carried forward to FFY 2021, however, CMS announced a new rule that violates both of these statutory directives. Specifically, under CMS's new policy, Section 401 hospitals would not be treated as rural in calculating the rural floor, and urban hospitals will be assigned a lower wage index than the one applicable to rural hospitals in the state. The issue presented in this appeal is whether CMS's new wage index rule is unlawful because it conflicts with the unambiguous requirements of the Medicare statute.[1]

The Provider is requesting "that the Board grant EJR of the Provider's appeal challenging the validity of CMS's rule excluding Section 401 hospitals from the calculation of the rural floor."[2]

[1] Petition for Expedited Judicial Review at 1 (Jan. 5, 2026).
[2] *Id.* at 9.

**Statutory and Regulatory Background:**

***1. Wage Index; Rural and Urban Classification***

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[3] known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs"). The base payment rate is comprised of a standardized amount[4] for all subsection (d) hospitals located in an "urban" or "rural" area.[5]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[6] adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).[7]

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

[3] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).
[4] The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27708, 27765-27766 (May 27, 1994). Section 1395ww(d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).
[5] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[6] of the Department of Health and Human Services.
[7] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index (last visited January 30, 2026).

the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts.[8]

In 1999, Congress recognized that in some cases, a hospital in one geographical area may compete for the same labor pool as hospitals in a nearby, larger urban area but receive lower reimbursement because they are geographically located in a lower wage index area. This resulted in some hospitals being underpaid for their labor costs. As a result, "Congress amended the Medicare Act in order to allow a hospital to seek reclassification from its geographically-based wage area to a nearby wage area for payment purposes if it met certain criteria"[9] and established the Medicare Geographic Review Board (MGCRB) to administer the reclassification process.[10,11]

Ten years after the MGCRB was established, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106-113).[12] This legislation instructed the Secretary that urban hospitals that applied to the MGCRB for redesignation as rural were to be treated as such. Hospitals that receive these redesignations are sometimes known as "Section 401" hospitals. Codified at 42 U.S.C. § 1395ww(d)(8)(E), the statute states that:

> (E)(i) For purposes of this subsection, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital described in clause (ii), the Secretary ***shall treat the hospital as being located in the rural area*** (as defined in paragraph (2)(D)) of the State in which the hospital is located.
> (ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban area (as defined in paragraph (2)(D)) and satisfies any of the following criteria:
> (I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).
> (II) The hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).
> (III) The hospital would qualify as a rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.
> (IV) The hospital meets such other criteria as the Secretary may specify.[13]

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[8] *Id.*
[9] *Robert Wood Johnson University Hosp. v. Thompson*, 297 F. 3d. 273, 276 (3d Cir. 2002).
[10] *Id.*
[11] 42 U.S.C. § 1395ww(d)(10)(D)(v).
[12] *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Public L. 106-113, app. F. § 401, 113, Stat. 1501, 1501A-321 (Nov. 29, 1999). Codified as 42 U.S.C. § 1395ww(d)(8).
[13] *Id.* (emphasis added).

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

> Hospitals qualifying under this section shall be eligible to qualify for all categories and designations available to rural hospitals, including sole community, Medicare dependent, critical access, and referral centers. Additionally, qualifying hospitals shall be eligible to apply to the [MGCRB] for geographic reclassification to another area. The [MGCRB] shall regard such hospital as rural and as entitled to the exceptions extended to referral centers and sole community hospitals, if such hospitals are so designated.[14]

### *2. Rural Floor Adjustment*

In 1997, Congress observed that the calculation of the wage index for all regions of a state can sometimes result in "some urban hospitals being paid less than the average rural hospital in their state."[15] To correct this problem, in the Balanced Budget Act of 1997, Congress provided that the wage index assigned to a hospital in an urban area must be at least as great as the wage index assigned to rural hospitals within the same state. The statute provides that:

> For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)) may not be less than the area wage index applicable under such section to hospitals located in rural areas in the State in which the hospital is located.[16]

This provision is commonly referred to as the "rural floor."

### *3. Changes to the Wage Index Calculation*

In the FFY 2019 IPPS proposed rule,[17] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information

[14] H.R. Conf. Rep. No. 106-479, 512 (1999).
[15] H.R. Rep. No. 105-149, at 1305 (1997).
[16] 42 U.S.C. § 1395ww note (Floor on Area Wage Index).
[17] 83 Fed. Reg. 20164 (May 7, 2018).

("RFI") as part of the FFY 2020 IPPS proposed rule.[18] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[19] In the FFY 2020 IPPS Final Rule, the Secretary proposed several policies to address wage index disparities.[20] Relevant to the issue under appeal here are the Secretary's proposals to prevent allegedly inappropriate payment increases due to rural reclassifications made under the provisions of 42 C.F.R. § 412.103.[21,22] The Secretary finalized without modification the proposals

- to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103); and
- for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . .(as implemented at § 412.103) from the calculation of 'the wage index for rural areas in the State in which the county is located' referred to in section [1395ww](d)(8)(C)(iii). . . .[23]

The Secretary contends that this policy "is necessary and appropriate to address the unanticipated effects of rural reclassification on the rural floor and resulting wage index disparities, including

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[18] 84 Fed Reg 19158, 19393-94 (May 3, 2019).
[19] *Id.*
[20] *See generally* 84 Fed. Reg. 42044, 42336-42339 (Aug. 16, 2019).
[21] 42 C.F.R. § 412.103 states in relevant part that:

> (a) General criteria. A prospective payment hospital that is located in an urban area (as defined in subpart D of this part) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
> (1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification, the Rural–Urban Commuting Area codes, . . . .
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.
> *****
> (7) For a hospital with a main campus and one or more remote locations under a single provider agreement where services are provided and billed under the inpatient hospital prospective payment system and that meets the provider-based criteria at § 413.65 of this chapter as a main campus and a remote location of a hospital, the hospital is required to demonstrate that the main campus and its remote location(s) each independently satisfy the location conditions specified in paragraphs (a)(1) and (2) of this section.

[22] *Id.* 84 Fed. Reg. at 42332.
[23] *Id.* at 42336.

the effects of the manipulation of the rural floor by certain hospitals."[24] The Secretary concludes that "the inclusion of reclassified hospitals in the rural floor calculation has had the unforeseen effect of exacerbating the wage index disparities between low and high wage index hospitals."[25]

Under the 2020 IPPS Final Rule, the Secretary "would continue to calculate the rural floor based on the physical non-MSA area of the state, which is the same rural area to which a hospital is reclassified under section [1395ww](d)(8)(E). However, for purposes of calculating the rural floor wage index for a state, [the Secretary] would not include in the rural area the data of hospitals that have been reclassified as rural under section [1395ww](d)(8)(E)."[26] The Secretary pointed out that the "legislative intent of the rural floor was to correct the 'anomaly' of 'some urban hospitals being paid less than the average rural hospital in their States.'"[27]

The Secretary found that "[u]nder the current rural floor wage index calculation, rather than raising the payment of some urban hospitals to the level of the average rural hospital in their State, urban hospitals may have their payments raised to the relatively high level of one or more geographically urban hospitals reclassified as rural."[28] The Secretary explained that "[w]hile urban hospitals in mostly rural states may benefit from an increase in the rural floor due to urban to rural reclassification . . . other states with high wage urban hospitals using [42 C.F.R.] § 412.103 reclassifications to raise the rural floor can mitigate those gains for mostly rural states, due to budget neutrality."[29] The Secretary believes that "excluding the data of hospitals that reclassify as rural under section [1395ww](d)(8)(E) from the rural floor wage index is necessary and appropriate to address these unanticipated effects of the rural reclassifications on the rural floor and the resulting wage index disparities."[30]

The Secretary contends that his reimbursement calculation "is permissible under [42 U.S.C. § 1395ww](d)(8)(E) (as implemented by [42 C.F.R.] § 412.103) and the rural floor statute [42 U.S.C. § 1395ww(d) note]" and notes that the statute "does not specify where the wage data of reclassified hospitals must be included."[31] Therefore, the Secretary believes that he has the "discretion to exclude the wage index data of such hospitals from the calculation of the rural floor. Furthermore, the rural floor statute does not specify how the rural floor wage index is to be calculated or what data are to be included in the calculation."[32] Consequently, the Secretary believes that he has the "discretion under the rural floor statute to exclude the wage data of hospitals reclassified under section [1395ww](d)(8)(E) from the calculation of the rural floor."[33]

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[24] *Id.* at 42333.
[25] *Id.*
[26] *Id.* at 42334.
[27] *Id.*
[28] *Id.*
[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] *Id.*

CMS has adopted the FY 2020 IPPS Final Rule's policy in its FY 2021 IPPS Final Rule, meaning for FFY 2021 it will calculate the rural floor in a state without reference to the wage index that applies for any hospitals in that state which were reclassified as rural pursuant to Section 401.[34]

**Positions of the Parties:**

***1. Provider's Appeal Request***

The Provider describes the appealed issue as follows:

> The Provider challenges the Secretary's calculation of the rural floor for federal fiscal year (FFY) 2021. The Secretary's calculation violates the plain meaning of the rural floor provision of the statute and the requirement to treat reclassified rural hospitals as rural hospitals for all purposes of the prospective payment system.
>
> ***
>
> For wage index purposes, there are two types of geographic areas: urban and rural.
>
> ***
>
> When a hospital reclassifies as rural, its wage and hour data is included in the calculation of the state rural wage index adjustment in the next federal fiscal year.
>
> The Medicare statute contains a provision requiring that no urban hospital can be assigned a wage index adjustment that is lower than the wage index assigned to rural hospitals in the state.
>
> ***
>
> In the Inpatient Prospective Payment System Rulemaking for FFY 2020, the . . . . rural wage index will continue to be calculated based on the average hourly wage of all rural hospitals and all urban hospitals that have reclassified as rural. The rural floor, however, will not include the wage and hour data of reclassified rural hospitals; it will be based solely on the wage data of naturally rural hospitals. The Secretary continued this policy in FFY 2021.
>
> As a direct result of this policy, in FFY 2021, urban hospitals in some states have been assigned a wage index that is lower than the wage index assigned to rural hospitals in those states.
>
> ***
>
> This result violates the rural floor, which expressly prohibits the Secretary from assigning a wage index to urban hospitals that is lower than the wage index of rural hospitals in the same state. *See* 42 U.S.C. § 1395ww note. Even if this result did not violate the rural floor (it does), the Secretary's

[34] 85 Fed. Reg. 58432, 58766 (Sept. 18, 2020).

> policy would separately violate 42 U.S.C. § 1395ww(d)(8)(E)(i), which requires the Secretary to treat a hospital that has elected to reclassify as rural as rural for the purposes of the prospective payment system. For the forging reasons, the Provider is seeking reversal of CMS's policy of divorcing the rural floor from the rural wage index.[35]

### *2. Provider's Request for EJR*

The Provider filed its Petition for EJR to challenge CMS' new wage index rules as unlawful because it conflicts with the Medicare statute.[36] It argues that the FY 2020 rulemaking (1) does not treat reclassified "Section 401" hospitals as being located in a rural area, as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[37]

It seeks to have its wage index recalculated in compliance with the requirements of the Medicare statute.[38] The Provider is specifically seeking the Board hold that:

> CMS's calculation of the FFY 2021 rural floor is unlawful because CMS does not have statutory authority to exclude data of Section 401 hospitals from the calculation of the rural floor and CMS cannot assign a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state, and to compel CMS to pay the Provider reimbursement that was withheld as a result of that regulation during the year under appeal.[39]

The Provider insists it has met the criteria set forth in 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), namely that the Board has jurisdiction over the appeal but lacks the authority to grant the relief the Provider seeks.[40]

### *3. Medicare Contractor's Position*

On **January 12, 2026**, the Medicare Contractor's designated representative, Federal Specialized Services ("FSS"), filed a response to the Request for Expedited Judicial Review. It took no position on the Request for EJR but noted "that the MAC will not file a substantive claim challenge and will not file a jurisdictional challenge."[41]

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[35] Statement of the Issue at 1-2 (Mar. 16, 2021).
[36] Petition for Expedited Judicial Review at 1 (Jan. 5, 2026).
[37] *Id.* at 1, 5-6.
[38] *Id.* at 1.
[39] *Id.* at 7.
[40] *Id.* at 6-9.
[41] Response to Provider's request for expedited judicial review at 1 (Jan. 12, 2026).

**Decision of the Board:**

The Provider that filed this Request for EJR has filed its appeal from policies established in the FFY 2021 IPPS Final Rule published in the Federal Register.

***1. Jurisdiction and Request for EJR***

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

As previously noted, the Provider filed an individual appeal from the FFY 2021 IPPS Final Rule.[42] The Board has determined that (1) the Provider's documentation shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal;[43] (2) the appeal was timely filed; and (3) Board review of the matter in this appeal is not precluded by statute or regulation. In finding that the Provider meets the $10,000 amount in controversy, the Board recognizes that amount in controversy illustrates the difference between the "current rural floor calculation" and "if [the] rural floor were calculated correctly."[44] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying Provider. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

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

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

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

[42] 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.
[43] *See* 42 C.F.R. § 405.1835(a)(2).
[44] Individual Appeal request, Impact Calculation.

> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **and describing** how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[45]

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.

[45] (Bold and underline emphasis added.)

> (b) *Summary of Procedures*.
>
> ***
>
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ***
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ***
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> (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**.[46]

These regulations are applicable to the cost reporting period under appeal for the Provider in the instant case, which has a cost reporting period 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 argument regarding the question of whether the provider's

[46] (Bold and underline emphasis added.)

> 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.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[47] 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.[48] In this case, the Medicare Contractor has indicated it will not file a Substantive Claim Challenge.[49]

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[50] 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).

### *3. Analysis Regarding Appealed Issue*

As set forth below, the Board finds that the Secretary's determination to (1) "calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103)"; and (2) "for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . . (as implemented at § 412.103) from the calculation of 'the wage index for rural areas in the State in which the county is located' referred to in section [1395ww](d)(8)(C)(iii). . . ."[51] was made through notice and comment in the form of an uncodified regulation.[52]

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[47] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[48] *See* 42 C.F.R. § 405.1873(a).
[49] 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."
[50] 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."
[51] 84 Fed. Reg. 42044 at 42336.
[52] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals."

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

> After consideration of the public comments we received, for the reasons discussed in this final rule and in the proposed rule, we are finalizing without modification our proposal to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103). Additionally, we are finalizing without modification our proposal, for purposes of applying the provisions of section 1886(d)(8)(C)(iii) of the Act, to remove the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103) from the calculation of "the wage index for rural areas in the State in which the county is located" referred to in section 1886(d)(8)(C)(iii) of the Act.[53]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as the "Uncodified Regulations on Rural Floor Calculation and Wage Index." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation.[54]

While this appeal involves the FFY 2021 IPPS Final Rule, the continuation of this policy was implemented in the same way as it was initially for FFY 2020.[55] The FY 2021 IPPS Final Rule did not make any changes to this policy. Therefore, the Board finds that this policy continues to be a binding but uncodified regulation for FFY 2021.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2021 IPPS Final Rule and the Board does not have the authority to grant the relief sought by the Provider, namely invalidating the Uncodified Regulations on Rural Floor Calculation and Wage Index which it alleges (1) does not treat reclassified "Section 401" hospitals as being located in a rural area, as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[56] As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in Case 21-1091.

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[53] 84 Fed. Reg. at 42336.
[54] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."
[55] 85 Fed. Reg. 58,432, 58,766 (Sept. 18, 2020).
[56] Consolidated Petition for Expedited Judicial Review at 1, 5-6.

***D. Board's Decision Regarding the EJR Request***

The Board finds that:

1) It has jurisdiction over the Uncodified Regulations on Rural Floor Calculation and Wage Index Issue for the subject year in Case 21-1091 and that the Provider in this appeal is entitled to a hearing before the Board;

2) While the Provider appealed a cost reporting period beginning after January 1, 2016, no substantive claim challenges[57] have been filed pursuant to 42 C.F.R. § 405.1873(a) to trigger either Board review under § 405.1873(b) or reporting under § 405.1873(d)(2);

3) Based upon the Provider's assertions regarding the FFY 2021 IPPS 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 codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2021 IPPS Final Rule is valid.

Accordingly, the Board finds that the question of the validity of the codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2021 IPPS 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.

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 this case, the Board hereby closes Case 21-1091 and removes it from its docket.

[57] As the Board explained in Board Rule 44.5, "[t]he Board adoption of the term "Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

Board Members Participating:

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

FOR THE BOARD:

2/3/2026

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, Esq., Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**Via Electronic Delivery**

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RE: ***Expedited Judicial Review Determination***
Case Number: 21-1371
University of Utah Hospitals and Clinics (Provider Number 46-0009)
Federal Fiscal Year 2021

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's Request for Expedited Judicial Review ("EJR") filed on **January 5, 2026** concerning the above referenced individual appeal. The Board's decision on jurisdiction and EJR for this case are set forth below.

**Issue:**

The Petition for EJR describes the issue as follows:

> The Medicare statute provides that "Section 401" hospitals must be treated as being located in a rural area for all purposes under the IPPS system, *see* 42 U.S.C. § 1395ww(d)(8)(E), and that no urban hospital can be assigned a wage index that is lower than the wage index assigned to rural hospitals in the same state, *see* 42 U.S.C. § 1395ww note. CMS has also established that it uses the IPPS wage index for purposes of OPPS payments. 42 C.F.R. § 419.43(c)(1). In its rulemakings for the Inpatient Prospective Payment System and the Outpatient Prospective Payment System for fiscal year 2020, and carried forward to FFY 2021, however, CMS announced a new rule that violates both of these statutory directives. Specifically, under CMS's new policy, Section 401 hospitals would not be treated as rural in calculating the rural floor, and urban hospitals will be assigned a lower wage index than the one applicable to rural hospitals in the state. The issue presented in this appeal is whether CMS's new wage index rule is unlawful because it conflicts with the unambiguous requirements of the Medicare statute.[1]

[1] Petition for Expedited Judicial Review at 1-2 (Jan. 5, 2026).

The Provider is requesting "that the Board grant EJR of the Provider's appeal challenging the validity of CMS's rule excluding Section 401 hospitals from the calculation of the rural floor."[2]

**Statutory and Regulatory Background:**

***1. Wage Index; Rural and Urban Classification***

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[3] known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs"). The base payment rate is comprised of a standardized amount[4] for all subsection (d) hospitals located in an "urban" or "rural" area.[5]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[6] adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).[7]

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives "an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a

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[2] *Id.* at 10.
[3] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).
[4] The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27708, 27765-27766 (May 27, 1994). Section 1395ww(d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).
[5] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[6] of the Department of Health and Human Services.
[7] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index (last visited January 30, 2026).

national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts."[8]

In 1999, Congress recognized that in some cases, a hospital in one geographical area may compete for the same labor pool as hospitals in a nearby, larger urban area but receive lower reimbursement because they are geographically located in a lower wage index area. This resulted in some hospitals being underpaid for their labor costs. As a result, "Congress amended the Medicare Act in order to allow a hospital to seek reclassification from its geographically-based wage area to a nearby wage area for payment purposes if it met certain criteria"[9] and established the Medicare Geographic Review Board (MGCRB) to administer the reclassification process.[10,11]

Ten years after the MGCRB was established, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106-113).[12] This legislation instructed the Secretary that urban hospitals that applied to the MGCRB for redesignation as rural were to be treated as such. Hospitals that receive these redesignations are sometimes known as "Section 401" hospitals. Codified at 42 U.S.C. § 1395ww(d)(8)(E), the statute states that:

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

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[8] *Id.*
[9] *Robert Wood Johnson University Hosp. v. Thompson*, 297 F. 3d. 273, 276 (3d Cir. 2002).
[10] *Id.*
[11] 42 U.S.C. § 1395ww(d)(10)(D)(v).
[12] *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Public L. 106-113, app. F. § 401, 113, Stat. 1501, 1501A-321 (Nov. 29, 1999). Codified as 42 U.S.C. § 1395ww(d)(8).

> (IV) The hospital meets such other criteria as the Secretary may specify.[13]

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

> Hospitals qualifying under this section shall be eligible to qualify for all categories and designations available to rural hospitals, including sole community, Medicare dependent, critical access, and referral centers. Additionally, qualifying hospitals shall be eligible to apply to the [MGCRB] for geographic reclassification to another area. The [MGCRB] shall regard such hospitals as rural and as entitled to the exceptions extended to referral centers and sole community hospitals, if such hospitals are so designated.[14]

### *2. Rural Floor Adjustment*

In 1997, Congress observed that the calculation of the wage index for all regions of a state can sometimes result in "some urban hospitals being paid less than the average rural hospital in the state."[15] To correct this problem, in the Balanced Budget Act of 1997, Congress provided that the wage index assigned to a hospital in an urban area must be at least as great as the wage index assigned to rural hospitals within the same state. The statute provides that:

> For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)) may not be less than the area wage index applicable under such section to hospitals located in rural areas in the State in which the hospital is located.[16]

This provision is commonly referred to as the "rural floor."

### *3. Changes to the Wage Index Calculation*

In the FFY 2019 IPPS proposed rule,[17] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information

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[13] *Id.* (emphasis added).
[14] H.R. Conf. Rep. No. 106-479, 512 (1999).
[15] H.R. Rep. No. 105-149, at 1305 (1997).
[16] 42 U.S.C. § 1395ww note (Floor on Area Wage Index).
[17] 83 Fed. Reg. 20164 (May 7, 2018).

("RFI") as part of the FFY 2020 IPPS proposed rule.[18] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[19] In the FFY 2020 IPPS Final Rule, the Secretary proposed several policies to address wage index disparities.[20] Relevant to the issue under appeal here are the Secretary's proposals to prevent allegedly inappropriate payment increases due to rural reclassifications made under the provisions of 42 C.F.R. § 412.103.[21,22] The Secretary finalized without modification the proposals

- to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103); and
- for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . .(as implemented at § 412.103) from the calculation of 'the wage index for rural areas in the State in which the county is located' referred to in section [1395ww](d)(8)(C)(iii). . . .[23]

The Secretary contends that this policy "is necessary and appropriate to address the unanticipated effects of rural reclassifications on the rural floor and resulting wage index disparities, including

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[18] 84 Fed Reg 19158, 19393-94 (May 3, 2019).
[19] *Id.*
[20] *See generally* 84 Fed. Reg. 42044, 42336-42339 (Aug. 16, 2019).
[21] 42 C.F.R. § 412.103 states in relevant part that:

> (a) General criteria. A prospective payment hospital that is located in an urban area (as defined in subpart D of this part) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
> (1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification, the Rural–Urban Commuting Area codes, . . . .
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.
> *****
> (7) For a hospital with a main campus and one or more remote locations under a single provider agreement where services are provided and billed under the inpatient hospital prospective payment system and that meets the provider-based criteria at § 413.65 of this chapter as a main campus and a remote location of a hospital, the hospital is required to demonstrate that the main campus and its remote location(s) each independently satisfy the location conditions specified in paragraphs (a)(1) and (2) of this section.

[22] 84 Fed. Reg. at 42332.
[23] *Id.* at 42336.

the effects of the manipulation of the rural floor by certain hospitals."[24] The Secretary concludes that "the inclusion of reclassified hospitals in the rural floor calculation has had the unforeseen effect of exacerbating the wage index disparities between low and high wage index hospitals."[25]

Under the 2020 IPPS Final Rule, the Secretary "would continue to calculate the rural floor based on the physical non-MSA area of the state, which is the same rural area to which a hospital is reclassified under section [1395ww](d)(8)(E). However, for purposes of calculating the rural floor wage index for a state, [the Secretary] would not include in the rural area the data of hospitals that have reclassified as rural under section [1395ww](d)(8)(E)."[26] The Secretary pointed out that the "legislative intent of the rural floor was to correct the 'anomaly' of 'some urban hospitals being paid less than the average rural hospital in their States.'"[27]

The Secretary found that "[u]nder the current rural floor wage index calculation, rather than raising the payment of some urban hospitals to the level of the average rural hospital in their State, urban hospitals may have their payments raised to the relatively high level of one or more geographically urban hospitals reclassified as rural."[28] The Secretary explained that "[w]hile urban hospitals in mostly rural states may benefit from an increase in the rural floor due to urban to rural reclassification . . . other states with high wage urban hospitals using [42 C.F.R.] § 412.103 reclassifications to raise the rural floor can mitigate those gains for mostly rural states, due to budget neutrality."[29] The Secretary believes that "excluding the data of hospitals that reclassify as rural under section [1395ww](d)(8)(E) from the rural floor wage index is necessary and appropriate to address these unanticipated effects of rural reclassifications on the rural floor and the resulting wage index disparities."[30]

The Secretary contends that his reimbursement calculation "is permissible under [42 U.S.C. § 1395ww](d)(8)(E) (as implemented by [42 C.F.R.] § 412.103) and the rural floor statute [42 U.S.C. § 1395ww(d) note]" and notes that the statute "does not specify where the wage data of reclassified hospitals must be included."[31] Therefore, the Secretary believes that he has the "discretion to exclude the wage index data of such hospitals from the calculation of the rural floor. Furthermore, the rural floor statute does not specify how the rural floor wage index is to be calculated or what data are to be included in the calculation."[32] Consequently, the Secretary believes that he has the "discretion under the rural floor statute to exclude the wage data of hospitals reclassified under section [1395ww](d)(8)(E) from the calculation of the rural floor."[33]

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[24] *Id. at* 42333.
[25] *Id.*
[26] *Id.* at 42334.
[27] *Id.*
[28] *Id.*
[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] *Id.*

CMS has adopted the FY 2020 IPPS Final Rule's policy in its FY 2021 OPPS Final Rule, meaning for FFY 2021 it will calculate the rural floor in a state without reference to the wage index that applies for any hospitals in that state which were reclassified as rural pursuant to Section 401.[34]

**Positions of the Parties:**

***1. Provider's Appeal Request***

The Provider describes the appealed issue as follows:

> The Provider challenges the Secretary's calculation of the rural floor in the outpatient prospective payment system (OPPS) final rule for calendar year (CY) 2021.
>
> ***
>
> For wage index purposes, there are two types of geographic areas: urban and rural.
>
> ***
>
> When a hospital reclassifies as rural, its wage and hour data is included in the calculation of the state rural wage index adjustment in the next federal fiscal year.
> The Medicare statute contains a provision requiring that no urban hospital can be assigned a wage index adjustment that is lower than the wage index assigned to rural hospitals in the state.
>
> ***
>
> In the IPPS final rule for FFY 2020, the . . . . rural wage index will continue to be calculated based on the average hourly wage of all rural hospitals and all urban hospitals that have reclassified as rural. The rural floor, however, will not include the wage and hour data of reclassified rural hospitals; it will be based solely on the wage data of naturally rural hospitals. Since adopting this policy, the Secretary has applied the same rural floor policy to the OPPS final rules for CY 2020 and 2021. In this appeal, the Provider challenges CMS's policy insofar as it was applied in the OPPS final rule for CY 2021.
>
> ***
>
> [A]s a direct result of this policy, in CY 2021, urban hospitals in some states have been assigned a wage index that is lower than the wage index assigned to rural hospitals in those states. This result violates the rural floor, which expressly prohibits the Secretary from assigning a wage index to urban hospitals that is lower than the wage index of rural hospitals in the same state. *See* 42 U.S.C. § 1395ww note. Even if this result did not

[34] 85 Fed. Reg. 85866, 85917 (Dec. 29, 2020) (stating "We also are continuing to apply for the CY 2021 OPPS wage index any other adjustments for the FY 2021 IPPS post-reclassified wage index, including, but not limited to, the rural floor adjustment . . . .").

> violate the rural floor (it does), the Secretary's policy would separately violate 42 U.S.C. § 1395ww(d)(8)(E)(i), which requires the Secretary to treat a hospital that has elected to reclassify as rural as rural for the purposes of the prospective payment system.
> For the forging reasons, the Provider requests that the Board reverse the Secretary's calculation of the rural floor for CY 2021 and direct the Secretary to recalculate its OPPS payments in the manner required by the statute.[35]

### *2. Provider's Request for EJR*

The Provider filed its Petition for EJR to challenge CMS' new wage index rules as unlawful because it conflicts with the Medicare statute.[36] It argues that the FY 2020 rulemaking (1) does not treat reclassified "Section 401" hospitals as being located in a rural are as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[37]

It seeks to have its wage index recalculated in compliance with the requirements of the Medicare statute.[38] The Provider is specifically seeking the Board hold that:

> CMS's calculation of the FFY 2021 rural floor is unlawful because CMS does not have statutory authority to exclude data of Section 401 hospitals from the calculation of the rural floor and CMS cannot assign a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state, and to compel CMS to pay the Provider reimbursement that was withheld as a result of that regulation during the year under appeal.[39]

The Provider insists it has met the criteria set forth in 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), namely that the Board has jurisdiction over the appeal but lacks the authority to grant the relief the Provider seeks.[40]

### *3. Medicare Contractor's Position*

On **January 12, 2026**, the Medicare Contractor's designated representative, Federal Specialized Services ("FSS"), filed a response to the Request for Expedited Judicial Review. It took no

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[35] Statement of the Issue (June 20, 2021).
[36] Petition for Expedited Judicial Review at 1-2 (Jan. 5, 2026).
[37] *Id.* at 1, 5-6.
[38] *Id.* at 2.
[39] *Id.* at 7.
[40] *Id.* at 6-10.

position on the Request for EJR but noted "that the MAC will file a substantive claim challenge in this case."[41] A challenge was filed on **January 26, 2026**, which is addressed below.

**Decision of the Board:**

The Provider has filed this Request for EJR based on its appeal from policies established in the 2021 OPPS Final Rule published in the Federal Register.

***1. Jurisdiction and Request for EJR***

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

As previously noted, the Provider filed an individual appeal from the 2021 OPPS Final Rule.[42] The Board has determined that (1) the Provider's documentation shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal;[43] (2) the appeal was timely filed; and (3) Board review of the matter in this appeal is not precluded by statute or regulation. In finding that the Provider meets the $10,000 amount in controversy, the Board recognizes that the filed amount in controversy illustrates the reimbursement difference between the "current rural floor calculation and "if [the] rural floor were calculated correctly" though the calculation erroneously refers to both FY 2021 and 2022 in separate locations.[44] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying Provider. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

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

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

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[41] Response to Provider's request for expedited judicial review at 1 (Jan. 12, 2026).
[42] 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.
[43] *See* 42 C.F.R. § 405.1835(a)(2).
[44] Individual Appeal request, Impact Calculation.

> (1) *General Requirement*. In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), **must include an appropriate claim for the specific item**, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **and describing** how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[45]

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

[45] (Bold and underline emphasis added.)

> 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 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-*
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> (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**.[46]

These regulations are applicable to the cost reporting period under appeal for the Provider in the instant case, which has a cost reporting period ending after December 31, 2016. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions

[46] (Bold and underline emphasis added.)

whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to

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

Board Rule 44.5.1 governs the timing of Substantive Claim Challenges filed pursuant to 42 C.F.R. § 405.1873(a) in an individual appeal, and requires:

> A party that questions whether *the cost report at issue* included an appropriate reimbursement claim for one or more issues being appealed must file a Substantive Claim Challenge no later than the filing deadline for the Medicare contractor's preliminary position paper, unless the moving party's filing demonstrates good cause. The moving party must summarize in its Substantive Claim Challenge the efforts that it made to contact the opposing party to discuss the merits of the challenge. If the moving party has attempted to confer but has been unsuccessful, briefly describe the attempts made. *See* Rule 44.2 for sample language. The opposing party(ies) has thirty (30) days to respond (including in the context of an EJR filing).
>
> - *Expedited Challenge Filing Deadline When an EJR Request Is Filed Per Board Rule 42*.---If the provider files an EJR request prior to the Medicare contractor filing its preliminary position paper, then any Substantive Claim Challenge *on the issue that is the subject of the EJR request* must be filed within five (5) business days of the EJR request (to the extent it has not already been filed or unless the moving party demonstrates good cause). In this situation (and consistent with 42 C.F.R. §§ 405.1842(e)(3), (3)(ii) and 405.1873(b)(1), (d)(2) and Board Rule 42.1), the Board will then 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.

In the instant case, the Medicare Contractor has not filed its Preliminary Position Paper and the current deadline for doing so is **June 22, 2026,** so the expedited challenge filing deadline for any Substantive Claim Challenges was within five (5) business days of the Request for EJR. The Request for EJR was filed on **January 5, 2026**, so the deadline for filing a Substantive Claim Challenge was **January 12, 2026**. FSS filed a Response to the Request for EJR on **January 12, 2026**, which stated "that the MAC will file a substantive claim challenge in this case."[47] The challenge was filed on **January 26, 2026**, which was untimely, pursuant to Board Rule 44.5.1, and thus, the Board declines to consider the challenge.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[48] 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.[49] In this case, the Medicare Contractor has failed to file a Substantive Claim Challenge[50] within the time frame specified by Board Rule 44.5.1 (2023).

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a) and in compliance with the Board's Rules, whether an appropriate claim was made,[51] 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).

### *3. Analysis Regarding Appealed Issue*

As set forth below, the Board finds that the Secretary's determination to (1) "calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103)"; and (2) "for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . . (as implemented at § 412.103) from the calculation of 'the wage index for rural areas in the State in which the county is located' referred to in section [1395ww](d)(8)(C)(iii). . . ."[52] was made through notice and comment in the form of an uncodified regulation.[53]

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[47] Response to Provider's request for expedited judicial review at 1.
[48] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[49] *See* 42 C.F.R. § 405.1873(a).
[50] 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."
[51] 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."
[52] 84 Fed. Reg. 42044 at 42336.
[53] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals."

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

> After consideration of the public comments we received, for the reasons discussed in this final rule and in the proposed rule, we are finalizing without modification our proposal to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103). Additionally, we are finalizing without modification our proposal, for purposes of applying the provisions of section 1886(d)(8)(C)(iii) of the Act, to remove the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103) from the calculation of "the wage index for rural areas in the State in which the county is located" referred to in section 1886(d)(8)(C)(iii) of the Act.[54]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as the "Uncodified Regulations on Rural Floor Calculation and Wage Index." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation.[55]

While this appeal involves the 2021 OPPS Final Rule, CMS has adopted the FY 2020 IPPS Final Rule's policy in its 2021 OPPS Final Rule, meaning for 2021 it will calculate the rural floor in a state without reference to the wage index that applies for any hospitals in that state which were reclassified as rural pursuant to Section 401.[56] Therefore, the Board finds that this policy continues to be a binding but uncodified regulation for 2021 as it applies to OPPS payments.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2021 OPPS Final Rule and the Board does not have the authority to grant the relief sought by the Provider, namely invalidating the Uncodified Regulations on Rural Floor Calculation and Wage Index which it alleges (1) does not treat reclassified "Section 401" hospitals as being located in a rural are as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural

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[54] 84 Fed. Reg. at 42336.
[55] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."
[56] 85 Fed. Reg. 85866, 85917 (Dec. 29, 2020) (stating "We also are continuing to apply for the CY 2021 OPPS wage index any other adjustments for the FY 2021 IPPS post-reclassified wage index, including, but not limited to, the rural floor adjustment . . . .").

hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[57] As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in Case 21-1371.

***D. Board's Decision Regarding the EJR Request***

The Board finds that:

1) It has jurisdiction over the Uncodified Regulations on Rural Floor Calculation and Wage Index Issue for the subject year in Case 21-1371 and that the Provider in this appeal is entitled to a hearing before the Board;

2) While the Provider appealed a cost reporting period beginning after January 1, 2016, no substantive claim challenges[58] have been filed pursuant to 42 C.F.R. § 405.1873(a) and in accordance with the Board's Rules to trigger either Board review under § 405.1873(b) or reporting under § 405.1873(d)(2);

3) Based upon the Provider's assertions regarding the FFY 2021 OPPS 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 codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2021 OPPS Final Rule is valid.

Accordingly, the Board finds that the question of the validity of the codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2021 OPPS 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.

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 this case, the Board hereby closes Case 21-1371 and removes it from its docket.

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[57] Petition for Expedited Judicial Review at 1, 5-6.
[58] As the Board explained in Board Rule 44.5, "[t]he Board adoption of the term "Substantive Claim Challenge' simply refers to any question raised by a party concerning whether *the cost report at issue* included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

Board Members Participating:

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

FOR THE BOARD:

2/3/2026

X Kevin D. Smith, CPA

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

cc: Dean Wolfe, Noridian Healthcare Solutions (J-F)
Scott Berends, Esq., Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**Via Electronic Delivery**

Daniel Hettich, Esq.
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RE: ***Expedited Judicial Review Determination***
Case Number: 21-1372
Middlesex Hospital (Provider Number 07-0020)
Federal Fiscal Year 2021

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's Request for Expedited Judicial Review ("EJR") filed on **January 5, 2026** concerning the above referenced individual appeal. The Board's decision on jurisdiction and EJR for this case are set forth below.

**Issue:**

The Petition for EJR describes the issue as follows:

> The Medicare statute provides that "Section 401" hospitals must be treated as being located in a rural area for all purposes under the IPPS system, *see* 42 U.S.C. § 1395ww(d)(8)(E), and that no urban hospital can be assigned a wage index that is lower than the wage index assigned to rural hospitals in the same state, *see* 42 U.S.C. § 1395ww note. CMS has also established that it uses the IPPS wage index for purposes of OPPS payments. 42 C.F.R. § 419.43(c)(1). In its rulemakings for the Inpatient Prospective Payment System and the Outpatient Prospective Payment System for fiscal year 2020, and carried forward to FFY 2021, however, CMS announced a new rule that violates both of these statutory directives. Specifically, under CMS's new policy, Section 401 hospitals would not be treated as rural in calculating the rural floor, and urban hospitals will be assigned a lower wage index than the one applicable to rural hospitals in the state. The issue presented in these appeals is whether CMS's new wage index rule is unlawful because it conflicts with the unambiguous requirements of the Medicare statute.[1]

[1] Petition for Expedited Judicial Review at 1-2 (Jan. 5, 2026).

The Provider is requesting "that the Board grant EJR of the Provider's appeal challenging the validity of CMS's rule excluding Section 401 hospitals from the calculation of the rural floor."[2]

**Statutory and Regulatory Background:**

***1. Wage Index; Rural and Urban Classification***

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[3] known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs"). The base payment rate is comprised of a standardized amount[4] for all subsection (d) hospitals located in an "urban" or "rural" area.[5]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[6] adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).[7]

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives "an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a

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[2] *Id.* at 10.
[3] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).
[4] The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27708, 27765-27766 (May 27, 1994). Section 1395ww(d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).
[5] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[6] of the Department of Health and Human Services.
[7] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index (last visited January 30, 2026).

national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts."[8]

In 1999, Congress recognized that in some cases, a hospital in one geographical area may compete for the same labor pool as hospitals in a nearby, larger urban area but receive lower reimbursement because they are geographically located in a lower wage index area. This resulted in some hospitals being underpaid for their labor costs. As a result, "Congress amended the Medicare Act in order to allow a hospital to seek reclassification from its geographically-based wage area to a nearby wage area for payment purposes if it met certain criteria"[9] and established the Medicare Geographic Review Board (MGCRB) to administer the reclassification process.[10,11]

Ten years after the MGCRB was established, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106-113).[12] This legislation instructed the Secretary that urban hospitals that applied to the MGCRB for redesignation as rural were to be treated as such. Hospitals that receive these redesignations are sometimes known as "Section 401" hospitals. Codified at 42 U.S.C. § 1395ww(d)(8)(E), the statute states that:

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

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[8] *Id.*
[9] *Robert Wood Johnson University Hosp. v. Thompson*, 297 F. 3d. 273, 276 (3d Cir. 2002).
[10] *Id.*
[11] 42 U.S.C. § 1395ww(d)(10)(D)(v).
[12] *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Public L. 106-113, app. F. § 401, 113, Stat. 1501, 1501A-321 (Nov. 29, 1999). Codified as 42 U.S.C. § 1395ww(d)(8).

> (IV) The hospital meets such other criteria as the Secretary may specify.[13]

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

> Hospitals qualifying under this section shall be eligible to qualify for all categories and designations available to rural hospitals, including sole community, Medicare dependent, critical access, and referral centers. Additionally, qualifying hospitals shall be eligible to apply to the [MGCRB] for geographic reclassification to another area. The [MGCRB] shall regard such hospitals as rural and as entitled to the exceptions extended to referral centers and sole community hospitals, if such hospitals are so designated.[14]

### *2. Rural Floor Adjustment*

In 1997, Congress observed that the calculation of the wage index for all regions of a state can sometimes result in "some urban hospitals being paid less than the average rural hospital in their state."[15] To correct this problem, in the Balanced Budget Act of 1997, Congress provided that the wage index assigned to a hospital in an urban area must be at least as great as the wage index assigned to rural hospitals within the same state. The statute provides that:

> For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)) may not be less than the area wage index applicable under such section to hospitals located in rural areas in the State in which the hospital is located.[16]

This provision is commonly referred to as the "rural floor."

### *3. Changes to the Wage Index Calculation*

In the FFY 2019 IPPS proposed rule,[17] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information

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[13] *Id.* (emphasis added).
[14] H.R. Conf. Rep. No. 106-479, 512 (1999).
[15] H.R. Rep. No. 105-149, at 1305 (1997).
[16] 42 U.S.C. § 1395ww note (Floor on Area Wage Index).
[17] 83 Fed. Reg. 20164 (May 7, 2018).

("RFI") as part of the FFY 2020 IPPS proposed rule.[18] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[19] In the FFY 2020 IPPS Final Rule, the Secretary proposed several policies to address wage index disparities.[20] Relevant to the issue under appeal here are the Secretary's proposals to prevent allegedly inappropriate payment increases due to rural reclassifications made under the provisions of 42 C.F.R. § 412.103.[21,22] The Secretary finalized without modification the proposals

- to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103); and
- for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . .(as implemented at § 412.103) from the calculation of ''the wage index for rural areas in the State in which the county is located'' referred to in section [1395ww](d)(8)(C)(iii). . . .[23]

The Secretary contends that this policy "is necessary and appropriate to address the unanticipated effects of rural reclassifications on the rural floor and resulting wage index disparities, including

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[18] 84 Fed Reg 19158, 19393-94 (May 3, 2019).
[19] *Id.*
[20] *See generally* 84 Fed. Reg. 42044, 42336-42339 (Aug. 16, 2019).
[21] 42 C.F.R. § 412.103 states in relevant part that:

> (a) General criteria. A prospective payment hospital that is located in an urban area (as defined in subpart D of this part) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
> (1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification, the Rural–Urban Commuting Area codes, . . . .
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.
> *****
> (7) For a hospital with a main campus and one or more remote locations under a single provider agreement where services are provided and billed under the inpatient hospital prospective payment system and that meets the provider-based criteria at § 413.65 of this chapter as a main campus and a remote location of a hospital, the hospital is required to demonstrate that the main campus and its remote location(s) each independently satisfy the location conditions specified in paragraphs (a)(1) and (2) of this section.

[22] 84 Fed. Reg. at 42332.
[23] *Id.* at 42336.

the effects of the manipulation of the rural floor by certain hospitals."[24] The Secretary concludes that "the inclusion of reclassified hospitals in the rural floor calculation has had the unforeseen effect of exacerbating the wage index disparities between low and high wage index hospitals."[25]

Under the 2020 IPPS Final Rule, the Secretary "would continue to calculate the rural floor based on the physical non-MSA area of the state, which is the same rural area to which a hospital is reclassified under section [1395ww](d)(8)(E). However, for purposes of calculating the rural floor wage index for a state, [the Secretary] would not include in the rural area the data of hospitals that have reclassified as rural under section [1395ww](d)(8)(E)."[26] The Secretary pointed out that the "legislative intent of the rural floor was to correct the 'anomaly' of 'some urban hospitals being paid less than the average rural hospital in their States.'"[27]

The Secretary found that "[u]nder the current rural floor wage index calculation, rather than raising the payment of some urban hospitals to the level of the average rural hospital in their State, urban hospitals may have their payments raised to the relatively high level of one or more geographically urban hospitals reclassified as rural."[28] The Secretary explained that "[w]hile urban hospitals in mostly rural states may benefit from an increase in the rural floor due to urban to rural reclassification . . . other states with high wage urban hospitals using [42 C.F.R.] § 412.103 reclassifications to raise the rural floor can mitigate those gains for mostly rural states, due to budget neutrality."[29] The Secretary believes that "excluding the data of hospitals that reclassify as rural under section [1395ww](d)(8)(E) from the rural floor wage index is necessary and appropriate to address these unanticipated effects of rural reclassifications on the rural floor and the resulting wage index disparities."[30]

The Secretary contends that his reimbursement calculation "is permissible under [42 U.S.C. § 1395ww](d)(8)(E) (as implemented by [42 C.F.R.] § 412.103) and the rural floor statute [42 U.S.C. § 1395ww(d) note]" and notes that the statute "does not specify where the wage data of reclassified hospitals must be included."[31] Therefore, the Secretary believes that he has the "discretion to exclude the wage index data of such hospitals from the calculation of the rural floor. Furthermore, the rural floor statute does not specify how the rural floor wage index is to be calculated or what data are to be included in the calculation."[32] Consequently, the Secretary believes that he has the "discretion under the rural floor statute to exclude the wage data of hospitals reclassified under section [1395ww](d)(8)(E) from the calculation of the rural floor."[33]

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[24] *Id. at* 42333.
[25] *Id.*
[26] *Id.* at 42334.
[27] *Id.*
[28] *Id.*
[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] *Id.*

CMS has adopted the FY 2020 IPPS Final Rule's policy in its 2021 OPPS Final Rule, meaning for 2021 it will calculate the rural floor in a state without reference to the wage index that applies for any hospitals in that state which were reclassified as rural pursuant to Section 401.[34]

**Positions of the Parties:**

***1. Provider's Appeal Request***

The Provider describes the appealed issue as follows:

> The Provider challenges the Secretary's calculation of the rural floor in the outpatient prospective payment system (OPPS) final rule for calendar year (CY) 2021.
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> For wage index purposes, there are two types of geographic areas: urban and rural.
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> ***
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> When a hospital reclassifies as rural, its wage and hour data is included in the calculation of the state rural wage index adjustment in the next federal fiscal year.
> The Medicare statute contains a provision requiring that no urban hospital can be assigned a wage index adjustment that is lower than the wage index assigned to rural hospitals in the state.
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> ***
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> In the IPPS final rule for FFY 2020, the . . . . rural wage index will continue to be calculated based on the average hourly wage of all rural hospitals and all urban hospitals that have reclassified as rural. The rural floor, however, will not include the wage and hour data of reclassified rural hospitals; it will be based solely on the wage data of naturally rural hospitals. Since adopting this policy, the Secretary has applied the same rural floor policy to the OPPS final rules for CY 2020 and 2021. In this appeal, the Provider challenges CMS's policy insofar as it was applied in the OPPS final rule for CY 2021.
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> ***
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> [A]s a direct result of this policy, in CY 2021, urban hospitals in some states have been assigned a wage index that is lower than the wage index assigned to rural hospitals in those states. This result violates the rural floor, which expressly prohibits the Secretary from assigning a wage index to urban hospitals that is lower than the wage index of rural hospitals in the same state. *See* 42 U.S.C. § 1395ww note. Even if this result did not violate the rural floor (it does), the Secretary's policy would separately

[34] 85 Fed. Reg. 85866, 85917 (Dec. 29, 2020) (stating "We also are continuing to apply for the CY 2021 OPPS wage index any other adjustments for the FY 2021 IPPS post-reclassified wage index, including, but not limited to, the rural floor adjustment . . . .").

> violate 42 U.S.C. § 1395ww(d)(8)(E)(i), which requires the Secretary to treat a hospital that has elected to reclassify as rural as rural for the purposes of the prospective payment system.
> For the forging reasons, the Provider requests that the Board reverse the Secretary's calculation of the rural floor for CY 2021 and direct the Secretary to recalculate its OPPS payments in the manner required by the statute.[35]

### *2. Provider's Request for EJR*

The Provider filed its Petition for EJR to challenge CMS' new wage index rules as unlawful because it conflicts with the Medicare statute.[36] It argues that the FY 2020 rulemaking (1) does not treat reclassified "Section 401" hospitals as being located in a rural area as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[37]

It seeks to have its wage index recalculated in compliance with the requirements of the Medicare statute.[38] The Provider is specifically seeking the Board hold that:

> CMS's calculation of the FFY 2021 rural floor is unlawful because CMS does not have statutory authority to exclude data of Section 401 hospitals from the calculation of the rural floor and CMS cannot assign a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state, and to compel CMS to pay the Provider reimbursement that was withheld as a result of that regulation during the year under appeal.[39]

The Provider insists it has met the criteria set forth in 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), namely that the Board has jurisdiction over the appeal but lacks the authority to grant the relief the Provider seeks.[40]

### *3. Medicare Contractor's Position*

On **January 12, 2026**, the Medicare Contractor's designated representative, Federal Specialized Services ("FSS"), filed a response to the Request for Expedited Judicial Review. It took no position on the Request for EJR but noted "that the MAC will not file a substantive claim challenge and will not file a jurisdictional challenge."[41]

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[35] Statement of the Issue (June 20, 2021).
[36] Petition for Expedited Judicial Review at 1-2 (Jan. 5, 2026).
[37] *Id.* at 1, 5-6.
[38] *Id.* at 2.
[39] *Id.* at 7.
[40] *Id.* at 6-10.
[41] Response to Provider's request for expedited judicial review at 1 (Jan. 12, 2026).

**Decision of the Board:**

The Provider has filed a Request for EJR based on its appeal from policies the 2021 OPPS Final Rule published in the Federal Register.

***1. Jurisdiction and Request for EJR***

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

As previously noted, the Provider filed an individual appeal from the 2021 OPPS Final Rule.[42] The Board has determined that (1) the Provider's documentation shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal;[43] (2) the appeal was timely filed; and (3) Board review of the matter in this appeal is not precluded by statute or regulation. In finding that the Provider meets the $10,000 amount in controversy, the Board recognizes that the filed amount in controversy illustrates the reimbursement difference between the "current rural floor calculation" and "if [the] rural floor were calculated correctly."[44] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying Provider. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

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

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

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

[42] 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.
[43] *See* 42 C.F.R. § 405.1835(a)(2).
[44] Individual Appeal request, Impact Calculation.

> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **and describing** how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[45]

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.

[45] (Bold and underline emphasis added.)

> (b) *Summary of Procedures*.
>
> ***
>
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ***
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ***
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> (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**.[46]

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

> give the parties an adequate opportunity to submit factual evidence and legal arguments regarding the question of whether the provider's

[46] (Bold and underline emphasis added.)

> 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.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[47] 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.[48] In this case, the Medicare Contractor has indicated it will not file a Substantive Claim Challenge.[49]

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[50] 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).

### *3. Analysis Regarding Appealed Issue*

As set forth below, the Board finds that the Secretary's determination to (1) "calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103)"; and (2) "for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . . (as implemented at § 412.103) from the calculation of 'the wage index for rural areas in the State in which the county is located' referred to in section [1395ww](d)(8)(C)(iii). . . ."[51] was made through notice and comment in the form of an uncodified regulation.[52]

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[47] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[48] *See* 42 C.F.R. § 405.1873(a).
[49] 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."
[50] 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."
[51] 84 Fed. Reg. 42044 at 42336.
[52] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals."

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

> After consideration of the public comments we received, for the reasons discussed in this final rule and in the proposed rule, we are finalizing without modification our proposal to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103). Additionally, we are finalizing without modification our proposal, for purposes of applying the provisions of section 1886(d)(8)(C)(iii) of the Act, to remove the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103) from the calculation of "the wage index for rural areas in the State in which the county is located" referred to in section 1886(d)(8)(C)(iii) of the Act.[53]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as the "Uncodified Regulations on Rural Floor Calculation and Wage Index." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation.[54]

While this appeal involves the 2021 OPPS Final Rule, CMS has adopted the FY 2020 IPPS Final Rule's policy in its 2021 OPPS Final Rule, meaning for 2021 it will calculate the rural floor in a state without reference to the wage index that applies for any hospitals in that state which were reclassified as rural pursuant to Section 401.[55] Therefore, the Board finds that this policy continues to be a binding but uncodified regulation for 2021 as it applies to OPPS payments.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2021 OPPS Final Rule and the Board does not have the authority to grant the relief sought by the Provider, namely invalidating the Uncodified Regulations on Rural Floor Calculation and Wage Index which it alleges (1) does not treat reclassified "Section 401" hospitals as being located in a rural are as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural

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[53] 84 Fed. Reg. at 42336.
[54] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."
[55] 85 Fed. Reg. 85866, 85917 (Dec. 29, 2020) (stating "We also are continuing to apply for the CY 2021 OPPS wage index any other adjustments for the FY 2021 IPPS post-reclassified wage index, including, but not limited to, the rural floor adjustment . . . .").

hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[56] As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in Case 21-1372.

***D. Board's Decision Regarding the EJR Request***

The Board finds that:

1) It has jurisdiction over the Uncodified Regulations on Rural Floor Calculation and Wage Index Issue for the subject year in Case 21-1372 and that the Provider in this appeal is entitled to a hearing before the Board;

2) While the Provider appealed a cost reporting period beginning after January 1, 2016, no substantive claim challenges[57] have been filed pursuant to 42 C.F.R. § 405.1873(a) to trigger either Board review under § 405.1873(b) or reporting under § 405.1873(d)(2);

3) Based upon the Provider's assertions regarding the 2021 OPPS 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 codified Regulations on Rural Floor Calculation and Wage Index published in the 2021 OPPS Final Rule is valid.

Accordingly, the Board finds that the question of the validity of the codified Regulations on Rural Floor Calculation and Wage Index published in the 2021 OPPS 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.

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 this case, the Board hereby closes Case 21-1372 and removes it from its docket.

[56] Consolidated Petition for Expedited Judicial Review at 1, 5-6.
[57] As the Board explained in Board Rule 44.5, "[t]he Board adoption of the term "Substantive Claim Challenge' simply refers to any question raised by a party concerning whether *the cost report at issue* included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

Board Members Participating:

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

FOR THE BOARD:

2/3/2026

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, Esq., Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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**Via Electronic Delivery**

Daniel Hettich, Esq.
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RE: ***Expedited Judicial Review Determination***

| | |
|---|---|
| 21-1374GC | *CHS CY 2021 OPPS Section 401 Hospitals Rural Floor CIRP Group* |
| 21-1375GC | *Hartford Health CY 2021 OPPS Section 401 Hospitals Rural Floor CIRP Group* |
| 21-1376GC | *Trinity New England CY 2021 OPPS Section 401 Hospitals Rural Floor CIRP Group* |
| 21-1377GC | *Intermountain CY 2021 OPPS Section 401 Hospitals Rural Floor CIRP Group* |

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Consolidated[1] Request for Expedited Judicial Review ("EJR") filed on **January 5, 2026** concerning the above referenced common issue related party ("CIRP") group appeals. The Board's decision on jurisdiction and EJR for these four (4) cases are set forth below.

**Issue:**

The Petition for EJR describes the issue as follows:

> The Medicare statute provides that "Section 401" hospitals must be treated as being located in a rural area for all purposes under the IPPS system, *see* 42 U.S.C. § 1395ww(d)(8)(E), and that no urban hospital can be assigned a wage index that is lower than the wage index assigned to rural hospitals in the same state, *see* 42 U.S.C. § 1395ww note. CMS has also established that it uses the IPPS wage index for purposes of OPPS payments. 42 C.F.R. § 419.43(c)(1). In its rulemaking for the Inpatient Prospective Payment System and the Outpatient Prospective Payment System for fiscal year 2020, and carried forward to FFY 2021, however, CMS announced a new rule that violates both of these statutory directives. Specifically, under CMS's new policy, Section 401 hospitals would not be treated as rural in calculating the rural floor, and urban hospitals will be assigned a lower wage index than the one applicable to rural hospitals in the state. The issue presented in these appeals is whether CMS's new

[1] The Petition also included Case 21-1373GC, which will be addressed under separate cover.

> wage index rule is unlawful because it conflicts with the unambiguous requirements of the Medicare statute.[2]

The Providers are requesting "that the Board grant EJR of the Providers appeals challenging the validity of CMS's rule excluding Section 401 hospitals from the calculation of the rural floor."[3]

**Statutory and Regulatory Background:**

***1. Wage Index; Rural and Urban Classification***

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[4] known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs"). The base payment rate is comprised of a standardized amount[5] for all subsection (d) hospitals located in an "urban" or "rural" area.[6]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[7] adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).[8]

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix

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[2] Case Nos. 21-1373GC *et al.*, Consolidated Petition for Expedited Judicial Review at 1-2 (Jan. 5, 2026).
[3] *Id.* at 10.
[4] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).
[5] The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27708, 27765-27766 (May 27, 1994). Section 1395ww(d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).
[6] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[7] of the Department of Health and Human Services.
[8] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index (last visited January 30, 2026).

Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives "an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts."[9]

In 1999, Congress recognized that in some cases, a hospital in one geographical area may compete for the same labor pool as hospitals in a nearby, larger urban area but receive lower reimbursement because they are geographically located in a lower wage index area. This resulted in some hospitals being underpaid for their labor costs. As a result, "Congress amended the Medicare Act in order to allow a hospital to seek reclassification from its geographically-based wage area to a nearby wage area for payment purposes if it met certain criteria"[10] and established the Medicare Geographic Review Board (MGCRB) to administer the reclassification process.[11,12]

Ten years after the MGCRB was established, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106-113).[13] This legislation instructed the Secretary that urban hospitals that applied to the MGCRB for redesignation as rural were to be treated as such. Hospitals that receive these redesignations are sometimes known as "Section 401" hospitals. Codified at 42 U.S.C. § 1395ww(d)(8)(E), the statute states that:

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

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[9] *Id.*
[10] *Robert Wood Johnson University Hosp. v. Thompson*, 297 F. 3d. 273, 276 (3d Cir. 2002).
[11] *Id.*
[12] 42 U.S.C. § 1395ww(d)(10)(D)(v).
[13] *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Public L. 106-113, app. F. § 401, 113, Stat. 1501, 1501A-321 (Nov. 29, 1999). Codified as 42 U.S.C. § 1395ww(d)(8).

> (III) The hospital would qualify as a rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.
> (IV) The hospital meets such other criteria as the Secretary may specify.[14]

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

> Hospitals qualifying under this section shall be eligible to qualify for all categories and designations available to rural hospitals, including sole community, Medicare dependent, critical access, and referral centers. Additionally, qualifying hospitals shall be eligible to apply to the [MGCRB] for geographic reclassification to another area. The [MGCRB] shall regard such hospital as rural and as entitled to the exceptions extended to referral centers and sole community hospitals, if such hospitals are so designated.[15]

### *2. Rural Floor Adjustment*

In 1997, Congress observed that the calculation of the wage index for all regions of a state can sometimes result in "some urban hospitals being paid less than the average rural hospital in their state."[16] To correct this problem, in the Balanced Budget Act of 1997, Congress provided that the wage index assigned to a hospital in an urban area must be at least as great as the wage index assigned to rural hospitals within the same state. The statute provides that:

> For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)) may not be less than the area wage index applicable under such section to hospitals located in rural areas in the State in which the hospital is located.[17]

This provision is commonly referred to as the "rural floor."

### *3. Changes to the Wage Index Calculation*

In the FFY 2019 IPPS proposed rule,[18] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information ("RFI") as part of the FFY 2020 IPPS proposed rule.[19] Therein, the Secretary noted that many

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[14] *Id.* (emphasis added).
[15] H.R. Conf. Rep. No. 106-479, 512 (1999).
[16] H.R. Rep. No. 105-149, at 1305 (1997).
[17] 42 U.S.C. § 1395ww note (Floor on Area Wage Index).
[18] 83 Fed. Reg. 20164 (May 7, 2018).
[19] 84 Fed Reg 19158, 19393-94 (May 3, 2019).

respondents expressed: (1) "a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[20] In the FFY 2020 IPPS Final Rule, the Secretary proposed several policies to address wage index disparities.[21] Relevant to the issue under appeal here are the Secretary's proposals to prevent allegedly inappropriate payment increases due to rural reclassifications made under the provisions of 42 C.F.R. § 412.103.[22,23] The Secretary finalized without modification the proposals

- to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103); and
- for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . .(as implemented at § 412.103) from the calculation of 'the wage index for rural areas in the State in which the county is located' referred to in section [1395ww](d)(8)(C)(iii). . . .[24]

The Secretary contends that this policy "is necessary and appropriate to address the unanticipated effects of rural reclassification on the rural floor and resulting wage index disparities, including the effects of the manipulation of the rural floor by certain hospitals."[25] The Secretary concludes that "the inclusion of reclassified hospitals in the rural floor calculation has had the unforeseen

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[20] *Id.*
[21] *See generally* 84 Fed. Reg. 42044, 42336-42339 (Aug. 16, 2019).
[22] 42 C.F.R. § 412.103 states in relevant part that:

> (a) General criteria. A prospective payment hospital that is located in an urban area (as defined in subpart D of this part) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
> (1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification, the Rural–Urban Commuting Area codes, . . . .
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.
> *****
> (7) For a hospital with a main campus and one or more remote locations under a single provider agreement where services are provided and billed under the inpatient hospital prospective payment system and that meets the provider-based criteria at § 413.65 of this chapter as a main campus and a remote location of a hospital, the hospital is required to demonstrate that the main campus and its remote location(s) each independently satisfy the location conditions specified in paragraphs (a)(1) and (2) of this section.

[23] 84 Fed Reg. at 42332.
[24] *Id.* at 42336.
[25] *Id.* at 42333.

effect of exacerbating the wage index disparities between low and high wage index hospitals."[26]

Under the 2020 IPPS Final Rule, the Secretary "would continue to calculate the rural floor based on the physical non-MSA area of the state, which is the same rural area to which a hospital is reclassified under section [1395ww](d)(8)(E). However, for purposes of calculating the rural floor wage index for a state, [the Secretary] would not include in the rural area the data of hospitals that have reclassified as rural under section [1395ww](d)(8)(E)."[27] The Secretary pointed out that the "legislative intent of the rural floor was to correct the 'anomaly' of 'some urban hospitals being paid less than the average rural hospital in their States.'"[28]

The Secretary found that "[u]nder the current rural floor wage index calculation, rather than raising the payment of some urban hospitals to the level of the average rural hospital in their State, urban hospitals may have their payments raised to the relatively high level of one or more geographically urban hospitals reclassified as rural."[29] The Secretary explained that "[w]hile urban hospitals in mostly rural states may benefit from an increase in the rural floor due to urban to rural reclassification . . . other states with high wage urban hospitals using [42 C.F.R.] § 412.103 reclassifications to raise the rural floor can mitigate those gains for mostly rural states, due to budget neutrality."[30] The Secretary believes that "excluding the data of hospitals that reclassify as rural under section [1395ww](d)(8)(E) from the rural floor wage index is necessary and appropriate to address these unanticipated effects of the rural reclassifications on the rural floor and the resulting wage index disparities."[31]

The Secretary contends that his reimbursement calculation "is permissible under [42 U.S.C. § 1395ww](d)(8)(E) (as implemented by [42 C.F.R.] § 412.103) and the rural floor statute [42 U.S.C. § 1395ww(d) note]" and notes that the statute "does not specify where the wage data of reclassified hospitals must be included."[32] Therefore, the Secretary believes that he has the "discretion to exclude the wage index data of such hospitals from the calculation of the rural floor. Furthermore, the rural floor statute does not specify how the rural floor wage index is to be calculated or what data are to be included in the calculation."[33] Consequently, the Secretary believes that he has the "discretion under the rural floor statute to exclude the wage data of hospitals reclassified under section [1395ww](d)(8)(E) from the calculation of the rural floor."[34]

CMS has adopted the FY 2020 IPPS Final Rule's policy in its FY 2021 OPPS Final Rule, meaning for FFY 2021 it will calculate the rural floor in a state without reference to the wage

[26] *Id.*
[27] *Id.* at 42334.
[28] *Id.*
[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] *Id.*
[34] *Id.*

index that applies for any hospitals in that state which were reclassified as rural pursuant to Section 401.[35]

**Positions of the Parties:**

***1. Providers' Appeal Requests***

The Providers describe the appealed issue as follows:

> The Providers in this group appeal challenge the Secretary's calculation of the rural floor in the outpatient prospective payment system (OPPS) final rule for calendar year (CY) 2021.
>
> ***
>
> For wage index purposes, there are two types of geographic areas: urban and rural.
>
> ***
>
> When a hospital reclassifies as rural, its wage and hour data is included in the calculation of the state rural wage index adjustment in the next federal fiscal year.
> The Medicare statute contains a provision requiring that no urban hospital can be assigned a wage index adjustment that is lower than the wage index assigned to rural hospitals in the state.
>
> ***
>
> The Secretary is bound by his own regulation to use the wage index values calculated in the inpatient prospective payment system (IPPS) final rule in determining the wage index values under the OPPS final rule for the calendar year ending in the same year. See 42 C.F.R. § 419.43(c). In the IPPS final rule for FFY 2020, . . . [t]he rural wage index will continue to be calculated based on the average hourly wage of all rural hospitals and all urban hospitals that have reclassified as rural. The rural floor, however, will not include the wage and hour data of reclassified rural hospitals; it will be based solely on the wage data of naturally rural hospitals. Since adopting this policy, the Secretary has applied the same rural floor policy to the OPPS final rules for CY 2020 and 2021. In this appeal, the Providers challenge CMS's policy insofar as it was applied in the OPPS final rule for CY 2021.
>
> ***
>
> [A]s a direct result of this policy, in CY 2021, urban hospitals in some states have been assigned a wage index that is lower than the wage index assigned to rural hospitals in those states. This result violates the rural floor, which expressly prohibits the Secretary from assigning a wage index

[35] 85 Fed. Reg. 85866, 85916-17 (Dec. 29, 2020) ("FY2021 OPPS Rule") (stating "We also are continuing to apply for the CY 2021 OPPS wage index any other adjustments for the FY 2021 IPPS post-reclassified wage index, including, but not limited to, the rural floor adjustment . . . .").

> to urban hospitals that is lower than the wage index of rural hospitals in the same state. *See* 42 U.S.C. § 1395ww note. Even if this result did not violate the rural floor (it does), the Secretary's policy would separately violate 42 U.S.C. § 1395ww(d)(8)(E)(i), which requires the Secretary to treat a hospital that has elected to reclassify as rural as rural for the purposes of the prospective payment system.
> For the forging reasons, the Providers in this group appeal request that the Board reverse the Secretary's calculation of the rural floor for CY 2021 and direct the Secretary to recalculate those payments in the manner required by the statute.[36]

### *2. Providers' Request for EJR*

The Providers filed their Petition for EJR to challenge CMS' new wage index rules as unlawful because it conflicts with the Medicare statute.[37] They argue that the FY 2020 rulemaking (1) does not treat reclassified "Section 401" hospitals as being located in a rural area as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[38]

They seek to have their wage indices recalculated in compliance with the requirements of the Medicare statute.[39] The Providers are specifically seeking the Board hold that:

> CMS's calculation of the FFY 2021 rural floor is unlawful because CMS does not have statutory authority to exclude data of Section 401 hospitals from the calculation of the rural floor and CMS cannot assign a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state, and to compel CMS to pay the Providers reimbursement that was withheld as a result of that regulation during the years under appeal.[40]

The Providers insist they have met the criteria set forth in 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), namely that the Board has jurisdiction over the appeal but lacks the authority to grant the relief the Providers seek.[41]

### *3. Medicare Contractor's Position*

On **January 12, 2026**, the Medicare Contractor's designated representative, Federal Specialized Services ("FSS"), filed a response to the Consolidated Request for Expedited Judicial Review. It took no position on the Request for EJR but noted "that the MAC filed a substantive claim

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[36] *E.g.*, Case 21-1374GC, Statement of the Issue at 1-2 (June 20, 2021).
[37] Consolidated Petition for Expedited Judicial Review at 1-2 (Jan. 5, 2026).
[38] *Id.* at 1, 5-6.
[39] *Id.* at 2.
[40] *Id.* at 7.
[41] *Id.* at 6-10.

challenge as to 21-1374GC on 4/8/24. The MAC will file a substantive claim challenge in 21-1373GC."[42]

The Board notes that FSS also filed a Substantive Claim Challenge in Case 21-1377GC. This challenge, and the one filed in Case 21-1374GC, are addressed below.

The Substantive Claim Challenge filed in Case 21-1373GC will be addressed under separate cover.

**Decision of the Board:**

The Providers participating in the group appeals included in this EJR request have filed their appeals from policies established in the FFY 2021 OPPS Final Rule published in the Federal Register.

***1. Jurisdiction and Request for EJR***

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

As previously noted, all of the participants in these group cases appealed from the FFY 2021 OPPS Final Rule.[43] The Board has determined that (1) the participants' documentation in the group appeals show that the estimated amounts in controversy exceeds $50,000, as required for a group appeal;[44] (2) the appeals were timely filed; and (3) Board review of the matter in this appeal is not precluded by statute or regulation. In finding that the groups meet the $50,000 amount in controversy, the Board recognizes that the filed amounts in controversy illustrate the difference in reimbursement between the "current rural floor calculation" and "if [the] rural floor were calculated correctly."[45] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying Providers. The estimated amounts in controversy are subject to recalculation by the Medicare contractors for the actual final amounts in each case.

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[42] Response to Provider's Request for Expedited Judicial Review at 1 (Jan. 12, 2026).
[43] 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.
[44] *See* 42 C.F.R. § 405.1837.
[45] *E.g.*, Case No. 21-1374GC, Impact Calculation, Northwest Medical Center (Prov. No. 03-0085).

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

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

> (1) *General Requirement*. In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), **must include an appropriate claim for the specific item**, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **and describing** how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[46]

[46] (Bold and underline emphasis added.)

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

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider **must include in its cost report an appropriate claim for the specific item** (as prescribed in § 413.24(j) of this chapter). If the provider files an appeal to the Board seeking reimbursement for the specific item and any party to such appeal questions whether the provider's cost report included an appropriate claim for the specific item, the Board must address such question in accordance with the procedures set forth in this section.
>
> (b) *Summary of Procedures*.
>
> ***
>
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ***
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ***
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> (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**.[47]

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

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

***a. Case 21-1374GC***

Board Rule 44.5.2 (2021) requires that a party which questions whether any participants in a group case included an appropriate claim *on the cost report at issue* must file a Substantive Claim Challenge within sixty (60) days of the final Schedule of Providers being filed. In Case 21-1374GC, the Providers' representative acknowledged that the group was complete and fully populated in OH CDMS pursuant to Board Rule 20, effectively finalizing the Schedule of Providers, on **June 17, 2022**. FSS filed a Substantive Claim Challenge on **April 8, 2024**, and a Response was filed on **May 3, 2024**.

Pursuant to Board Rule Board Rule 44.5.2 (2021), any Substantive Claim Challenges would typically have been due no later than **August 16, 2022**. The deadline to file the challenge, however, was indefinitely stayed via Board Alert 19 due to the public health emergency created by the COVID-19 pandemic. (*Available at* https://www.cms.gov/files/document/prrb-alerts.pdf). This indefinite stay was lifted effective December 7, 2022 via Board Alert 23, 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.***" (*Available at* https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/current-prrb-alerts) (emphasis in original). There was no correspondence in Case 21-1374GC, or any general notice applicable to this case, which re-established deadlines for Substantive Claim Challenges. As such, the stay for the deadline for a Substantive Claim Challenge was never lifted and FSS' filing was not untimely.

[47] (Bold and underline emphasis added.)

*1. Medicare Contractor's Argument*

The Medicare Contractor claims that neither participant in this case made an appropriate claim on its cost report for the issue under appeal for either of their cost reports occurring in in CY 2021.[48]

For both Providers, the Medicare Contractor claims the disputed issue impacts Part B OPPS reimbursement, but that both report $0 in Part B protested amounts on the applicable cost report worksheets.[49]

*2. Group Representative's Argument*

The Providers do not dispute that they failed to include an appropriate cost report claim for the issue under appeal. Instead, they argue that consideration of the Substantive Claim Challenge is premature because they could file amended cost reports which include additional self-disallowed items.[50] The remainder of the response argues that the regulations requiring an appropriate cost report claim are unlawful and unenforceable. They cite *Bethesda Hosp. Ass'n v. Bowen*[51] and *Banner Heart Hospital v. Burwell*[52] in support of their position that these regulations are unlawful.[53]

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

The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[54] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

The Providers do not dispute that they failed to include an appropriate cost report claim for the IPPS Section 401 Hospital Rural Floor issue under appeal. The Board therefore finds that they did not.

***b. Case 21-1377GC***

Board Rule 44.5.2 (2021) governs the timing for filing substantive claim challenges pursuant to 42 C.F.R. § 405.1873(a) and reads:

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[48] Case No. 21-1374GC, Medicare Administrative Contractor's Substantive Claim Letter at 1 (Apr. 8, 2024).
[49] *Id.* at 3-4.
[50] Response to MAC's Substantive Claim Letter at 4 (May 3, 2024).
[51] 485 U.S. 399 (1988).
[52] 201 F.Supp.3d 131 (D.D.C. 2016)
[53] Response to MAC's Substantive Claim Letter at 4-6.
[54] (Emphasis added.)

> A party that questions whether the one or more participants in a group case (CIRP or optional) included an appropriate claim *on the cost report at issue* for the common issue being appealed in the group ***must file a Substantive Claim Challenge sixty (60) days after the group files its final Schedule of Providers (SOP) unless the moving party's filing demonstrates good cause***.[55] The moving party must summarize in its Substantive Claim Challenge the efforts that it made to contact the opposing party to discuss the merits of the Substantive Claim Challenge. If the moving party has attempted to confer but has been unsuccessful, briefly describe the attempts made. *See* sample language in Rule 44.2. The opposing party(ies) has thirty (30) days to respond (including in the context of an EJR filing).
>
> - *Expedited Challenge Filing Deadline When an EJR Request Is Filed per Board Rule 42.---If the final SOP is filed concurrent with an EJR request or 60 days has not yet transpired between the filing of the final SOP and the EJR request, then refer to Rule 44.6 for special instructions on deadlines for filing Substantive Claim Challenges and any response thereto.*

For group cases where an EJR Request is filed within 60 days of the Final Schedule of Providers, Board Rule 44.6 (2021) governs. In those instances:

> [T]he Medicare contractor . . . 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***.

In Case 21-1377GC, the Providers' representative acknowledged that the group was complete and fully populated in OH CDMS pursuant to Board Rule 20, effectively finalizing the Schedule of Providers, on **June 17, 2022**. As noted above for Case 21-1374GC, Alert 19 was in effect at that time and thus the deadline for a Substantive Claim Challenge was indefinitely stayed. A Substantive Claim Challenge was filed on **January 26, 2026**. While the Board never set a new

[55] (Emphasis added.)

deadline, FSS should have certified that it would be filing a Substantive Claim Challenge in its initial response to the Request for EJR to put the Board and Providers on notice that a challenge was incoming; it did not. The Board, therefore, will not consider the challenge.

c. ***Cases 21-1375GC, 21-1376GC, and 21-1377GC***

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[56] 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.[57] In these cases, the Medicare Contractor has failed to file a Substantive Claim Challenge[58] within the time frame specified by Board Rule 44.5.1 (2023).

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made in Cases 21-1375GC, 21-1376GC and 21-1377GC,[59] 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 for Cases 21-1375GC, 21-1376GC, and 21-1377GC. 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).

***3. Analysis Regarding Appealed Issue***

As set forth below, the Board finds that the Secretary's determination to (1) "calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103)"; and (2) "for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . . (as implemented at § 412.103) from the calculation of 'the wage index for rural areas in the State in which the county is located' referred to in section [1395ww](d)(8)(C)(iii). . . ."[60] was made through notice and comment in the form of an uncodified regulation.[61]

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

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[56] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[57] *See* 42 C.F.R. § 405.1873(a).
[58] Board Rule 44.5 (2023) 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."
[59] 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."
[60] 84 Fed. Reg. 42044 at 42336.
[61] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals."

> After consideration of the public comments we received, for the reasons discussed in this final rule and in the proposed rule, we are finalizing without modification our proposal to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103). Additionally, we are finalizing without modification our proposal, for purposes of applying the provisions of section 1886(d)(8)(C)(iii) of the Act, to remove the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103) from the calculation of "the wage index for rural areas in the State in which the county is located" referred to in section 1886(d)(8)(C)(iii) of the Act.[62]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as the "Uncodified Regulations on Rural Floor Calculation and Wage Index." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation.[63]

While this appeal involves the FFY 2020 OPPS Final Rule, CMS has adopted the FY 2020 IPPS Final Rule's policy in its FY 2021 OPPS Final Rule, meaning for FFY 2021 it will calculate the rural floor in a state without reference to the wage index that applies for any hospitals in that state which were reclassified as rural pursuant to Section 401.[64] Therefore, the Board finds that this policy is a binding but uncodified regulation for FFY 2021 for the purposes of the OPPS.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2021 OPPS Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulations on Rural Floor Calculation and Wage Index which they allege (1) does not treat reclassified "Section 401" hospitals as being located in a rural area as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[65] As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in Cases 21-1374GC, 21-1375GC, 21-1376GC, and 21-1377GC.

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[62] 84 Fed. Reg. at 42336.
[63] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."
[64] 85 Fed. Reg. 85866, 85916-17 (Dec. 29, 2020) ("FY2021 OPPS Rule") (stating "We also are continuing to apply for the CY 2021 OPPS wage index any other adjustments for the FY 2021 IPPS post-reclassified wage index, including, but not limited to, the rural floor adjustment . . . .").
[65] Consolidated Petition for Expedited Judicial Review at 1, 5-6.

***D. Board's Decision Regarding the EJR Request***

The Board finds that:

1) It has jurisdiction over the Uncodified Regulations on Rural Floor Calculation and Wage Index Issue for the subject year in Cases 21-1374GC, 21-1375GC, 21-1376GC, and 21-1377GC and that the Providers in these group appeals are entitled to a hearing before the Board;

2) While the Providers appealed cost reporting periods beginning after January 1, 2016, no substantive claim challenges[66] have been filed pursuant to 42 C.F.R. § 405.1873(a) and in accordance with the Board's Rules in Cases 21-1375GC, 21-1376GC, and 21-1377GC to trigger either Board review under § 405.1873(b) or reporting under § 405.1873(d)(2);

3) For Case 21-1374GC, the review process in 42 C.F.R. § 405.1873(a)-(b) has been triggered for both Providers in this case and the Board specifically finds that both 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) Based upon the Providers' assertions regarding the FFY 2021 OPPS 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 codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2021 OPPS Final Rule is valid.

Accordingly, the Board finds that the question of the validity of the codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2021 OPPS 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 Cases 21-1374GC, 21-1375GC, 21-1376GC, and 21-1377GC and removes them from its docket.

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[66] As the Board explained in Board Rule 44.5, "[t]he Board adoption of the term "Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

Board Members Participating:

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

FOR THE BOARD:

2/3/2026

X Kevin D. Smith, CPA

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

Enclosure: Schedules of Providers

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Dean Wolfe, Noridian Healthcare Solutions (J-F)
Danelle Decker, National Government Services, Inc. (J-K)
Scott Berends, Esq., Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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**Via Electronic Delivery**

Daniel Hettich, Esq.
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RE: ***Expedited Judicial Review Determination***

| | |
|---|---|
| 22-1045GC | *Intermountain Healthcare CY 2022 OPPS Section 401 Hospitals Rural Floor CIRP Group* |
| 22-1046GC | *Steward Health Care CY 2022 OPPS Section 401 Hospitals Rural Floor CIRP Group* |
| 22-1048GC | *CHS CY 2022 OPPS Section 401 Hospitals Rural Floor CIRP Group* |
| 22-1051GC | *CHRISTUS Health CY 2022 OPPS Section 401 Hospitals Rural Floor CIRP Group* |
| 22-1052GC | *Ardent Health CY 2022 OPPS Section 401 Hospitals Rural Floor CIRP Group* |
| 23-1445G | *King & Spalding CY 2022 OPPS Section 401 Hospitals Rural Floor Group* |

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Consolidated Request for Expedited Judicial Review ("EJR") filed on **January 5, 2026** concerning the above referenced common issue related party ("CIRP") and optional group appeals. The Board's decision on jurisdiction and EJR for these six (6) cases are set forth below.

**Issue:**

The Petition for EJR describes the issue as follows:

> The Medicare statute provides that "Section 401" hospitals must be treated as being located in a rural area for all purposes under the IPPS system, *see* 42 U.S.C. § 1395ww(d)(8)(E), and that no urban hospital can be assigned a wage index that is lower than the wage index assigned to rural hospitals in the same state, *see* 42 U.S.C. § 1395ww note. CMS has also established that it uses the IPPS wage index for purposes of OPPS payments. 42 C.F.R. § 419.43(c)(1). In its rulemaking for the Inpatient Prospective Payment System and the Outpatient Prospective Payment System for fiscal year 2020, and carried forward to FFY 2022, however, CMS announced a new rule that violates both of these statutory directives. Specifically, under CMS's new policy, Section 401 hospitals would not be

> treated as rural in calculating the rural floor, and urban hospitals will be assigned a lower wage index than the one applicable to rural hospitals in the state. The issue presented in these appeals is whether CMS's new wage index rule is unlawful because it conflicts with the unambiguous requirements of the Medicare statute.[1]

The Providers are requesting "that the Board grant EJR of the Providers appeals challenging the validity of CMS's rule excluding Section 401 hospitals from the calculation of the rural floor."[2]

**Statutory and Regulatory Background:**

***1. Wage Index; Rural and Urban Classification***

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[3] known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs"). The base payment rate is comprised of a standardized amount[4] for all subsection (d) hospitals located in an "urban" or "rural" area.[5]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[6] adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).[7]

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[1] Case Nos. 22-1045GC *et al.*, Consolidated Petition for Expedited Judicial Review at 1-2 (Jan. 5, 2026).
[2] *Id.* at 10.
[3] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).
[4] The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27708, 27765-27766 (May 27, 1994). Section 1395ww(d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).
[5] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[6] of the Department of Health and Human Services.
[7] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index (last visited January 30, 2026).

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives "an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts."[8]

In 1999, Congress recognized that in some cases, a hospital in one geographical area may compete for the same labor pool as hospitals in a nearby, larger urban area but receive lower reimbursement because they are geographically located in a lower wage index area. This resulted in some hospitals being underpaid for their labor costs. As a result, "Congress amended the Medicare Act in order to allow a hospital to seek reclassification from its geographically-based wage area to a nearby wage area for payment purposes if it met certain criteria"[9] and established the Medicare Geographic Review Board (MGCRB) to administer the reclassification process.[10,11]

Ten years after the MGCRB was established, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106-113).[12] This legislation instructed the Secretary that urban hospitals that applied to the MGCRB for redesignation as rural were to be treated as such. Hospitals that receive these redesignations are sometimes known as "Section 401" hospitals. Codified at 42 U.S.C. § 1395ww(d)(8)(E), the statute states that:

> (E)(i) For purposes of this subsection, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital described in clause (ii), the Secretary ***shall treat the hospital as being located in the rural area*** (as defined in paragraph (2)(D)) of the State in which the hospital is located.
> (ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban area (as defined in paragraph (2)(D)) and satisfies any of the following criteria:
> (I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

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[8] *Id.*
[9] *Robert Wood Johnson University Hosp. v. Thompson*, 297 F. 3d. 273, 276 (3d Cir. 2002).
[10] *Id.*
[11] 42 U.S.C. § 1395ww(d)(10)(D)(v).
[12] *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Public L. 106-113, app. F. § 401, 113, Stat. 1501, 1501A-321 (Nov. 29, 1999). Codified as 42 U.S.C. § 1395ww(d)(8).

> (II) The hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).
> (III) The hospital would qualify as a rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.
> (IV) The hospital meets such other criteria as the Secretary may specify.[13]

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

> Hospitals qualifying under this section shall be eligible to qualify for all categories and designations available to rural hospitals, including sole community, Medicare dependent, critical access, and referral centers. Additionally, qualifying hospitals shall be eligible to apply to the [MGCRB] for geographic reclassification to another area. The [MGCRB] shall regard such hospital as rural and as entitled to the exceptions extended to referral centers and sole community hospitals, if such hospitals are so designated.[14]

### *2. Rural Floor Adjustment*

In 1997, Congress observed that the calculation of the wage index for all regions of a state can sometimes result in "some urban hospitals being paid less than the average rural hospital in their state."[15] To correct this problem, in the Balanced Budget Act of 1997, Congress provided that the wage index assigned to a hospital in an urban area must be at least as great as the wage index assigned to rural hospitals within the same state. The statute provides that:

> For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)) may not be less than the area wage index applicable under such section to hospitals located in rural areas in the State in which the hospital is located.[16]

This provision is commonly referred to as the "rural floor."

### *3. Changes to the Wage Index Calculation*

In the FFY 2019 IPPS proposed rule,[17] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage

[13] *Id.* (emphasis added).
[14] H.R. Conf. Rep. No. 106-479, 512 (1999).
[15] H.R. Rep. No. 105-149, at 1305 (1997).
[16] 42 U.S.C. § 1395ww note (Floor on Area Wage Index).
[17] 83 Fed. Reg. 20164 (May 7, 2018).

index. The Secretary discussed the responses it received from this request for information ("RFI") as part of the FFY 2020 IPPS proposed rule.[18] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[19] In the FFY 2020 IPPS Final Rule, the Secretary proposed several policies to address wage index disparities.[20] Relevant to the issue under appeal here are the Secretary's proposals to prevent allegedly inappropriate payment increases due to rural reclassifications made under the provisions of 42 C.F.R. § 412.103.[21,22] The Secretary finalized without modification the proposals

- to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103); and
- for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . .(as implemented at § 412.103) from the calculation of 'the wage index for rural areas in the State in which the county is located' referred to in section [1395ww](d)(8)(C)(iii). . . .[23]

The Secretary contends that this policy "is necessary and appropriate to address the unanticipated effects of rural reclassification on the rural floor and resulting wage index disparities, including

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[18] 84 Fed Reg 19158, 19393-94 (May 3, 2019).
[19] *Id.*
[20] *See generally* 84 Fed. Reg. 42044, 42336-42339 (Aug. 16, 2019).
[21] 42 C.F.R. § 412.103 states in relevant part that:

> (a) General criteria. A prospective payment hospital that is located in an urban area (as defined in subpart D of this part) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
> (1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification, the Rural–Urban Commuting Area codes, . . . .
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.
> *****
> (7) For a hospital with a main campus and one or more remote locations under a single provider agreement where services are provided and billed under the inpatient hospital prospective payment system and that meets the provider-based criteria at § 413.65 of this chapter as a main campus and a remote location of a hospital, the hospital is required to demonstrate that the main campus and its remote location(s) each independently satisfy the location conditions specified in paragraphs (a)(1) and (2) of this section.

[22] 84 Fed. Reg. at 42332.
[23] *Id.* at 42336.

the effects of the manipulation of the rural floor by certain hospitals."[24] The Secretary concludes that "the inclusion of reclassified hospitals in the rural floor calculation has had the unforeseen effect of exacerbating the wage index disparities between low and high wage index hospitals."[25]

Under the 2020 IPPS Final Rule, the Secretary "would continue to calculate the rural floor based on the physical non-MSA area of the state, which is the same rural area to which a hospital is reclassified under section [1395ww](d)(8)(E). However, for purposes of calculating the rural floor wage index for a state, [the Secretary] would not include in the rural area the data of hospitals that have been reclassified as rural under section [1395ww](d)(8)(E)."[26] The Secretary pointed out that the "legislative intent of the rural floor was to correct the 'anomaly' of 'some urban hospitals being paid less than the average rural hospital in their States.'"[27]

The Secretary found that "[u]nder the current rural floor wage index calculation, rather than raising the payment of some urban hospitals to the level of the average rural hospital in their State, urban hospitals may have their payments raised to the relatively high level of one or more geographically urban hospitals reclassified as rural."[28] The Secretary explained that "[w]hile urban hospitals in mostly rural states may benefit from an increase in the rural floor due to urban to rural reclassification . . . other states with high wage urban hospitals using [42 C.F.R.] § 412.103 reclassifications to raise the rural floor can mitigate those gains for mostly rural states, due to budget neutrality."[29] The Secretary believes that "excluding the data of hospitals that reclassify as rural under section [1395ww](d)(8)(E) from the rural floor wage index is necessary and appropriate to address these unanticipated effects of rural reclassifications on the rural floor and the resulting wage index disparities."[30]

The Secretary contends that his reimbursement calculation "is permissible under [42 U.S.C. § 1395ww](d)(8)(E) (as implemented by [42 C.F.R.] § 412.103) and the rural floor statute [42 U.S.C. § 1395ww(d) note]" and notes that the statute "does not specify where the wage data of reclassified hospitals must be included."[31] Therefore, the Secretary believes that he has the "discretion to exclude the wage index data of such hospitals from the calculation of the rural floor. Furthermore, the rural floor statute does not specify how the rural floor wage index is to be calculated or what data are to be included in the calculation."[32] Consequently, the Secretary believes that he has the "discretion under the rural floor statute to exclude the wage data of hospitals reclassified under section [1395ww](d)(8)(E) from the calculation of the rural floor."[33]

CMS has adopted the FY 2020 IPPS Final Rule's policy in its FY 2022 OPPS Final Rule, meaning for FFY 2022 it will calculate the rural floor in a state without reference to the wage

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[24] *Id. at* 42333.
[25] *Id.*
[26] *Id.* at 42334.
[27] *Id.*
[28] *Id.*
[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] *Id.*

index that applies for any hospitals in that state which were reclassified as rural pursuant to Section 401.[34]

**Positions of the Parties:**

***1. Providers' Appeal Requests***

The Providers describe the appealed issue as follows:

> The Providers in this group appeal challenge the Secretary's calculation of the rural floor in the outpatient prospective payment system (OPPS) final rule for calendar year (CY) 2022.
>
> ***
>
> For wage index purposes, there are two types of geographic areas: urban and rural.
>
> ***
>
> When a hospital reclassifies as rural, its wage and hour data is included in the calculation of the state rural wage index adjustment in the next federal fiscal year.
> The Medicare statute contains a provision requiring that no urban hospital can be assigned a wage index adjustment that is lower than the wage index assigned to rural hospitals in the state.
>
> ***
>
> The Secretary is bound by his own regulation to use the wage index values calculated in the inpatient prospective payment system (IPPS) final rule in determining the wage index values under the OPPS final rule for the calendar year ending in the same year. See 42 C.F.R. § 419.43(c). In the IPPS final rule for FFY 2020, . . . . [t]he rural wage index will continue to be calculated based on the average hourly wage of all rural hospitals and all urban hospitals that have reclassified as rural. The rural floor, however, will not include the wage and hour data of reclassified rural hospitals; it will be based solely on the wage data of naturally rural hospitals. Since adopting this policy, the Secretary has applied the same rural floor policy to the OPPS final rules for CY 2020, 2021, and 2022. In this appeal, the Providers challenge CMS's policy insofar as it was applied in the OPPS final rule for CY 2022.
>
> ***
>
> [A]s a direct result of this policy, in CY 2022, urban hospitals in some states have been assigned a wage index that is lower than the wage index assigned to rural hospitals in those states. This result violates the rural floor, which expressly prohibits the Secretary from assigning a wage index

[34] 86 Fed. Reg. 63458, 63511 (Nov. 16, 2021) (stating "We are continuing to apply for the CY 2022 OPPS wage index any adjustments for the FY 2022 IPPS post-reclassified wage index, including, but not limited to, the rural floor adjustment . . . .").

> to urban hospitals that is lower than the wage index of rural hospitals in the same state. *See* 42 U.S.C. § 1395ww note. Even if this result did not violate the rural floor (it does), the Secretary's policy would separately violate 42 U.S.C. § 1395ww(d)(8)(E)(i), which requires the Secretary to treat a hospital that has elected to reclassify as rural as rural for the purposes of the prospective payment system.
> For the forging reasons, the Providers in this group appeal request that the Board reverse the Secretary's calculation of the rural floor for CY 2022 and direct the Secretary to recalculate those payments in the manner required by the statute.[35]

### *2. Providers' Request for EJR*

The Providers filed their Petition for EJR to challenge CMS' new wage index rules as unlawful because it conflicts with the Medicare statute.[36] They argue that the FY 2020 rulemaking (1) does not treat reclassified "Section 401" hospitals as being located in a rural are as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[37]

They seek to have their wage indices recalculated in compliance with the requirements of the Medicare statute.[38] The Providers are specifically seeking the Board hold that:

> CMS's calculation of the FFY 2022 rural floor is unlawful because CMS does not have statutory authority to exclude data of Section 401 hospitals from the calculation of the rural floor and CMS cannot assign a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state, and to compel CMS to pay the Providers reimbursement that was withheld as a result of that regulation during the years under appeal.[39]

The Providers insist they have met the criteria set forth in 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), namely that the Board has jurisdiction over the appeal but lacks the authority to grant the relief the Providers seek.[40]

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[35] *E.g.*, Case No. 22-1045GC, Statement of the Issue at 1-2 (May 16, 2022).
[36] Consolidated Petition for Expedited Judicial Review at 1 (Jan. 5, 2026).
[37] *Id.* at 1, 5-6.
[38] *Id.* at 2.
[39] *Id.* at 7.
[40] *Id.* at 6-10.

### *3. Medicare Contractor's Position*

On **January 12, 2026**, the Medicare Contractor's designated representative, Federal Specialized Services ("FSS"), filed a response to the Consolidated Request for Expedited Judicial Review. It took no position on the Request for EJR but noted "that the MAC will file a substantive claim challenge in 22-1051GC, 22-1052GC, and 22-1048GC."[41]

The Board notes that FSS never filed a Substantive Claim Challenge in Case 22-1048GC. It did, however, file challenges in Cases 22-1051GC and 22-1052GC. Though it did not certify that it would file any challenges in Cases 22-1045GC and 22-1046GC, FSS did ultimately file challenges in those cases, as well. All five (5) of the Substantive Claim Challenges are addressed below.

## **Decision of the Board:**

The Providers participating in the group appeals included in this EJR request have filed their appeals from policies established in the FFY 2022 OPPS Final Rule published in the Federal Register.

### *1. Jurisdiction and Request for EJR*

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

As previously noted, all of the participants in these group cases appealed from the FFY 2022 OPPS Final Rule.[42] The Board has determined that (1) the participants' documentation in the group appeals show that the estimated amount in controversy exceeds $50,000, as required for a group appeal;[43] (2) the appeals were timely filed; and (3) Board review of the matter in this appeal is not precluded by statute or regulation. In finding that the groups meet the $50,000 amount in controversy, the Board recognizes that the filed amounts in controversy illustrate the difference in reimbursement between the "current rural floor calculation" and "if [the] rural floor were calculated correctly."[44] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying Providers. The estimated amounts in controversy are subject to recalculation by the Medicare contractors for the actual final amounts in each case.

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[41] Response to Provider's Request for Expedited Judicial Review at 1 (Jan. 12, 2026).
[42] 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.
[43] *See* 42 C.F.R. § 405.1837.
[44] *E.g.*, Case No. 22-1045GC, Impact Calculation, Alta View Hospital (Prov. No. 46-0044).

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

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

> (1) *General Requirement*. In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), **must include an appropriate claim for the specific item**, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **and describing** how the provider calculated the estimated re-imbursement amount for each specific self-disallowed item.[45]

[45] (Bold and underline emphasis added.)

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

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider **must include in its cost report an appropriate claim for the specific item** (as prescribed in § 413.24(j) of this chapter). If the provider files an appeal to the Board seeking reimbursement for the specific item and any party to such appeal questions whether the provider's cost report included an appropriate claim for the specific item, the Board must address such question in accordance with the procedures set forth in this section.
>
> (b) *Summary of Procedures*.
>
> ***
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> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ***
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ***
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> (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**.[46]

These regulations are applicable to the cost reporting periods under appeal for all of 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 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.

Board Rule 44.5.2 (2021) governs the timing for filing substantive claim challenges, pursuant to 42 C.F.R. § 405.1873(a), and reads:

> A party that questions whether the one or more participants in a group case (CIRP or optional) included an appropriate claim *on the cost report at issue* for the common issue being appealed in the group ***must file a Substantive Claim Challenge sixty (60) days after the group files its final Schedule of Providers (SOP) unless the moving party's filing demonstrates good cause***.[47] The moving party must summarize in its Substantive Claim Challenge the efforts that it made to contact the opposing party to discuss the merits of the Substantive Claim Challenge. If the moving party has attempted to confer but has been unsuccessful, briefly describe the attempts made. *See* sample language in Rule 44.2. The opposing party(ies) has thirty (30) days to respond (including in the context of an EJR filing).
>
> - *Expedited Challenge Filing Deadline When an EJR Request Is Filed per Board Rule 42.---If the final SOP is filed concurrent with an EJR request or 60 days has not yet transpired between the filing of the final SOP and the EJR request, then refer to Rule 44.6 for special instructions on deadlines for filing Substantive Claim Challenges and any response thereto.*

In Cases 22-1045GC, 22-1046GC, 22-1051GC, and 22-1052GC, the Providers certified that the groups were complete and fully populated in OH CDMS, pursuant to Board Rule 20, effectively

[46] (Bold and underline emphasis added.)
[47] (Emphasis added.)

finalizing their Schedules of Providers, on **May 16, 2023**. In Case 23-1445G, the Providers made this Board Rule 20 certification on **August 9, 2024**. Substantive Claim Challenges were filed in these five (5) cases on **January 23 and 26, 2026**, well beyond the sixty (60) day timeframe for filing the challenge mandated by Board Rule 44.5.2 (2021). Since these challenges were not timely, the Board declines to consider them.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[48] 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.[49] In these cases, the Medicare Contractor has failed to file a Substantive Claim Challenge[50] within the time frame specified by Board Rule 44.5.2 (2021).

As such, since no party to these appeals has questioned, pursuant to § 405.1873(a) and in compliance with the Board's Rules, whether an appropriate claim was made,[51] 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 for these six (6) cases. 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).

### *3. Analysis Regarding Appealed Issue*

As set forth below, the Board finds that the Secretary's determination to (1) "calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103)"; and (2) "for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . . (as implemented at § 412.103) from the calculation of 'the wage index for rural areas in the State in which the county is located' referred to in section [1395ww](d)(8)(C)(iii). . . ."[52] was made through notice and comment in the form of an uncodified regulation.[53]

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

---

[48] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[49] *See* 42 C.F.R. § 405.1873(a).
[50] Board Rule 44.5 (2023) 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."
[51] 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."
[52] 84 Fed. Reg. 42044 at 42336.
[53] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals."

> After consideration of the public comments we received, for the reasons discussed in this final rule and in the proposed rule, we are finalizing without modification our proposal to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103). Additionally, we are finalizing without modification our proposal, for purposes of applying the provisions of section 1886(d)(8)(C)(iii) of the Act, to remove the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103) from the calculation of "the wage index for rural areas in the State in which the county is located" referred to in section 1886(d)(8)(C)(iii) of the Act.[54]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as the "Uncodified Regulations on Rural Floor Calculation and Wage Index." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation.[55]

While this appeal involves the FFY 2022 OPPS Final Rule, CMS has adopted the FY 2020 IPPS Final Rule's policy in its FY 2022 OPPS Final Rule, meaning for FFY 2022 it will calculate the rural floor in a state without reference to the wage index that applies for any hospitals in that state which were reclassified as rural pursuant to Section 401.[56] Therefore, the Board finds that this policy is a binding but uncodified regulation for FFY 2022 for the purposes of the OPPS.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2022 OPPS Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulations on Rural Floor Calculation and Wage Index which they allege (1) does not treat reclassified "Section 401" hospitals as being located in a rural are as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[57] As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in Cases 22-1045GC, 22-1046GC, 22-1048GC, 22-1051GC, 22-1052GC, and 23-1445G.

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[54] 84 Fed. Reg. at 42336.
[55] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."
[56] 86 Fed. Reg. 63458, 63511 (Nov. 16, 2021) (stating "We are continuing to apply for the CY 2022 OPPS wage index any adjustments for the FY 2022 IPPS post-reclassified wage index, including, but not limited to, the rural floor adjustment . . . .").
[57] Consolidated Petition for Expedited Judicial Review at 1, 5-6.

***D. Board's Decision Regarding the EJR Request***

The Board finds that:

1) It has jurisdiction over the Uncodified Regulations on Rural Floor Calculation and Wage Index Issue for the subject year in Cases 22-1045GC, 22-1046GC, 22-1048GC, 22-1051GC, 22-1052GC, and 23-1445G and that the Providers in these group appeals are entitled to a hearing before the Board;

2) While the Providers appealed cost reporting periods beginning after January 1, 2016, no substantive claim challenges[58] have been filed pursuant to 42 C.F.R. § 405.1873(a) and in accordance with the Board's Rules in Cases 22-1045GC, 22-1046GC, 22-1048GC, 22-1051GC, 22-1052GC, and 23-1445G to trigger either Board review under § 405.1873(b) or reporting under § 405.1873(d)(2);

3) Based upon the Providers' assertions regarding the FFY 2022 OPPS 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 codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2022 OPPS Final Rule is valid.

Accordingly, the Board finds that the question of the validity of the codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2022 OPPS 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 Cases 22-1045GC, 22-1046GC, 22-1048GC, 22-1051GC, 22-1052GC, and 23-1445G and removes them from its docket.

[58] As the Board explained in Board Rule 44.5 (2023), "[t]he Board adoption of the term "Substantive Claim Challenge' simply refers to any question raised by a party concerning whether *the cost report at issue* included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

Board Members Participating:

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

FOR THE BOARD:

2/3/2026

X Kevin D. Smith, CPA

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

Enclosure: Schedules of Providers

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Dean Wolfe, Noridian Healthcare Solutions (J-F)
Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Scott Berends, Esq., Federal Specialized Services

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

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**Via Electronic Delivery**

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RE: ***Board Decision* – Medicaid Eligible Days Issue**
Houston Methodist Sugarland Hospital (Provider No. 45-0820)
FYE 12/31/2016
Case No. 20-0531

Dear Mr. Ravindran and Mr. Zarling,

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. 20-0531***

On **July 23, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2016.

On **December 19, 2019**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. DSH Payment/SSI Percentage (Provider Specific)[1]
2. DSH/SSI (Systemic Errors)[2]
3. DSH Payment – SSI Fraction/Medicare Managed Care Part C Days[3]
4. DSH Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[4]
5. DSH Payment – Medicaid Eligible Days
6. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days[5]
7. DSH Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[6]
8. Standardized Payment Amount[7]

[1] The Board dismissed this issue on September 4, 2025.
[2] On August 7, 2020, this issue was transferred to Case No. 20-0745GC.
[3] On August 7, 2020, this issue was transferred to Case No. 20-0746GC.
[4] On August 7, 2020, this issue was transferred to Case No. 20-0747GC.
[5] On August 7, 2020, this issue was transferred to Case No. 20-0748GC.
[6] On August 7, 2020, this issue was transferred to Case No. 20-0750GC.
[7] On August 7, 2020, this issue was transferred to Case No. 20-0751GC.

The Provider is commonly owned/controlled by Houston Methodist Hospital System and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **August 7, 2020**, the Provider transferred Issues 2, 3, 4, 6, 7 and 8 to Houston Methodist Hospital System groups. As a result, there is one (1) remaining issue in this appeal: Issue 5 (DSH Payment – Medicaid Eligible Days).

On **December 31, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[8]

On **August 11, 2020**, the Provider timely filed its preliminary position paper.

On **November 18, 2020**, the Medicare Contractor timely filed its preliminary position paper.

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

On **July 11, 2025**, the Board issued the 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*** *also include* ***any exhibits*** *the Provider will use to support to support its position. See* Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.[9]

On **December 24, 2025**, the Provider timely filed its final position paper.

[8] (Emphasis added.)
[9] (Emphasis added.)

On **December 24, 2025**, the Medicare Contractor filed a Motion to Dismiss with the Board over Issue 5 requesting that the Board dismiss this issue. Pursuant to Board Rule 44.3, the Provider had 30 days in which to file a response to the Motion to Dismiss. However, the Provider ***failed*** to file any response.

On **January 8, 2026**, the Medicare Contractor timely filed its final position paper.

### *B. Description of Issue 5 in the Appeal Request*

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations. The Provider describes Issue 5 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.
>
> HMSLH is seeking reimbursement for an additional 186 Medicaid Eligible days. The Provider, in this appeal, contends that the documentation necessary to pursue DSH was not available from the State of Texas in time to include all DSH/Medicaid Eligible Days on the cost report.[10]

Regarding the Medicaid eligible days issue, the Provider argues in its Final Position Paper that pursuant to the *Jewish Hospital* case[11] 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.[12] The Provider then, for the first time in this appeal, states it is seeking

[10] Appeal Request at Issue 5.
[11] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[12] Provider's Final Position Paper at 8-9 (Dec. 24, 2025).

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 [or Providers'] 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).[13]

**MAC's Contentions**

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

> a. That the Provider has filed to furnish documentation in support of its claim for its additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable.
>
> b. That the Provider has made affirmative statement in its appeal request and PPP that the MAC excluded the Medicaid Eligible Days from the settled cost report yet supplied no evidence of such exclusion.
>
> c. That the Provider's failure to furnish such documentation (or describe why such documentation is unavailable) is in violation of PRRB Rule 7, 25.2.1 and 25.2.2.
>
> d. That the Provider has effectively abandoned its claim for the additional Medicaid Eligible Days.
>
> e. That the Provider's claim for additional Medicaid Eligible Days is therefore dismissed.[14]

**Provider's Response**

Board Rule 44.3 specifies: "Unless the Board imposes a different deadline, an opposing party may file a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party." The MAC filed its Motion to Dismiss on December 24, 2025. The Provider failed to file a response and the time for doing so has elapsed.

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[13] *Id.* at 9.
[14] MAC Motion to Dismiss at 4 (Dec. 24, 2025).

**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. 5.

***A. DSH Payment – Medicaid Eligible Days***

The Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation.[15]

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

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

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

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

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

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

[15] Individual Appeal Request, Issue 5; *see supra* p. 3 at B. Description Issue 5 in the Appeal Request.

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*.[16]

Similarly, with regard to position papers,[17] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[18] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* 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.[19]

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);

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

- if the Board is unable to contact the provider or representative at the last known address; or
- upon failure to appear for a scheduled hearing.

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 December 19, 2019 (over 6 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 final position paper indicated that it would be sending the eligibility listing under separate cover.[20] ***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.[21] 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.

### *B. 1115 Waiver Days*

The Board finds that the section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. The Provider failed to include section 1115 Waiver days as a cost issue in its appeal request and failed to timely and properly add this additional issue to the 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 December 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…

[20] Provider's Final Position Paper at 9.

[21] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[22]

Board Rule 7.2.1 (2018) elaborated on this regulatory requirement, instructing providers:

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>   - the adjustment, including the adjustment number,
>   - the controlling authority,
>   - why the adjustment is incorrect,
>   - how the payment should be determined differently,
>   - the reimbursement effect, and
>   - the basis for jurisdiction before the PRRB.

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

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include:
>
> . . . ***Section 1115 waiver days (program/waiver specific). . .***[23]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[24]

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

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

[22] 42 C.F.R. § 405.1835(b).
[23] (Bold and italic emphasis added).
[24] *See* 73 Fed. Reg. 30190 (May 23, 2008).

. . .

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

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider 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.[25] 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) 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.**

[25] 65 FR 47054, 47087 (Aug. 1, 2000).

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

Because the Provider did not raise the section 1115 Waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The 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 final position paper, the Provider fails to identify what section 1115 waiver program(s) are involved and whether or not the section 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." The Provider failed to fully develop its final 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*.[26] 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 . . ."[27] 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."[28] 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.[29] Here, the Board makes the same finding based on similarly *overly generalized language*.

****

In summary, the Board dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for submitting fully developed and complete position papers in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 20-0531 and removes it from the Board's docket.

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[26] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[27] *Id*. at *11.
[28] *Id.*
[29] *Id.*

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:

2/3/2026

X Nicole E. Musgrave

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Via Electronic Delivery**

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

Re: ***Board Decision re: Filing Requirements***
Hollywood Presbyterian Medical Center (05-0063)
Appealed Period: FYE 05/31/2004
PRRB Case No.: 26-0745

Dear Mr. Ravindran:

The above-captioned appeal was filed with the Provider Reimbursement Review Board ("Board") via the Office of Hearings Case and Document Management System ("OH CDMS"). After review of the facts outlined below, the Board has determined that the appeal request was not filed in accordance with the Board Rules and regulations. The Board's review and determination is set forth below.

## BACKGROUND:

On December 15, 2025, the Provider filed the above-referenced appeal request with a sole issue in dispute: Improper Recalculation of SSI. The Board notes that the final determination type was entered into OH CDMS as a Revised Notice of Program Reimbursement ("RNPR") with an issuance date of June 13, 2025. However, the support document uploaded for the final determination is a copy of the HCRIS – DSH Report and not a copy of the Revised Notice of Program Reimbursement. In addition, the supporting documents uploaded as Reopening Notices were worksheets and not Reopening Notices associated with a RNPR.

The Provider subsequently filed supplemental jurisdictional documents on December 16, 2025. One of the supplemental documents filed was a copy of the Revised Notice of Program Reimbursement dated June 13, 2025.

## BOARD DECISION:

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

42 C.F.R. § 405.1835(b) outlines the content requirements for a request for Board hearing from a final determination:

> (b) *Contents of request for a Board hearing on a 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.
>
> ***
>
> (3) A copy of the final contractor or Secretary determination under appeal. . .

The Board rules further reiterate the regulatory requirement to submit a copy of the final determination with the Provider's appeal request:

> **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.**
>
> ***
>
> **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. . .

> ***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.

The Board finds that this appeal does not meet the regulatory requirements for filings as the Provider failed to submit the final determination, dated June 13, 2025, on which the appeal is based, as required by 42 C.F.R. § 405.1835(b)(3) and the Board Rules.

Although the Provider did file supplemental documentation, including the revised NPR final determination, that document was not timely filed. As discussed above, the regulations and Board rules require that the final determination is filed with the appeal request. The regulations and Board rules further require that appeals must be timely filed. Pursuant to 42 C.F.R. § 405.1801(a) and Board Rule 4.5, the date of filing is the date of receipt by the Board, or the date of delivery by a nationally recognized next-day courier.

42 C.F.R. § 405.1835(a)(3) reads:

> 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.[1]

Similarly, Board Rules state the following about due dates for filing appeals:

> **4.3.1 Contractor/CMS/Secretary Final Determination**
>
> ***
>
> The date of receipt of a contractor/CMS/Secretary final determination is presumed to be five (5) days after the date of issuance. This presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date. See 42 C.F.R. § 405.1801(a)(1)(iii).
>
> The appeal period begins on the date of receipt of the contractor final determination as defined above and ends 180 days from that date.

[1] Emphasis added.

> ***
> **4.4.1 Due Dates for New Appeals**
>
> New appeals must be received by the Board ***no later than 180 days*** from the commencement of the appeal period as specified in Rule 4.3. *See* Rule 2.1.4 for instructions on requesting an extension under 42 C.F.R. § 405.1836 "due to extraordinary circumstance beyond [the party's] control."[2]

Here, the date of the final determination was June 13, 2025. Taking into account the five (5) day mailing presumption, the Provider's appeal must have been filed by Monday December 15, 2025. As noted above, the Provider did file its appeal on that date, however it did not include a copy of the final determination. That document was not submitted until the following day, which was then untimely.

Board Rules and regulations require that providers meet filing deadlines, or the Board may determine that jurisdictional requirements have not been met and dismiss the appeal.

Therefore, the Board finds that the Provider's appeal request, as filed on December 15, 2025, does not meet the regulatory requirements for filings as the Provider failed to submit the final determination on which the appeal is based as required by 42 C.F.R. § 405.1835(b)(3) and the Board Rules. Furthermore, although the Provider did file additional documentation on the following day, the Board finds that this was not timely.

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 26-0745, in its entirety, and removes it from its docket.

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

Board Members:

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

FOR THE BOARD:

2/5/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[2] Bold and italic emphasis added.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
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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***
Mary Lanning Healthcare (Prov. No. 28-0032), FYE 12/31/2017, Case No. 21-1772

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 21-1772 in response to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). Set forth below is the decision of the Board to dismiss the two (2) remaining issues in this appeal challenging the Provider's DSH Supplemental Security Income ("SSI") (Provider Specific) and DSH Medicaid Eligible Days issues.

**Background:**

**A.** ***Procedural History for Case No. 21-1772***

On **April 1, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2017.

On **September 3, 2021**, Mary Lanning Healthcare ("Mary Lanning"/the Provider) filed its individual appeal request. The Appeal Request included seven (7) issues:

1. DSH SSI (Provider Specific)
2. DSH SSI Percentage[1]
3. DSH Medicaid Eligible Days
4. DSH Medicare Managed Care Part C Days (SSI & Medicaid Fraction)[2]
5. DSH Dual Eligible Days (SSI Fraction)[3]
6. Standardized Payment Amount[4]
7. DSH Dual Eligible Days (Medicaid Fraction)[5]

[1] On 4/14/2022, QRS transferred this issue to Case No. 22-0292G.
[2] On 4/14/2022, QRS transferred this issue to Case No. 22-0293G.
[3] On 4/14/2022, QRS transferred this issue to Case No. 22-0294G.
[4] On 4/14/2022, QRS transferred this issue to Case No. 22-0276G.
[5] On 4/13/2022, QRS transferred this issue to Case No. 22-0295G.

On **September 21, 2021**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

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

On **April 13, 2022**, the Provider authorized Quality Reimbursement Services, Inc. ("QRS") to be its representative, which the Board acknowledged on **April 14, 2022**.

On **May 2, 2022**, QRS filed the Provider's PPP.

On **May 3, 2023,** the Medicare Contractor ("MAC") filed a copy of its request to the Provider for the DSH package for the Eligible Days.

On **June 7, 2023**, the MAC filed a 2nd Request for the DSH Package.

On **July 28, 2022**, the MAC filed a jurisdictional challenge for the last two issues under appeal: the SSI Provider Specific and Medicaid Eligible Days.

On **July 28, 2022,** the MAC also filed its PPP.

On **August 15, 2022**, the MAC filed a Substantive Claim Challenge.

On **September 9, 2025,** the Board issued a Notice of Hearing scheduling the case for a hearing on **May 18, 2026**.

### *B. Description of Issue 1 in the Individual Appeal Request and the Provider's Participation in Case No. 22-0292G*

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

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider

[6] (Emphasis added.)

> disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[7]

The group issue statement in Case No. 22-0292G, to which the Provider transferred the SSI Percentage (Issue 2), questions whether the DSH calculation was properly calculated and whether CMS should have to use a denominator based solely upon covered and paid for Medicare Part A days, or whether it should expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days.

The legal basis reads:

> 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

[7] Issue Statement at 1 (Sept. 3, 2021).

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.

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.[8]

[8] Group Issue Statement, Case No. 22-0292G.

In the Provider's May 2, 2022 PPP in Case No. 21-1772, the following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (December 31).
>
> The Provider contends that the SSI percentage issued by CMD and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[9]

The amount in controversy listed for each SSI Issue 1 and 2 in the Provider's individual appeal request is $27,000.

### *C. Description of Issue 3 in the Individual Appeal Request*

According to its Appeal Request, the Provider questions whether the MAC properly excluded Medicaid eligible days from the DSH calculation. The Statement of the Legal Basis is as follows:

> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation

[9] Provider's PPP at 8-9 (May 2, 2022).

> of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[10]

The estimated reimbursement impact for this issue was listed at: $32,000.

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[11] 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.[12]

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

In its Jurisdictional Challenge, the MAC argues that the Board lacks jurisdiction over this issue. According to the Provider's appeal request, Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) Individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the two portions related to SSI data accuracy should be dismissed because they are duplicative of the SSI Percentage (Issue 2) - that was transferred to group Case No. 22-0292G. The remaining component which is related to SSI realignment should be dismissed because: 1) it was not briefed in the PPP; 2) there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[13]

**MAC's Contentions Issue 3 – Medicaid Eligible Days**

The MAC also argued that the Provider abandoned the Medicaid Eligible Days issue. The MAC contends that the Provider failed to include a list of additional Medicaid eligible days they expected to be included with their appeal or the PPP (even though the Provider advised that it would send a listing of additional Medicaid eligible days under separate cover.)[14] In addition, 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 PPP because it neglected to include all supporting documentation, nor did it meet the requirements for unavailable or omitted documents as discussed in Board Rule 25.2.2.[15]

---

[10] Issue Statement at 3 (Sept. 3, 2021).
[11] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[12] Provider's PPP at 7 (May 2, 2022).
[13] MAC's Jurisdictional Challenge at 2 (July 28, 2022).
[14] *Id*. at 10-11.
[15] *Id*.

**Provider's (*Lack of*) Jurisdictional Response**

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[16] Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." The Provider failed to file a response to the MAC's challenge.

**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. DSH 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 ". . . because CMS failed to include all patients that were entitled to SSI benefits in their calculation"—is duplicative of the SSI Percentage issue that the Provider transferred to Case No. 22-0292G. The Provider argues 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.

[16] Board Rule 44.4.3, v. 3.1 (Nov. 1, 2021).

This component of Issue 1 is repeated word for word in the Provider's description of Issue 2, which was transferred to Case No. 22-0292G. Because the Provider is arguing the same issues in both the instant case and the Group case, the Provider is appealing an issue from a single final determination in more than one appeal, which would be considered a prohibited duplicate per Board Rule 4.6.[17]

Additionally, 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.[18] 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 "SSI Accuracy" and CMS policy concerning individuals who are eligible for SSI but did not receive SSI payment issue as argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the issue appealed in Case No. 22-0292G.

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 entitlement issue in Case No. 22-0292G. 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.

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. 22-0292G both argue the same component regarding individuals who are eligible for SSI but did not receive SSI payment. Because 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

[17] PRRB Rules v. 3.1 (Nov. 1, 2021).
[18] 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).

this written request, the MAC cannot issue a final determination with which the Provider can be dissatisfied for Board appeal purposes. There is nothing in the record to indicate the MAC has made a final determination regarding DSH SSI Percentage realignment. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

### *B. Medicaid Eligible Days*

The Provider's appeal request 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*. Neither the Provider's appeal request, nor the PPP, included a list of the specific additional Medicaid eligible days that are in dispute in this appeal.

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

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

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

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

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

**No Access to Data**

> 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 multicomponent 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(b) addresses position papers and specifies in pertinent part:

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

Similarly, with regard to position papers,[20] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[21] 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 September 3, 2021 (more than four 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.[22]

---

[19] (Emphasis added).
[20] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.
[21] (Emphasis added).
[22] Provider's PPP at 8 (May 2, 2022).

Based on the Provider's failure to submit the Eligible Days Listing as promised, on May 2, 2022, and after two unanswered requests for DSH Packages from the MAC[23], the MAC filed a Jurisdictional Challenge, requesting dismissal of the Medicaid eligible days issue. The MAC contends that: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish the list of additional Medicaid eligible days with its PPP in violation of Board Rules 25.2.1 and 25.2.2. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the regulations and the Board Rules.[24] Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the MAC's Jurisdictional Challenge. However, the Provider failed to respond by the August 27, 2022 filing deadline (i.e., 30 days after July 28, 2022).

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

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a

[23] The MAC requested DSH Packages on May 3, 2022 and on June 7, 2022. Both requests were uploaded in OH CDMS.
[24] 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.
[25] (Emphasis added).

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.[26]

****

Based on the foregoing, the Board is dismissing the two (2) remaining issues in this case: SSI Percentage (Provider Specific) - Issue 1 and Medicaid Eligible Days - Issue 3. As no issues remain, the Board hereby closes Case No. 21-1772 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:

2/5/2026

X Nicole E. Musgrave

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

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

[26] 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.

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**

Randall Gienko
Strategic Reimbursement Group, LLC
360 W. Butterfield Road, Suite 310
Elmhurst, IL 60126

RE: ***Notice of Dismissal***
Mercy Health System Corp (Provider Number 52-0066)
FYE: 06/30/2016
Case Number: 20-0472

Dear Mr. Gienko:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 20-0472. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's SSI Calculation Error.

## Background

### *A. Procedural History of Case No. 20-0472*

On **July 2, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2016. The Provider is represented by Strategic Reimbursement Group, LLC ("SRG").

On **December 10, 2019**, SRG filed the Provider's individual appeal request. The initial Individual Appeal Request contained six (6) issues:

1. Unmatched Medicaid Days (Unpaid Medicaid Eligible Days)[1]
2. SSI Calculation Error (Medicare Fraction Dual Eligible Part A Exhausted Medicare Benefits Days Exclusion, Part C Days Exclusion, Matching Errors) DSH Payment – Medicaid Eligible Days
3. Medicaid Fraction – Dual Eligible Medicare Part C Days should be Included[2]
4. Medicare Fraction (SSI Ratio) – All Medicare Part C Days should be Removed[3]
5. DRG Understatement[4]

[1] On July 17, 2020, this issue was transferred to Case No. 20-1732GC.
[2] On July 17, 2020, this issue was transferred to Case No. 20-1731GC.
[3] On July 17, 2020, this issue was transferred to Case No. 20-1730GC.
[4] On January 20, 2020, this issue was transferred to Case No. 20-0672GC.

6. Transfer Case Underpayment[5]

After the various transfers, one issue remains pending in the appeal: Issue 2 – SSI Calculation Error (Medicare Fraction Dual Eligible Part A Exhausted Medicare Benefits Days Exclusion, Part C Days Exclusion, Matching Errors). (This issue was transferred to a group case, 20-1729GC, on July 17,2020, but the case failed to meet the necessary $50,000 Amount in Controversy, and therefore, the issue was transferred back to the individual appeal in 2022.)

On **December 19, 2019**, the Board issued the notice of Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. The 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 **September 5, 2023**, the Provider timely filed its preliminary position paper.

On **November 30, 2023**, the Medicare Contractor timely filed its preliminary position paper.

On **December 4, 2025**, the Medicare Contractor filed a Motion to Dismiss Issue 2 – DSH SSI Fraction.

### *B. Description of Issue 2 in the Appeal Request*

In its appeal request, the Provider's SSI – Calculation Error issue is as follows:

> Section 951 of the Medicare Modernization Act requires that the Secretary of Health and Human Services ("Secretary") "arrange to furnish . . . the data necessary . . . for hospitals to compute the number of patient days used in computing the disproportionate patient percentage under [42 U.S.C. 1395ww(d)(5)(F)] for that hospital for the current cost reporting year." The Secretary has failed to do so in a meaningful way.

[5] On January 20, 2020, this issue was transferred to Case No. 20-0673GC.
[6] Emphasis added.

The provider challenges the Medicare Fraction (also referred to as the Supplemental Security Income Ratio ["SSI Ratio"]) as calculated by the Centers for Medicare and Medicaid Services ("CMS") used in the Medicare Administrative Contractor's adjustments pertaining to the Operating Disproportionate Share Hospital and Capital Disproportionate Share Hospital adjustment calculations (collectively "Calculations") because CMS has failed to fulfill the Secretary's obligation under the Act.

It is the provider's position that the methodologies and practices applied by CMS in the determination of the Medicare Fractions are flawed. *See Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008). The provider believes these flaws include, but are not limited to, the following:

- The method CMS implements to **match** hospitals' patients to Federal **SSI** databases. The provider contends that the Medicare Fractions as generated by the SSA and put forth by CMS is understated.
- Failure to properly include in the numerator of the Medicare Fraction certain "Dual Eligible" patients (patients with both Medicaid and Medicare Part A coverage) whose **Medicare Part A benefits** have been **exhausted** and qualify for SSI benefits.
- Failure to properly include in the numerator of the Medicare Fraction certain patients with **Medicare Part C** (Medicare Advantage Plan) coverage and qualify for SSI benefits.
- Failure by CMS to include in the numerator of the Medicare Fraction patients with Medicare Part A or C coverage that fall under **certain SSI payment classifications**.

The provider requests that CMS provide all underlying information used to calculate the provider's Medicare Fraction and allow the provider to review, test, and submit a corrected Medicare Fraction for purposes of revising the Calculations in accordance with 42 CFR Subpart G Section 412.106 and 42 CFR Subpart M Section 412.320. The provider has estimated that the reimbursement impact associated with the flawed SSI data, based on industry experience, is the SSI% used in the audited cost report plus 5% and has calculated the reimbursement impact in the attached calculations, but asserts that its reimbursement should be based on

> the accurate SSI data for its cost reporting year and not the estimate made on data to which it does not have access.[7]

On **September 5, 2023**, the Board received the Provider's Preliminary Position Paper. The Paper addresses the underlying information in dispute as follows:

> The information needed to perform the necessary review of the Calculations is contained in CMS' data sets referred to as "MedPAR SSI Data Files" which had been temporarily unavailable pending the release of CMS' revised SSI ratios. During 2012, CMS issued revised SSI ratios for FFY 2006 – 2010 as required by CMS' Ruling 1498R (April 28th, 2010) and, at the same time, the MedPAR SSI Data Files became available for review by hospitals receiving IPPS DSH payments.[8]

**MAC's Contentions**

The Medicare Contractor filed a jurisdictional challenge and then also a Motion to Dismiss the SSI percentage issue. In its jurisdictional challenge, 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 25.2 and 25.3.[9]

In its Motion to Dismiss, the Medicare Contractor argues that the Board should dismiss the remaining issue in the case for several reasons:

a. [T]he Provider has failed to furnish documentation in support of its claim for a correction to the published SSI percentage or describe why such documentation was and continues to be unavailable.
b. [T]he Provider has failed to furnish documentation in support that it reconciled MedPAR data, which it has received at least twice despite its claim in its Final Position Paper that the MedPAR data is unavailable, and as a result, has identified and supplied to the MAC a list of discrepancies found.
c. [T]he Provider's failure to furnish such documentation (or describe why such documentation is unavailable) is in violation of PRRB Rules 7, 25.2.1 and 25.2.2. As a result, the Provider has failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claims in its preliminary position paper in violation of PRRB Rule 25.3.[10]

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[7] Statement of the Issue, Issue 2 (emphasis in original).
[8] Provider's Preliminary Position Paper at 16 (Sept. 5, 2023).
[9] Jurisdictional Challenge at 3 (Dec. 18, 2023).
[10] Motion to Dismiss at 4 (Dec. 4, 2025),

Additionally, in its Final Position Paper, filed on December 10, 2025, the Medicare Contractor noted that "Although CMS complied with its statutory obligations, the Provider has not identified any issues with the data. The MedPAR data has been available, and the Provider has had ample amount of time to fully review the data."[11]

**Provider's Response**

Int its Response to the Medicare Contractor's Jurisdictional Challenge, the Provider contends that "the Medicare Contractor has usurped its authority by raising issues that it does not have the right to raise at this juncture."[12]

Further, the Provider argues that its "Preliminary Position Paper addresses the dispute regarding the SSI data as best is possible, given the Provider's lack of control over the data" and complies with rules and regulations regarding position papers.[13] They go on to posit that they have "not been able to furnish more detailed concerns with the data because they do not have access to any data set other than the MedPAR data."[14]

The Board Rules require that Provider Responses to the MAC's Motion must be filed within thirty (30) days of the filing of the motion.[15] The Provider has not filed a response to the Motion to Dismiss, and the time for doing so has elapsed. Board Rule 44.3 specifies: "Unless the Board imposes a different deadline, an opposing party may file a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and the 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.

The Board finds that the Provider's Preliminary Position Paper in this matter failed to set forth the relevant facts and arguments regarding the merits of their Medicare payment claims. The Provider's Preliminary Position Paper states that "the methodologies and practices applied by CMS in the determination of the SSI ratios are flawed, including, but not limited to, the method CMS implements to match hospitals' patients to Federal SSI databases. The providers contend that the SSI ratios as generated by the SSA and put forth by CMS are understated."[16] As supporting exhibits, the Provider included excerpts from the Federal Register.

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[11] Medicare Contractor's Final Position Paper at 9 (Dec. 10, 2025).
[12] Response to MAC Jurisdictional Challenge at 2 (Dec. 20, 2023).
[13] *Id*.
[14] *Id*.
[15] PRRB Rules v. 3.2 (Dec. 15, 2023).
[16] Provider's Preliminary Position Paper at 16.

The Provider's Preliminary Position Paper states that "[t]he providers have requested the necessary MedPAR SSI Data Files and are performing reviews to identify discrepancies in the accumulation of data and the methodology for computing the Medicare Fraction used in the determination of their Calculations. The detailed review will be provided forthcoming [sic]."[17] 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 the issue and identify, or explain the nature of, any alleged "errors" and include *all* exhibits.

By failing to identify the SSI days they believe should be included in the numerators of their respective Medicare fractions, nor the codes that they feel should have been excluded from inclusion in the Medicare fractions, the Board finds the Provider failed to file a complete preliminary position paper in violation of Board Rule 25 and 42 C.F.R. § 405.1853(b)(2). The Board dismisses the issue from the appeal.

* * * * *

Based on the foregoing, the Board has dismissed the remaining issue in this case. As no issues remain, the Board hereby closes Case No. 20-0472 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:

2/5/2026

X Kevin D. Smith, CPA

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

cc: Pamela VanArsdale, National Government Services, Inc. (J-6)
Wilson Leong, FSS

[17] *Id.*

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Provider Reimbursement Review Board
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**Via Electronic Delivery**

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

RE: ***Notice of Dismissal***
Baylor Medical Center at Irving, Prov. No. 45-0079, FYE 06/30/2017
PRRB Case No. 21-0282

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 21-0282. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days.

## Background

### A. *Procedural History for Case No. 21-0282*

On **March 25, 2020**, the Medicare Contractor ("MAC") issued a Notice of Program Reimbursement ("NPR") for Baylor Medical Center at Irving ("BMC - Irving") for its fiscal year end ("FYE") June 30, 2017.

On **September 17, 2020**, Baylor Scott & White Health filed an appeal on behalf of BMC - Irving which included nine (9) issues:

1. SSI Percentage (Provider Specific)[1]
2. SSI Percentage[2]
3. SSI Fraction Medicare Managed Care Part C Days[3]
4. SSI Fraction Dual Eligible Days[4]
5. Medicaid Eligible Days
6. Medicaid Fraction Medicare Managed Care Part C Days[5]
7. Medicaid Fraction Dual Eligible Days[6]
8. 2 Midnight Census IPPS Payment Reduction[7]
9. Standardized Payment Amount[8]

[1] On November 21, 2025, Issue 1 was withdrawn.
[2] On April 27, 2021, Issue 2 was transferred to a CIRP group, Case No. 20-1342GC.
[3] On April 27, 2021, Issue 3 was transferred to a CIRP group, Case No. 20-1343GC.
[4] On April 27, 2021, Issue 4 was transferred to a CIRP group, Case No. 20-1344GC.
[5] On April 27, 2021, Issue 6 was transferred to a CIRP group, Case No. 20-1345GC.
[6] On April 27, 2021, Issue 7 was transferred to a CIRP group, Case No. 20-1346GC.
[7] On May 12, 2021, Issue 8 was withdrawn.
[8] On April 27, 2021, Issue 9 was transferred to a CIRP group, Case No. 19-1989GC.

The Provider is commonly owned/controlled by Baylor Scott & White (hereinafter "BSW") and, thereby, is subject to the mandatory common issue related party "CIRP" group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **April 27, 2021**, BSW transferred issues 2, 3, 4, 6, 7 and 9 to BSW CIRP Groups.

On **November 24, 2020**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[9]

On **September 9, 2021**, the MAC filed its PPP in which indicated that it had not received a listing of additional Medicaid eligible days, although the Provider indicated one was being sent under separate cover with its PPP.[10] On **September 13, 2021**, the MAC filed a corrected PPP narrative.

On **September 14, 2024**, the MAC filed a jurisdiction challenge over the SSI Provider Specific issue (#1). *The issue was subsequently withdrawn.*

On **May 9, 2023**, BSW requested that Quality Reimbursement Services, Inc. ("QRS") be made the representative. The following day, the Board acknowledged that QRS was the new representative for Case No. 21-0282.

On **May 19, 2025**, the Board issued a Notice of Hearing scheduling the case for a Feb. 23, 2026 hearing date.

On **November 25, 2025**, QRS filed the Provider's final PP and a copy of a redacted Medicaid Eligible Days listing.

On **December 5, 2025**, the MAC filed its final PP.

On **December 8, 2025** the MAC filed a jurisdictional challenge over the last issue: Medicaid eligible days issue. The MAC claimed the Provider failed to file a complete PPP and final pp w/ all supporting exhibits per Board Rules 25 & 27 and 42 CFR § 405.1853(b)(2). The MAC also challenged the untimely and improper addition of the 1115 waiver days issue via its final PP.

On **December 10, 2025**, QRS submitted a responsive brief to the jurisdictional challenge.

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[9] (Emphasis added.)
[10] MAC PPP at 16 (Sept. 9, 2021).

On **February 3, 2026**, QRS requested a postponement to give the Parties time to finalize an Administrative Resolution. The MAC advised that it would not begin its audit of the Medicaid Eligible Days until the Board made a determination over the previous jurisdiction challenge.

**MAC's Contentions re: Issue 5 – DSH Payment – Medicaid Eligible Days**

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

***Section 1115 Waiver Days***

Finally, the MAC argues that the Provider is attempting to untimely and improperly add the Section 1115 waiver days issue as a sub-issue via its final position paper filed on November 25, 2025. The Provider 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.

Neither the appeal request, nor the PPP, identified or mentioned the Section 1115 waiver days issue. It was not until the final position paper submission that the Provider raised the issue – (*which was 5 years after the regulatory deadline to add a new issue to the case*.) Therefore, the MAC contends that the Section 1115 waiver days, which is a separate issue from the Medicaid eligible days issue, should be dismissed on the grounds that it was untimely and improperly added to the case.

**Provider's Jurisdictional Response**

QRS filed a responsive jurisdictional brief which responded to the MAC's challenge regarding its claim that the Medicaid Eligible days issue was abandoned. QRS asserted that, in accordance with the Rules that were in effect at the time of its PPP submission (Version 2.0 – Aug. 29, 2018), it was reasonable for the Provider to assume that the "outside date for submission of the listing of additional Medicaid eligible days was the Final Position Paper deadline."[11] A redacted listing of additional Medicaid eligible days and Section 1115 days was filed on November 25, 2025 and an unredacted version was purportedly sent to the MAC.

**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

[11] Provider's Responsive Brief at 1 (Dec. 10, 2025)

$10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

### *A. DSH Payment – Medicaid Eligible Days*

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

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

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

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

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[12]

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

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

[12] (Bold emphasis added.)

**Rule 25 - Preliminary Position Papers**[13]

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

**25.1 Content of Position Paper Narrative**

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

**25.1.1 The Provider's Position Paper**

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

**25.2 Position Paper Exhibits**

**25.2.1 General**

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

**25.2.2 Unavailable and Omitted Documents**
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

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

> 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 November 24, 2020 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 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)(iii) places the burden of production on the provider, stating:

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

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

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

[14] (Emphasis added.)

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

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

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

On May 12, 2021, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[15] Significantly, the PPP did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $22,659 based on an estimated 50 days). The Provider's complete briefing of this issue in its PPP is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:

[15] Provider's PPP at 8 (May 12, 2021).

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

In its December 8, 2025 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid eligible days issue because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish an unredacted, auditable list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the Board Rules.[16] In addition, the MAC argued the Provider was attempting to untimely, and improperly, add the Section 1115 waiver days issue by including it in its final PP submission.

On November 25, 2025, QRS uploaded a "Redacted Medicaid Eligible Days Listing" in the Office of Hearings Case and Document Management System ("OH CDMS"). The 30-page listing did not include the sum, but when extracted and totaled, it shows 5,640 "1115 Waiver and Additional ME Days Consolidated." The Listing does not explain why the number of days included was over the initial 50 days the Provider claimed in its appeal, nor did it explain why it was being submitted at this late date. Regardless, the filing ***was 4.5 years past the deadline for including it with the Provider's PPP*** for which the deadline was May 15, 2021.

The Board concurs with the MAC - that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the

[16] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

The Board rejects the Provider's attempts to include the eligible days listing uploaded to OH CDMS on November 25, 2025 (*purportedly, as a supplement to its November 25, 2025 final position paper*) because:

1. The upload was filed ***4.5 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 5,640 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 nearly 5 years after this appeal was filed and more than 8 years after the fiscal year at issue had closed).

3. Neither the Board Rules, nor the November 24, 2020 Case Acknowledgment and Critical Due Dates notice, permit the Provider to file a "Supplement" to its PPP (nor did the Provider allege in the upload that they do).

4. Given that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the PPP filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its PPP or a supplement of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the appeal request, nor the PPP, identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the uploaded listing cannot be considered a refinement of the position paper since no specific days or listing were included with the PPP (indeed the *tentative* 5,640 days listed in the late exhibit is, without explanation, *significantly* larger than the original estimated 50 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 position paper filing (much less provide the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

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

### *B. 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. 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 September of 2020 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[19]

Board Rule 7.2.1 (2018) elaborated on this regulatory requirement, instructing providers:

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>   - the adjustment, including the adjustment number,
>   - the controlling authority,
>   - why the adjustment is incorrect,
>   - how the payment should be determined differently,
>   - the reimbursement effect, and
>   - the basis for jurisdiction before the [Board].

Board Rule 8 (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 are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**

[19] 42 C.F.R. § 405.1835(b).

> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[20]

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

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

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

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

In this regard, the Board notes that Section 1115 waiver days are not traditional Medicaid eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.[22] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 waiver days. Indeed, not every state Medicaid program has a qualifying Section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a Section 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

[20] (Bold and italic emphasis added).
[21] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[22] 65 FR 47054, 47087 (Aug. 1, 2000).

> **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

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

Regardless, even if the Provider had included in its appeal request (which it did not), the Provider failed to properly develop the issue in its PPP filing. First, the Provider's PPP does not even mention Section 1115 waiver days (much less 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 (Aug. 2018). As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 waiver days sub-issue.

Finally, even in the Provider's final PP, the Provider fails to identify what Section 1115 waiver program(s) are involved and whether or not the Section 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the final PP is perfunctory in that it only makes cursory conclusions.[23] Again, the

[23] For example, BSW 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, BSW fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue.

Provider failed to so develop its PP, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Aug. 2018) as applied via Board Rule 27.2.

The Board's finding that neither the appeal request nor the final PP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[24] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[25] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[26] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[27] Here, the Board makes the same finding based on similar *overly generalized language.*

* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible Days (Issue No. 5). As no issues remain, the Board hereby closes Case No. 21-0282 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:

2/6/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

Is BSW asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? BSW 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."

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

[25] *Id*. at *11.

[26] *Id.*

[27] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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**Via Electronic Delivery**

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

RE: ***Notice of Dismissal***
MercyOne Waterloo Medical Center (Prov. No. 16-0067), FYE 06/30/2018, Case No. 22-1328

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-1328 in response to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). Set forth below is the decision of the Board to dismiss the two (2) remaining issues in this appeal challenging the Provider's DSH SSI Percentage (Provider Specific) and DSH Medicaid Eligible Days issues.

**Background:**

**A.** ***Procedural History for Case No. 22-1328***

On **February 22, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2018.

On **August 19, 2022**, Quality Reimbursement Services, Inc. ("QRS") filed an individual appeal on behalf of MercyOne Waterloo Medical Center ("Mercy-Waterloo"/the Provider). The Appeal Request included three (3) issues:

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

On **August 22, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates ("ACDD"), 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

[1] On 8/19/2022, QRS transferred this issue to Case No. 22-0058G.

> how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[2]

On **October 14, 2022**, QRS added three (3) additional issues:

4. DSH Unduly Narrow Definition of SSI Entitlement[3]
5. DSH SSI & MCD Fractions - Medicare Managed Care Part C Days[4]
6. DSH SSI & MCD Fractions - Dual Eligible Days[5]

On **March 7, 2023**, the Board issued a new Critical Due Dates notification, setting revised PPP due dates.

On **March 10, 2023**, QRS transferred issues 4, 5 and 6 to optional groups.

On **April 10, 2023**, QRS filed the Provider's PPP.

On **July 17, 2023**, the MAC filed a jurisdictional challenge for the last two issues under appeal: the DSH SSI (Provider Specific) and DSH Medicaid Eligible Days.

On **July 26, 2023,** the MAC filed its PPP.

On **November 19, 2025,** the Board issued a Notice of Hearing scheduling the case for a hearing on **June 12, 2026**.

### *B. Description of Issue 1 in the Individual Appeal Request and the Provider's Participation in Case No. 22-0058G*

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

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' SSI percentage published by 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.

---

[2] (Emphasis added.)
[3] On 3/10/2023, QRS transferred this issue to Case No. 23-0316G.
[4] On 3/10/2023, QRS transferred this issue to Case No. 23-0317G.
[5] On 3/10/2023, QRS transferred this issue to Case No. 23-0318G.

> 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).[6]

The group issue statement in Case No. 22-0058G, to which the Provider transferred the SSI Percentage (Systemic Errors) (Issue 3), questions whether the DSH calculation was properly calculated and whether CMS should have to use a denominator based solely upon covered and paid for Medicare Part A days, or whether it should expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days.

The legal basis reads:

> 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.
>
> 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

[6] Issue Statement at 1 (Aug. 19, 2022).

> 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.[7]

In the Provider's April 10, 2023 PPP in Case No. 22-1328, 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

[7] Group Issue Statement, Case No. 22-0058G.

> 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.[8]

The amount in controversy listed for both SSI Issues 1 and 3 in the Provider's individual appeal request is $31,173.

### *C. Description of Issue 2 in the Individual Appeal Request*

According to its Appeal Request, the Provider questions whether the MAC properly excluded Medicaid eligible days from the DSH calculation. The Statement of the Legal Basis is as follows:

> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[9]

The estimated reimbursement impact for this issue is listed at: $124,555.

In its PPP, the Provider argues 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]

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

In its Jurisdictional Challenge, the MAC argues that the Board lacks jurisdiction over this issue. According to the Provider's appeal request, Issue 1 has two components: 1) SSI data accuracy and 2) SSI realignment. The MAC contends that the portion related to SSI data accuracy should be dismissed because it is duplicative of the SSI Percentage (Systemic Errors)(Issue 3) - that was transferred to group Case No. 22-0058G. The remaining component which is related to SSI realignment should be

[8] Provider's PPP at 10 (April 10, 2023).
[9] Issue Statement at 2 (Aug. 19, 2022).
[10] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[11] Provider's PPP at 8 (Apr. 10, 2023).

dismissed because: 1) it was not briefed in the PPP; 2) there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[12]

**MAC's Contentions Issue 2 – Medicaid Eligible Days**

The MAC also argued that the Provider abandoned the Medicaid Eligible Days issue. The MAC contends that the Provider failed to include a list of additional Medicaid eligible days they expected to be included with their appeal or the PPP (even though the Provider advised that it would send a listing of additional Medicaid eligible days under separate cover.)[13] In addition, 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 PPP because it neglected to include all supporting documentation, nor did it meet the requirements for unavailable or omitted documents as discussed in Board Rule 25.2.2.[14]

**Provider's (*Lack of*) Jurisdictional Response**

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[15] Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." The Provider failed to file a response to the MAC's challenge by the August 16, 2023 deadline.

**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 2.

***A. DSH 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.

[12] MAC's Jurisdictional Challenge at 2 (July 17, 2023).
[13] Id at 10-11.
[14] Id.
[15] Board Rule 44.4.3, v. 3.1 (Nov. 1, 2021).

*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 ". . . because CMS failed to include all patients that were entitled to SSI benefits in their calculation"—is duplicative of the SSI Percentage (Systemic Errors) issue that the Provider transferred to Case No. 22-0058G. The dispute set forth in the SSI Percentage (Systemic Errors) issue involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

Because the Provider is arguing the same issue (*the accuracy of the SSI percentage*) in both the instant case and the Group case, the Provider is appealing an issue from a single final determination in more than one appeal, which is considered a prohibited duplicate per Board Rule 4.6.[16]

Additionally, 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.[17] 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 "SSI Accuracy" and CMS policy concerning individuals who are eligible for SSI but did not receive SSI payment issue as argued in Issue 3, and why those alleged "provider specific" errors should not be subsumed into the issue appealed in Case No. 22-0058G.

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 entitlement issue in Case No. 22-0058G. 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.

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. 22-0058G both argue the same component regarding individuals who are eligible for SSI but did not receive SSI payment. Because 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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[16] PRRB Rules v. 3.1 (Nov. 1, 2021).

[17] 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).

*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.

***B. Medicaid Eligible Days***

The Provider's appeal request asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider's issue statement for Issue 2 is stated above. Neither the Provider's appeal request, nor the PPP, included a list of the specific additional Medicaid eligible days that are in dispute in this appeal.

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

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

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

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

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

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multicomponent 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(b) addresses position papers and specifies in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[18]

Similarly, with regard to position papers,[19] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[20] 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.

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[18] (Emphasis added).
[19] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.
[20] (Emphasis added).

This appeal was initiated on August 19, 2022 (almost 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.[21]

Based on the Provider's failure to submit the Eligible Days Listing as promised, on April 10, 2023, the MAC filed a Jurisdictional Challenge, requesting dismissal of the Medicaid eligible days issue. The MAC contends that: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish the list of additional Medicaid eligible days with its PPP in violation of Board Rules 25.2.1 and 25.2.2. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the regulations and the Board Rules.[22] Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the MAC's Jurisdictional Challenge. However, the Provider failed to respond by the August 16, 2023 filing deadline (i.e., 30 days after July 17, 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)(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 provide 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"[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 less provided the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2) - (3) and

[21] Provider's PPP at 9 (Apr. 10, 2023).
[22] 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.
[23] (Emphasis added).

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.[24]

****

Based on the foregoing, the Board is dismissing the two (2) remaining issues in this case: SSI Percentage (Provider Specific) - Issue 1 and Medicaid Eligible Days - Issue 2. As no issues remain, the Board hereby closes Case No. 22-1328 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:

2/6/2026

X Nicole E. Musgrave

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

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

[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.

**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**

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

RE: ***Notice of Dismissal***
WilkesBarre General Hospital, Prov. No. 37-0137, FYE 06/30/2013
Case No. 21-0296

Dear Mr. Summar:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 21-0296. 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. 21-0296*

On **May 5, 2020**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2013.

On **October 30, 2020**, the Board received the Provider's individual appeal request. The Individual Appeal Request contained five (5) issues:

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

On **November 30, 2020**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the

[1] On November 26, 2025, this issue was withdrawn.
[2] On May 20, 2021, this issue was transferred to PRRB Case No. 18-0983GC.

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

The Provider is commonly owned/controlled by Community Health Systems (hereinafter "CHS") and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **May 20, 2021**, the Provider transferred Issue 2 to CHS groups.

On **June 24, 2021**, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 3 set forth therein:

> Specifically, the Provider disagrees with the MAC's calculation of the 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:
>
> > [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 2013 cost report does not reflect an accurate number

[3] (Emphasis added).

> of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal court decisions.[4]

On **September 30, 2021**, the Medicare Contractor filed its preliminary position paper.

On **May 19, 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.[5]

On **November 20, 2025**, the Provider timely filed its final position paper. The following is the Provider's ***complete*** position on Issue 3 set forth therein:

> Specifically, the Provider disagrees with the MAC's calculation of the 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:
>
> > [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

[4] Provider's Preliminary Position Paper at 7-8 (Jun. 24, 2021).
[5] (Emphasis added).

> 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.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover directly to the MAC (redacted listing to follow), the Provider contends that the total number of days reflected in its 2013 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.[6]

On **December 9, 2025**, the Medicare Contractor timely filed its final position paper.

On **December 24, 2025**, the Medicare Contractor filed a motion to dismiss, requesting the dismissal of Issue 3. The Provider did not file a timely response to the Medicare Contractor's motion to dismiss.

### *B. Description of Issue 3 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

[6] Provider's Final Position Paper at 8-9 (Nov. 20, 2025).

> the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[7]

The Provider estimated the reimbursement impact of the issue at $82,677based on an increase of 150 additional Medicaid days but failed to include a list of the additional days.[8]

**MAC's Motion to Dismiss**

***Issue 3 – 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.[9]

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 7, 25.2.1 and 25.2.2. 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. [10]

Additionally, 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 twelve years have elapsed since the end of the cost reporting period, and five years since the appeal was filed. [11]

**Provider's Response**

***Issue 3 – DSH Payment – Medicaid Eligible Days***

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[7] Issue Statement at 3 (Oct. 30, 2020).
[8] *Id.*
[9] Medicare Contractor's Motion to Dismiss at 3 (Dec. 24, 2025).
[10] *Id.* at 3-4.
[11] *Id.* at 3-4.

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.)"

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."

The Medicare Contractor filed its Motion to Dismiss on December 24, 2025, after the final position paper deadlines. The Provider, to date, has not filed a Jurisdictional Challenge Response. As a result, the Board will not consider the Provider's contentions.

## 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*

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.[12]

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

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

> **Rule 25 Preliminary Position Papers**[13]
>
> **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**

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

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 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 November 30, 2020 included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 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)(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.[14]

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

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

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

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

- if it has reasonable basis to believe that the issues have been

[14] (Emphasis added.)

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

On June 24, 2021, the Provider filed its preliminary position paper in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[15] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $82,677 based on an estimated 150 days).

On November 20, 2025, the Provider filed its final position paper. The position paper stated that a redacted version of the Provider's Medicaid Eligible Days listing was to follow, but no such listing was provided. No explanation was provided as to why the listing of days has not been submitted, ***more than 12 years after the fiscal year at issue had closed***. Importantly, it has been ***more than 4 years past the deadline for including it with the preliminary position paper*** since the position paper deadline was June 27, 2021.

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"[16] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to 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.

[15] Provider's Preliminary Position Paper at 8.
[16] (Emphasis added.)

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.[17]

Based on the foregoing, the Board dismisses the lone remaining issue in this case – Issue 3. As no issues remain, the Board hereby closes Case No. 21-0296 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:

2/6/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[17] *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.

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Provider Reimbursement Review Board
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Baltimore, MD 21244
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**Via Electronic Delivery**

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

RE: ***Notice of Dismissal***
Alliance Health Woodward, Prov. No. 37-0002, FYE 05/31/2019
Case No. 23-0420

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0420. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific).

## Background

### A. *Procedural History for Case No. 23-0420*

On **July 8, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2019. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **December 21, 2022**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
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]

[1] On July 14, 2023, this issue was transferred to Case No. 22-1031GC.
[2] This issue was withdrawn on December 16, 2025.
[3] On July 14, 2023, this issue was transferred to Case No. 23-0078GC.
[4] On January 30, 2024, the Board approved the bifurcation of this issue into Issue No. 5 (DSH Payment – SSI Fraction – Dual Eligible Days) and Issue No. 6 (DSH Payment – Medicaid Fraction – Dual Eligible Days). On

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 **July 14, 2023 and February 8, 2024**, the Provider transferred Issues 2, 4, 5 and 6 to CHS CIRP groups.

As a result of the case transfers, there is one (1) remaining issue in this appeal: Issue 1 (the DSH – SSI Percentage Provider Specific).

On **December 22, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[5]

On **July 31, 2023**, the Provider timely filed its preliminary position paper.

On **September 14, 2023**, the Medicare Contractor timely filed a Jurisdictional Challenge[6] with the Board over Issue 1, 3 and 5 requesting that the Board dismiss these issues.[7] 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.

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February 8, 2024, Issue No. 5 was transferred to Case No. 22-1006GC and Issue No. 6 was transferred to Case No. 23-0079GC.

[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).

[7] As noted above, Issue Nos. 3 and 5 were subsequently withdrawn and transferred, respectively.

On **September 15, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **November 17, 2023**, the Medicare Contractor filed its preliminary position paper.

On **July 11, 2025**, the Board issued the 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*** *also include* ***any exhibits*** *the Provider will use to support to support its position*. *See* Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.[8]

On **December 22, 2025**, the Provider timely filed its final position paper.

On **January 6, 2026**, the Medicare Contractor timely filed its final position paper.

### *B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 22-1031GC – CHS CY 2019 DSH SSI Percentage CIRP Group*

In 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).[9]

[8] (Emphasis added.)
[9] Issue Statement at 1 (Dec. 21, 2022).

The Group issue Statement in Case No. 22-1031GC, to which the Provider transferred Issue No. 2, reads, in part:

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

On July 31, 2023, the Board received the Provider's preliminary position paper in Case No. 23-0420. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Issue #1: Provider Specific**

[10] Group Issue Statement, Case No. 22-1031GC.

> 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).[11]

**MAC's Contentions**

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. 21-1031GC.[12] 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.[13] Further, did not brief the issue in its preliminary position paper.[14]

Finally, the MAC argues "the Provider did not file a **complete** preliminary and final [sic][15] position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3."[16] The

[11] Provider's Preliminary Position Paper at 8-9 (Jul. 31, 2023).
[12] Medicare Contractor's Jurisdictional Challenge at 5 (Sept. 14, 2023).
[13] *Id*. at 7.
[14] *Id*. at 6-7.
[15] Note: The language referring to a final position paper was in error, as final position papers had not yet been filed as of the date of the Jurisdictional Challenge.
[16] *Id*. at 8.

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]

**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."

**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

[17] *Id*. at 9.
[18] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[19] Issue Statement at 1.
[20] *Id.*

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 Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 21-1031GC 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. 23-0420 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 21-1031GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6, 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.[22] 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" 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. 21-1031GC.

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. 21-1031GC, 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.[23] 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

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[21] *Id.*

[22] 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).

[23] 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.

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.[24]

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.[25]

[24] (Italics and underline emphasis added.)
[25] Last accessed Oct. 15, 2024.

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[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. 21-1031GC.

Accordingly, *based on the record before it*,[27] the Board finds that the SSI Provider Specific issue in Case No. 23-0420 and the group issue from the CHS CIRP group under Case No. 21-1031GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the 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 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*.[28]

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.

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[26] (Emphasis added).
[27] Again, the Board notes that the Provider failed to timely respond to the Jurisdictional Challenge and the Board must make its determination based on the record before it.
[28] (Emphasis added).

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.

* * * * *

Based on the foregoing, the Board has dismissed the remaining issue in this case – (Issue 1-DSH Payment/SSI Percentage (Provider Specific)). As no issues remain, the Board hereby closes Case No. 23-0420 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:

2/6/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Via Electronic Delivery**

Randall Gienko, Senior Consultant
Strategic Reimbursement Group
360 W. Butterfield Road, Suite 310
Elmhurst, IL 60126

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

Mercyhealth CYs 2018 - 2020 SSI Calculation Error CIRP Group
Case Number: 25-1407GC

Mercyhealth CYs 2018 - 2020 Unmatched Medicaid Days CIRP Group
Case Number: 25-1408GC

Mercyhealth CYs 2019 - 2020 Understatement of PPS Standardized Amount CIRP Group
Case Number: 25-1409GC

Dear Mr. Gienko:

The Provider Reimbursement Review Board ("Board") has reviewed the subject common issue related party ("CIRP") group appeals 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 **January 13**, **2025**, Strategic Reimbursement Group, LLC ("Strategic") formed the following three groups:

- Mercyhealth CYs 2018 - 2020 SSI Calculation Error CIRP Group under Case No. 25-1407GC
- Mercyhealth CYs 2018 - 2020 Unmatched Medicaid Days CIRP Group under Case No. 25-1408GC
- Mercyhealth CYs 2019 - 2020 Understatement of PPS Standardized Amount CIRP Group under Case No. 25-1409GC

On **January 14, 2025**, the Board acknowledged each group in a Case Acknowledgement and Critical Due Dates notification ("ACDD"). The Board's ACDD notices gave the Group Representative a

**January 13, 2026** deadline to file the "Group's Comments Regarding Full Formation."[1]

On **January 16, 2026**, after Strategic failed to file a timely response to the "Group's Comments Regarding Full Formation," the Board issued a Show Cause Order and notice deeming the three groups to be fully formed.[2] The Board's Order required the Representative to submit its comments by **January 28, 2026**, showing cause as to why the cases should not be dismissed. Accordingly, Strategic was obligated to respond by the deadline. The Board's Order explicitly stated that "[f]ailure of the Group Representative to file its response by this deadline, will result in the Board taking remedial action and the cases will be dismissed."

To date there has been no response to the Show Cause Order in any of the groups.

**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. (Emphasis added.)

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 Strategic's failure to respond to the Comments Regarding Full Formation **and its failure to respond** to the Board's Show Cause Order. Strategic 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, Strategic failed to comply with Board Rule 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."

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[1] The January 14, 2025 notification 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."

[2] The Board notes this is not the first instance where Strategic has missed the "comments regarding full formation deadline." ***See***, Case No. 25-0595GC.

[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)

In conclusion, given its discretionary authority in 42 C.F.R. § 405.1868 and Board Rule 41.2, which states that the Board may dismiss a case upon failure of the group to comply with Board procedures or filing deadlines, the Board **dismisses Case Nos. 25-1407GC, 25-1408GC and 25-1409GC**.

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:

2/10/2026

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 C. Leong, 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 North Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Dismissal of Sole Issue: Medicare Fraction (SSI) – Statutory & Systemic Errors***
Lawrence & Memorial Hospital (part of Yale-New Haven Health Sytem)
Provider Number: 07-0007
FYE: 09/30/2013
Case Number: 25-2372

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the "Board"), on its own motion, has reviewed the subject appeal and notes an impediment to jurisdiction. Set forth below are the pertinent facts and the decision of the Board to dismiss the appeal.

## Introduction

On February 10, 2025, Quality Reimbursement Services, Inc. ("QRS") filed the above-referenced individual appeal in the Office of Hearings Case & Document Management System ("OH CDMS"). The Provider contends that the that the Medicare/SSI Fractions published on CMS' website on August 13, 2024, pursuant to CMS transmittal 12785, were determined incorrectly due to the "inclusion of Medicare Part C days in the denominator of the Fraction, and . . . exclusion of days from the numerator of the Medicare Fraction associated with individuals who were entitled to Supplemental Security Income (SSI) during their hospital stay but who were not in SSI pay status during such stays, or were in SSI pay status during their hospital stay but were not assigned payment status code C01, M01 or M02."[1]

## Background

### *A. Medicare DSH Payment and Realignment*

Part A of the Medicare statute covers inpatient hospital services. Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the

[1] *See e.g.*, Case No. 25-2372, Provider's Issue Statement at 1 (Feb. 10, 2025).

inpatient prospective payment system ("IPPS").[2] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[3]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[4] This case involves the hospital-specific disproportionate share hospital ("DSH") adjustment, which requires the Secretary to provide increased PPS payments to hospitals that "serve [] a significantly disproportionate number of low-income patients."[5]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[6] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and the amount of the DSH payment to be paid to a qualifying hospital.[7] The DPP is defined as the sum of two fractions expressed as percentages.[8] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction."

This matter concerns the Medicare/SSI fraction.[9] 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 . . . .

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 eligibility for and if eligible, the amount of any DSH payment adjustment.[10] CMS calculates the Medicare/SSI Fractions used to calculate Medicare DSH payments based on discharges in the respective federal fiscal year, but hospitals are permitted under 42 C.F.R. § 412.106(b)(3) to request that CMS recalculate, or "realign," their Medicare/SSI Fractions based on discharges in the hospital's cost reporting period.

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[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] The other component of the DPP not at issue in this matter is the "Medicaid Fraction" which is the number of hospital patient days for patients eligible for medical assistance under a State Medicaid plan (*i.e.* a plan approved by the Secretary under 42 U.S.C. § 1396 *et* seq.) but who were not entitled to Medicare Part A, divided by the total number of hospital patient days. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). *See also* 42 C.F.R. § 412.106(b)(4).
[10] 42 C.F.R. § 412.106(b)(2)-(3).

### *B. Appeal of Publication of Medicare/SSI Fraction Data Pursuant to CMS Transmittal 12785*

The Provider in this case states that it is appealing from the publication of Medicare/SSI Fractions on CMS' website on August 13, 2024, that was done pursuant to CMS Transmittal 12785, "Instructions for Processing Requests for SSI Realignment for Cost Reporting Periods Starting Before October 1, 2013." Transmittal 12785 replaced and updated Transmittal 12747 that was originally issued on July 26, 2024. The original Transmittal 12747 announced that CMS was resuming the processing of realignment requests for cost reporting periods starting before October 1, 2013. With realignment, hospitals are permitted under 42 C.F.R. § 412.106(b)(3) to request that CMS recalculate, or "realign," their Medicare/SSI Fractions based on discharges in the hospital's cost reporting period, rather than CMS' calculated Medicare/SSI Fractions based on discharges in the respective federal fiscal year.

The original Transmittal 12747, which was replaced by Transmittal 12785, describes how CMS temporarily halted the processing of realignment requests for cost reporting periods starting before October 1, 2013, due "to a lack of policy established through notice-and-comment rulemaking regarding the treatment of Part C days for that period of time."[11] However, on June 9, 2023, CMS issued Final Rule CMS-1739-F, finalizing the treatment of Medicare Part C days in determining a hospital's DPP, whereby such days are to be included in the Medicare/SSI Fraction and excluded from the numerator of the Medicaid fraction. Both transmittals announce that with the issuance of final rule CMS-1739-F, and the publication of provider Medicare/SSI Fractions on the CMS website, the agency was resuming the processing of realignment requests for such cost reporting periods.

The original Transmittal 12747 states that the Medicare/SSI Fractions available on the CMS website for cost reporting periods starting before October 1, 2013, like the federal fiscal year Medicare/SSI Fractions for the same period, were determined pursuant to final rule CMS-1739-F. The transmittal directs MACs to use such fractions to determine DSH payments for realignment requests in appropriate cases. The Transmittal explains that for realignment requests for such cost reporting periods, "CMS will calculate cost reporting period SSI ratios for all periods, for all hospitals, and post those ratios to the CMS DSH website . . . ."[12] Both Transmittal 12785 and the earlier Transmittal 12747 which it updates are nearly identical and focused on the realignment process. The ***only*** change in Transmittal 12785 from the earlier Transmittal 12747 is addressing a formatting change "to update the DSH Adjustment and Realignment files years 1988-2013, so that the SSI Ratio column is consistently rounded to four (4) decimals in all files. All other information remains the same."[13]

[11] CMS Transmittal 12747 at 3 (July 26, 2024).
[12] *Id*.
[13] CMS Transmittal 12785 at 1 (Aug. 13, 2024).

**Medicare Contractor Jurisdictional Challenge**

In its Jurisdictional Challenge, filed on November 20, 2025, the Medicare Contractor asserts that the Board does not have jurisdiction over the issue in these group appeals because "the appeal does not arise from a 'final determination' as that term is used in 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 1835(a) (as also cross-referenced in 42 C.F.R. § 405.1837(a)(1))."[14] The Medicare Contractor explains that the Providers appealed from Transmittal 12785, and argues that neither Transmittal 12785 nor Transmittal 12747 are appealable final determinations.[15]

The Medicare Contractor also argues that the court decisions the Provider referenced in their appeals are inapplicable to the instant appeals.[16] The Medicare Contractor explains that the Providers recognized the Board's previous dismissal of appeals from the publication of SSI percentages by stating:

> The Provider [Group] is aware that the PRRB has taken the position that the publication of SSI Ratio is not a final determination and that providers must await a Notice of Program Reimbursement (NPR) setting its total reimbursement before challenging its Medicare Fraction, but the Provider [Group] respectfully submits that the PRRB is incorrect, as decided in two recent court decisions. *See Battle Creek Health Sys. v. Becerra*, Civil Action 17-0545 (CKK) (D.D.C. Oct. 31, 2023); *Baylor All Saints Med Ctr. v. Becerra,* Civil Action 4:24-cv-00432-P (N.D. TX Aug. 15, 2-24).[17]

The Medicare Contractor points to a prior Board decision in which it distinguished the decision in *Battle Creek* from the facts of the appeal before the Board, and argues that the Board should make a similar finding here with respect to the applicability of *Battle Creek* to these transmittal appeals.[18] With respect to *Baylor All Saints*, the Medicare Contractor argues that "[b]ecause the Court failed to address the statutory requirements for Board jurisdiction, the Providers' reliance on *Baylor All Saints Med. Ctr.* is without merit.[19]

**Provider's Jurisdictional Response**

The Provider, in its December 4, 2025 Jurisdictional Response, acknowledges that the Board has:

> [T]aken the position that the publication of SSI ratio is not a final determination and that the provider must await a[n NPR] setting its

[14] Jurisdictional Challenge at 2.
[15] *Id.* at 1-2.
[16] *Id.* at 5-7.
[17] *Id.* at 6.
[18] *Id.*
[19] *Id.* at 7.

> total reimbursement before challenging its Medicare Fraction, but the Provider respectfully submits that the PRRB is incorrect, as decided in two recent decisions. See Battle Creek Health Sys. V. Becerra, Civil Action 17-0545 (CKK) (D.D.C. Oct. 31, 2023); Baylor All Saints Med. Ctr. v. Becerra, Civil Action 4:24-cv-00432-P (N.D. Tex. Aug. 15, 2024).[20]

The Provider's argument continues, stating that jurisdiction is conferred on the Board under 42 U.S.C. § 1878(a)(1)(A)(ii) as the provider is "dissatisfied with a final determination of the Secretary as to the amount of payment under [42 U.S.C. § 1886(b) or (d)]."[21]

**Board Determination**:

*A. Transmittals 12747 and 12785 Are Not Appealable Final Determinations*

In this case, the Provider maintains that CMS' publication of Medicare Fraction data on its website pursuant to Transmittal 12785 on August 13, 2024, "constitutes 'a final determination of the Secretary as to the amount of the payment under subsection . . . (d) of section 1886' of the Social Security Act (the Act)" and because the Provider "is dissatisfied with this determination . . . the PRRB has jurisdiction over" the appeal.[22] However, the publication of Medicare/SSI Fractions in conjunction with Transmittal 12785, which merely requires a formatting change to the Medicare/SSI Fraction data posted on CMS' website so that the "SSI Ratio column is consistently rounded to four (4) decimals in all files" is not a "final determination" from which a provider may appeal. As explained below, the Board dismisses this matter for lack of jurisdiction over the Provider's appeal in this case.

The Medicare statute authorizes providers to seek hearings before the PRRB in two sets of circumstances: First, where the provider is dissatisfied with "the amount of total program reimbursement" as set forth in a Notice of Program Reimbursement (NPR);[23] and second, where the provider is dissatisfied with a "final determination" "as to the amount of the payment" under the prospective payment system.[24] In this case, the Provider has not yet received its NPR and has based its appeal, pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(ii), on their dissatisfaction with Medicare/SSI Fraction data that was published on the CMS website in conjunction with Transmittal 12785.

The Provider, in its Issue Statement, acknowledges that the Board "has taken the position that publication of [Medicare/SSI Fraction data on CMS' website] is not a final determination."[25] But the Provider also notes disagreement with the Board's position, citing *Battle Creek Health*

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[20] Jurisdictional Challenge Response at 1 (Dec. 4, 2025).
[21] *Id.* at 1-2.
[22] Provider's Issue Statement at 1.
[23] 42 U.S.C. § 1395oo(a)(1)(A)(i).
[24] *Id*. § 1395oo(a)(1)(A)(ii).
[25] Provider's Issue Statement at 1.

*Sys. v. Becerra*,[26] and *Baylor All Saints Med. Ctr. v. Becerra*,[27] decisions where courts held that providers met the requirements for a Board appeal before receiving a final appealable determination as to the amount of DSH payment.[28]

The Board has continued to find that the district court's decision in *Battle Creek* is inapposite because, unlike in the instant case, the challenged Transmittal and publication of data in that case was described by the court as being a "*fait accompli*."[29] The district court in *Battle Creek* observed that the challenged Transmittal and publication of data there "provided, with some finality, advance knowledge of the amount of [the DSH] payment."[30] On appeal, however, the Court of Appeals for the D.C. Circuit very recently disagreed with the lower court's reasoning, and reversed that decision finding:

> According to the Board, the hospitals needed to wait until they knew the final amount of their DSH adjustment rather than just the determination of one component of it. The district court disagreed and concluded that the hospitals' challenge could go forward. Because we agree with the Board, we reverse the district court.[31]

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

> This case is different. Here, the Medicare fraction had been published and the hospitals sought to challenge its calculation. But other components of the DSH adjustment (and thus of the per-patient payment amount) had yet to be finalized. Indeed, the hospitals could not know that they would be eligible for a DSH adjustment based on the Medicare fraction alone. The Medicaid fraction remained outstanding, and so too, therefore, did the disproportionate-patient percentage, and ultimately the hospitals' eligibility for, and amount of, any DSH adjustment. *See* pp. —— – ——, ——, *supra*. Those are finally settled upon issuance of an NPR. Unlike in *Washington Hospital Center*, then, in this case there had been no "final determination of the Secretary as to the amount of the payment" under the PPS. 42 U.S.C. § 1395oo(a)(1)(A)(ii).[32]

The Board agrees, and has found that the publication of the challenged Transmittal and accompanying Medicare/SSI Fraction data, provided by CMS for the purpose of informing provider choice as to whether to request realignment of the Medicare/SSI Fraction, does not

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[26] 2023 WL 7156125 (D.D.C. Oct. 31, 2023), *rev'd*, No. 23-5310, 2025 WL 2423686 (D.C. Cir. Aug. 22, 2025).
[27] 745 F.Supp.3d 464 (N.D. Tex. Aug. 15, 2024), *appeal docketed*, No. 34-10934 (5th Cir. Oct. 17, 2024).
[28] *See e.g.* Case No 25-2372, Provider's Issue Statement at 1.
[29] *Battle Creek*, 2023 WL 7156125 at *5.
[30] *Id*.
[31] *Battle Creek Health Sys. v. Kennedy*, No. 23-5310, 2025 WL 2423686, at *1 (D.C. Cir. Aug. 22, 2025).
[32] *Id.* at *6.

definitively inform whether a provider qualifies for the DSH adjustment, much less the amount of DSH reimbursement that a provider could receive.

In recent Board decisions, the Board has continued to notice its disagreement with the district court decision in *Battle Creek* and by extension, other court decisions like *Baylor All Saints*.[33] The Board maintains that *Memorial Hospital v. Becerra*,[34] and now the Court of Appeals decision *Battle Creek* are better-reasoned decisions. In *Memorial Hospital*, a group of providers filed an appeal similar to the Provider's appeal in this case. The *Memorial Hospital* providers challenged CMS' publication of Medicare/SSI Fraction data, arguing that there are certain instances where a provider can file a Board appeal prior to receiving an NPR. The court in *Memorial Hospital* ultimately agreed with the Board that CMS' publication of Medicare/SSI Fractions was not an appealable final determination.

The court distilled the parties' positions as "boil[ing] down to a dispute about whether Plaintiffs have conflated a determination by the Secretary about one of several undetermined elements that eventually flows into the amount of payment and 'a final determination of the Secretary as to the amount of payment.'"[35] The court held that CMS' publication of Medicare/SSI Fractions, even if the publication of such fractions had been issued as "final," could and would not be a final determination "as to the amount of payment" because the Medicare/SSI Fractions are "just one of the variables that determines whether hospitals receive a DSH payment and, if so, for how much."[36] For the court, a challenge to an element of payment under 42 U.S.C. § 1395oo(a)(1)(A)(ii) is only appropriate if, as the D.C. Circuit has explained, "the Secretary ha[s] firmly established 'the only variable factor in the final determination as to the amount of payment under § 1395ww(d).'"[37]

Using the reasoning in *Battle Creek* and *Memorial Hospital*, given the nature of the DSH adjustment, the publication of hospitals' Medicare/SSI Fractions on CMS' website is not final a determination as to the amount of payment due to any provider because the Medicare/SSI Fraction alone does not determine the amounts hospitals will be paid under the adjustment. Instead, the Medicare/SSI Fraction is incorporated, along with the Medicaid Fraction, into the DPP, which is ultimately the calculation that determines eligibility for and the amount of any DSH adjustment. The DPP must also exceed certain thresholds to qualify for any DSH adjustment.[38] Thus, although CMS calculates and publishes the Medicare/SSI Fraction for every hospital that receives Medicare reimbursement, the determination of whether a hospital receives reimbursement is made only after the hospital submits its year-end cost report.

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[33] *See, e.g.*, Board decisions in PRRB Case Nos. 24-0491, 24-1531GC, and 24-0413GC.
[34] 2022 WL 888190 (D.D.C. Mar. 25, 2022).
[35] *Id*. at *8.
[36] *Id*. at *9
[37] *Id*. at *8 (quoting *Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807, 811 (D.C. Cir. 2001) (quoting *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 147 (D.C. Cir. 1986)) (emphasis added); *see also Samaritan Health Serv. v. Sullivan*, 1990 WL 33141 at *3 (9th Cir. 1990) (unpublished table decision) ("We have held that if the Secretary's classification of a hospital effectively fixes the hospital's reimbursement rate, then that decision is a 'final determination' as referred to 42 U.S.C. § 1395oo(a)(1)(A)(ii).").
[38] 42 C.F.R. § 412.106(d)(2)(i)-(ii).

In this matter, the Provider contends that the Medicare/SSI Fractions published on CMS' website on August 13, 2024, pursuant to CMS transmittal 12785, were determined incorrectly due to the "inclusion of Medicare Part C days in the denominator of the Fraction" and . . . "exclusion of days from the numerator of the Medicare Fraction associated with individuals who were entitled to Supplemental Security Income (SSI) during their hospital stay but who were not in SSI pay status during such stays, or were in SSI pay status during their hospital stay but were not assigned payment status code C01, M01 or M02."[39] Transmittal 12785 bears no connection to the issue under appeal as the Transmittal merely implements a formatting change to the SSI Fraction data that was previously made available through the earlier Transmittal 12747 in order to ensure that the SSI Ratio column is consistently rounded to four decimals in all files. This information was published originally (in Transmittal 12747) so that providers have sufficient information available to inform whether they want to request realignment. Providers cannot claim that with publication of Medicare/SSI Fraction data on CMS' website in a new decimal format pursuant to Transmittal 12785, they are somehow "dissatisfied with a final determination of Secretary as to the amount of payment."[40]

Neither the publication of the Medicare/SSI Fraction data, nor the decimal formatting change described in Transmittal 12785 informs whether a provider qualifies for the DSH adjustment, much less the amount of DSH reimbursement that a provider could receive. The Provider here has included no proof that it has requested realignment, nor even that with realignment it would be eligible for DSH reimbursement (changes in either the Medicare/SSI or Medicaid fractions could potentially result in a DPP below that required to qualify for the DSH adjustment). That CMS is providing such information to inform a provider's choice as to whether to request realignment of the Medicare/SSI Fraction that will be calculated for use in determining the DPP that ultimately determines whether a provider qualifies for DSH and how much they could receive, clearly indicates that the publication of SSI Fraction data is not a final determination as to the amount of payment. Additionally, this particular Provider has a September 30 fiscal year end, and is appealing for its FYE 9/30/2013. As such, the Provider's cost reporting period and the federal fiscal year (on which SSI Ratios are normally calculated) are congruent. In such a case, realignment of the SSI would have no effect on the ratio in this case. Therefore, this data, issued for decisions on whether or not to request realignment, has no effect on this Provider, in particular.

*B. Appeal Not Timely Filed*

Assuming *arguendo* that the Provider could persuade the Board that the Transmittals and accompanying SSI Fraction data are final appealable determinations, the Board must still dismiss the Provider's appeal because it would be untimely. Pursuant to 42 U.S.C. § 1395oo(a)(3), a provider's request for a hearing must be filed within 180 days of the date of receipt of the final determination.[41] Given the nature of the Provider's challenge, it appears that it is actually

[39] Provider's Issue Statement at 1. Although the Providers characterize this as the "sole issue" under appeal, the issue statement appears to encompass two separate and distinct issues: 1) the inclusion of Medicare Part C days in the denominator of the Medicare/SSI Fraction; and 2) the exclusion of patient days for individuals eligible for both Medicare and SSI from the numerator of the Medicare/SSI Fraction.
[40] *See* 42 U.S.C. § 1395oo(a)(1)(A)(ii).
[41] *See also* 42 C.F.R. § 405.1835(a)(3).

challenging Final Ruling CMS-1739-F rather than the Transmittals and accompanying SSI Fraction data. The Transmittals merely implement the Ruling in providing the providers with SSI Fractions recalculated or "realigned" based on the hospitals' cost reporting period instead of the federal fiscal year. Final Ruling CMS-1739-F was issued June 9, 2023, and the Provider's appeal was filed on February 10, 2025, long past the expiration of the 180-day period to file an appeal. Moreover, CMS Transmittal 12747 was originally issued on July 26, 2024, and the Provider's February 10, 2025 appeal was filed on the 181st day, after the 180 day appeal period had expired, if calculated from that date. Even if the Provider was to argue that the appeal was timely based on the later issuance of Transmittal 12785 on August 13, 2024, this Transmittal bears no connection to the issue under appeal as the Transmittal merely implements a formatting change to the SSI Fraction data that was previously made available through the earlier Transmittal 12747 so that the SSI Ratio column is consistently rounded to four decimals in all files.

**Conclusion**

As the Medicare/SSI Fraction data published pursuant to Transmittal 12785 is not an appropriately appealable final determination, the Provider has failed to meet the jurisdictional requirements for a hearing. Thus, the Board hereby dismisses Case No. 25-2372 and removes it from the Board's docket.

Review of this determination may be available under the provision 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:

2/10/2026

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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**Via Electronic Delivery**

Isaac Blumberg
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Los Angeles, CA 90064-1582

RE: ***Expedited Judicial Review Determination***
Case Numbers: 25-1299GC *et al.* (12 cases – *see* **Appendix A**)
*Blumberg Ribner CMS1739F Challenge: MCR Part C Days in the Medicare Fraction Groups*

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed between **January 12 and 29, 2026** in the above-referenced group appeals. The Board's decision on jurisdiction and EJR is set forth below.

**Background and Issue:**

Between **December, 2024 and February, 2025**, the Board received twelve (12) requests to establish Common Issue Related Party ("CIRP") and optional groups. The Providers in all twelve (12) groups are appealing from original and revised Notices of Program Reimbursement ("NPRs" and "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 Year Ends ("FYEs") spanning from 2001 to 2013.

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]

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] *E.g.*, Case No. 25-1299GC, Statement of Issue at 1 (Jan. 6, 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]

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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 required the parties to file supplemental briefs addressing whether vacatur of the June 9, 2023 Final Rule is the appropriate remedy.[50]

**Providers' Position:**

***A. Providers' Appeal Requests***

The Providers' appeal requests argue 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

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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. 25-1299GC, 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)).

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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. Providers' Petitions 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 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]

The Medicare Contractor's representative, Federal Specialized Services, has filed timely responses to the Requests for EJR in each case. In Case No. 25-1299GC, the response simply stated, "[t]he MAC will not file a jurisdictional challenge in this case."[57] In other cases, the response stated, "the MAC will not file a jurisdictional challenge in this case, the MAC will not file a substantive claim challenge in this case."[58]

**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.

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[54] *Id.* at ¶¶ 6-18.
[55] *E.g.*, Case No. 25-1299GC, Providers' Petition for Expedited Judicial Review at 1-4 (Jan. 12, 2026).
[56] *Id.* at 11.
[57] *E.g.*, Case No 25-1299GC, Response to Provider's Request for Expedited Judicial Review at 1 (Jan. 21, 2026). In this case, no mention was made in the response as to whether a substantive claim challenge would be filed, but neither was any filed within the time frame allowed.
[58] *E.g.*, Case No. 25-3435G, Response to Provider's Request for Expedited Judicial Review at 1 (Feb. 3, 2026). The Board notes that Jurisdictional Challenges were originally filed in Cases 25-1221G and 25-1234G, but these were withdrawn once the challenged Providers were withdrawn from their respective appeals.

### *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; [59]
- 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.[60]

For these twelve (12) groups, the providers all appealed from original or 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 NPRs and/or RNPRs or were transferred to the group from a timely individual appeal. Finally, 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 filed timely appeals from their original and 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 NPRs and RNPRs. The Board also finds that the amount in controversy exceeds $50,000 as required by 42 C.F.R. § 405.1837(a)(3). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

### *B. Board's Decision Regarding the EJR Requests*

The Board finds that:

1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject 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;

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[59] 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).
[60] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

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 the twelve (12) cases listed in **Appendix A** and removes them from its docket.

Board Members Participating:

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

FOR THE BOARD:

2/10/2026

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)
Cecile Huggins, Palmetto GBA (J-J)
Scott Berends, Federal Specialized Services

## Appendix A

| | |
|---|---|
| 25-1299GC | *MaineHealth CY 2007 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group* |
| 25-1436GC | *Medisys Health CYs 2005 & 2008 -2013 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group* |
| 25-1221G | *Blumberg Ribner CY 2009 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction Group* |
| 25-1234G | *Blumberg Ribner CY 2008 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction Group* |
| 25-1241G | *Blumberg Ribner CY 2010 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction Group* |
| 25-1246G | *Blumberg Ribner CY 2011 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction Group* |
| 25-1732G | *Blumberg Ribner CY 2012 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction Group* |
| 25-1334GC | *Continuum Health CYs 2001 - 2004 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group* |
| 25-1337GC | *Ballad Health CY 2002 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group* |
| 25-2131G | *Blumberg Ribner CY 2007 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction Group* |
| 25-3435G | *Blumberg Ribner CY 2013 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction Group* |
| 25-2288G | *Blumberg Ribner CY 2006 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction Group* |

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**

Randall Gienko
Strategic Reimbursement Group, LLC
360 W. Butterfield Road, Suite 310
Elmhurst, IL 60126

RE: ***Notice of Dismissal***
Mercy Health System Corp (Provider Number 52-0066)
FYE: 06/30/2015
Case Number: 20-0278

Dear Mr. Gienko:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 20-0278. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's SSI Calculation Error.

## Background

### *A. Procedural History of Case No. 20-0278*

On **May 16, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2015. The Provider is represented by Strategic Reimbursement Group, LLC ("SRG").

On **November 5, 2019**, SRG filed the Provider's individual appeal request. The initial Individual Appeal Request contained six (6) issues:

1. Unmatched Medicaid Days (Unpaid Medicaid Eligible Days)[1]
2. SSI Calculation Error (Medicare Fraction Dual Eligible Part A Exhausted Medicare Benefits Days Exclusion, Part C Days Exclusion, Matching Errors)
3. Medicaid Fraction – Dual Eligible Medicare Part C Days should be Included[2]
4. Medicare Fraction (SSI Ratio) – All Medicare Part C Days should be Removed[3]
5. DRG Understatement[4]
6. Transfer Case Underpayment[5]

[1] On June 4, 2020, this issue was transferred to PRRB Case No. 20-1732GC.
[2] On June 4, 2020, this issue was transferred to PRRB Case No. 20-1731GC.
[3] On June 4, 2020, this issue was transferred to PRRB Case No. 20-1730GC.
[4] On June 4, 2020, this issue was transferred to PRRB Case No. 20-1733GC.
[5] On June 4, 2020, this issue was transferred to PRRB Case No. 20-1734GC.

After various transfers one issue remains pending in the appeal: Issue 2 – SSI Calculation Error (Medicare Fraction Dual Eligible Part A Exhausted Medicare Benefits Days Exclusion, Part C Days Exclusion, Matching Errors).[6]

On **May 3, 2023**, the Board issued the notice of Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. The 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.[7]

On **September 5, 2023**, the Provider timely filed its preliminary position paper.

On **November 30, 2023**, the Medicare Contractor timely filed its preliminary position paper.

On **December 18, 2023**, the Medicare Contractor filed a jurisdictional challenge. The Provider filed its response to the challenge on **December 20, 2023**.

### *B. Description of Issue 2*

In the Statement of Group Issues, the Providers' representative summarizes its SSI – Calculation Error issue as follows:

> Section 951 of the Medicare Modernization Act requires that the Secretary of Health and Human Services ("Secretary") "arrange to furnish . . . the data necessary . . . for hospitals to compute the number of patient days used in computing the disproportionate patient percentage under [42 U.S.C. 1395ww(d)(5)(F)] for that hospital for the current cost reporting year." The Secretary has failed to do so in a meaningful way.
>
> The provider challenges the Medicare Fraction (also referred to as the Supplemental Security Income Ratio ["SSI Ratio"]) as calculated by the Centers for Medicare and Medicaid Services

[6] This issue was originally transferred to a group appeal in 2020, but the group failed to meet the required $50,000 amount in controversy and the issue was returned to the individual appeal in 2022.
[7] Emphasis added.

("CMS") used in the Medicare Administrative Contractor's adjustments pertaining to the Operating Disproportionate Share Hospital and Capital Disproportionate Share Hospital adjustment calculations (collectively "Calculations") because CMS has failed to fulfill the Secretary's obligation under the Act.

It is the provider's position that the methodologies and practices applied by CMS in the determination of the Medicare Fractions are flawed. *See Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008). The provider believes these flaws include, but are not limited to, the following:

- The method CMS implements to **match** hospitals' patients to Federal **SSI** databases. The provider contends that the Medicare Fractions as generated by the SSA and put forth by CMS is understated.
- Failure to properly include in the numerator of the Medicare Fraction certain "Dual Eligible" patients (patients with both Medicaid and Medicare Part A coverage) whose **Medicare Part A benefits** have been **exhausted** and qualify for SSI benefits.
- Failure to properly include in the numerator of the Medicare Fraction certain patients with **Medicare Part C** (Medicare Advantage Plan) coverage and qualify for SSI benefits.
- Failure by CMS to include in the numerator of the Medicare Fraction patients with Medicare Part A or C coverage that fall under **certain SSI payment classifications**.

The provider requests that CMS provide all underlying information used to calculate the provider's Medicare Fraction and allow the provider to review, test, and submit a corrected Medicare Fraction for purposes of revising the Calculations in accordance with 42 CFR Subpart G Section 412.106 and 42 CFR Subpart M Section 412.320. The provider has estimated that the reimbursement impact associated with the flawed SSI data, based on industry experience, is the SSI% used in the audited cost report plus 5% and has calculated the reimbursement impact in the attached calculations, but asserts that its reimbursement should be based on the accurate SSI data for its cost reporting year and not the estimate made on data to which it does not have access.[8]

[8] Statement of the Issue, Issue 2.

On September 5, 2023, the Board received the Provider's Preliminary Position Paper. The Paper addresses the underlying information in dispute as follows:

> The information needed to perform the necessary review of the Calculations is contained in CMS' data sets referred to as "MedPAR SSI Data Files" which had been temporarily unavailable pending the release of CMS' revised SSI ratios. During 2012, CMS issued revised SSI ratios for FFY 2006 – 2010 as required by CMS' Ruling 1498R (April 28th, 2010) and, at the same time, the MedPAR SSI Data Files became available for review by hospitals receiving IPPS DSH payments.[9]

**MAC's Contentions**

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 25.2 and 25.3.[10]

**Provider's Response**

The Provider contends that "[t]he Medicare Contractor has usurped its authority by raising issues that it does not have the right to raise at this juncture."[11]

Further, the Provider argues that its' "Preliminary Position Paper addresses the dispute regarding the SSI data as best is possible, given the Provider's lack of control over the data" and complies with rules and regulations regarding position papers.[12] They go on to posit that they have "not been able to furnish some detailed concerns with the data because they do not have access to any data set other than the MedPAR data."[13]

**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.

The Board finds that the Provider's Preliminary Position Paper in this matter failed to set forth the relevant facts and arguments regarding the merits of their Medicare payment claims. The

---

[9] Provider's Preliminary Position Paper at 16 (Sept. 5, 2023).
[10] Jurisdictional Challenge at 3 (Dec. 18, 2023).
[11] Jurisdictional Response at 2 (Dec. 20, 2023).
[12] *Id*.
[13] *Id*.

Provider's Preliminary Position Paper states that "the methodologies and practices applied by CMS in the determination of the SSI ratios are flawed, including, but not limited to, the method CMS implements to match hospitals' patients to Federal SSI databases. The providers contend that the SSI ratios as generated by the SSA and put forth by CMS are understated."[14] As supporting exhibits, the Provider included excerpts from the Federal Register.

The Provider's Preliminary Position Paper states that "the providers have requested the necessary MedPAR SSI Data Files and are performing reviews to identify discrepancies in the accumulation of data and the methodology for computing the Medicare Fraction used in the determinations of their Calculations. The detailed review will be provided forthcoming [sic]." 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 preliminary 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 the issue and explain the nature of the any alleged "errors" and include *all* exhibits. Indeed, almost 2 years after the filing of the Preliminary Position Paper, no additional documentation has been filed, although it was promised to be "forthcoming."

By failing to identify the (or any) SSI days they believe should be included in the numerator of their Medicare fraction, nor the codes that they feel should have been excluded from inclusion in the Medicare fraction, the Board finds the Provider failed to file a complete preliminary position paper, in violation of Board Rule 25 and 42 C.F.R. § 405.1853(b)(2). The Board dismisses the issue from the appeal.

* * * * *

Based on the foregoing, the Board has dismissed the remaining issue in this case. As no issues remain, the Board hereby closes Case No. 20-0278 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

2/10/2026

X Kevin D. Smith, CPA

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

cc: Pamela VanArsdale, National Government Services, Inc. (J-6)
Wilson Leong, FSS

[14] Provider's Preliminary Position Paper at 16.

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Provider Reimbursement Review Board
7500 Security Blvd.
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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 09/30/2019
Case No. 24-0309

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 24-0309. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific).

## Background

### A. *Procedural History for Case No. 24-0309*

On **June 12, 2023**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2019. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **December 1, 2023**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained four (4) issues:

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

[1] This issue was withdrawn on February 9, 2026.
[2] On June 26, 2024, this issue was transferred to PRRB Case No. 23-0078GC.
[3] On June 3, 2024, CHS requested to bifurcate this issue into separate issues for the SSI Fraction (Issue No. 4) and the Medicaid Fraction (Issue No. 5). On June 18, 2024, the Board did approve the bifurcation of the Medicaid Fraction issue to Issue No. 5, but dismissed the SSI Fraction in Issue No. 4, finding that it was excluded in the original appeal request. Subsequently, on June 26, 2024, Issue No. 5 was transferred 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 **June 26, 2024**, the Provider transferred Issues 3 and 5 to CHS CIRP groups.

As a result of the case transfers, there is one (1) remaining issue in this appeal: Issue 2 (the DSH Payment – Medicaid Eligible Days).

On **December 5, 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 **July 24, 2024**, the Provider timely filed its preliminary position paper.

On **September 18, 2024**, the Medicare Contractor timely filed a Jurisdictional Challenge[5] 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 **September 19, 2024**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

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

**B.** ***Description of Issue 2 in the Appeal Request***

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

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[4] (Emphasis added.)

[5] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

**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): 9,28,31,S-D

Estimated Reimbursement Amount: $82,432[6]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the *Jewish Hospital* case[7] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[8]

**MAC's Contentions**

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**

[6] Appeal Request at Issue 2.
[7] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[8] Provider's Preliminary Position Paper at 9-10 (Jul. 24, 2024).

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[9] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. 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 remaining issue.

***A. DSH Payment – 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 (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**

[9] Board Rule 44.4.3, v. 3.2 (Dec. 2023).

> **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.[10]

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**[11]
>
> **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,

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

regulations, policy, or case law) supporting the provider's position.
- Provides a conclusion applying the material facts to the controlling authorities.

C. Comply with Rule 25.2 addressing Exhibits.

. . .

**25.2 Position Paper Exhibits**

**25.2.1 General**

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

**25.2.2 Unavailable and Omitted Documents**

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

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

Once the documents become available, promptly forward them to the Board and the opposing party…

**25.2.3 List of Exhibits**

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

**25.3 Filing Requirements to 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 December 5, 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 2, 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.[12]

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

[12] (Emphasis added.)

- upon failure to appear for a scheduled hearing.

On July 24, 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.[13] 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 #2: 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 of the Social Security Act and regarded as and treated as Medicaid

[13] Provider's Preliminary Position Paper at 10.

> 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 2019 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

The redacted listing included with the preliminary position paper was 14 pages with roughly 2,006 Medicaid eligible days. The Provider's filing did not explain why the listing of so many days (again around 2,006 days) was being submitted at this late date or why it was not final (*i.e*., why it was "pending finalization") at this late date, ***more than 5 years after the fiscal year at issue had closed***. NOTE—the roughly 2,006 included in this belated listing is *exponentially* larger than the original estimate of 150 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 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"[14] 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

[14] (Emphasis added.)

evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[15]

### *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 December of 2023 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) how and why the provider believes Medicare payment must be determined differently for each disputed item…[16]

Board Rule 7.2.1 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:

---

[15] *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.

[16] 42 C.F.R. § 405.1835(b).

- 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.[17]

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

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include, but are not limited to:
>
> …
>
> - ***Section 1115 waiver days (program/waiver specific)***[18]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[19]
42 C.F.R. § 405.1835(e) provides in relevant part:

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

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

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[17] v. 3.1 (Nov. 2021).
[18] (Bold and italic emphasis added).
[19] *See* 73 Fed. Reg. 30190 (May 23, 2008).

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

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

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

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

Finally, even in the Provider's preliminary position paper, the Provider fails to identify what

[20] 65 FR 47054, 47087 (Aug. 1, 2000).

§ 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 preliminary position paper is perfunctory in that it only makes perfunctory conclusions.[21] 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*.[22] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[23] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[24] The Court found that this 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.[25] 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 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.[26] 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.

---

[21] For example, CHS 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, CHS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is CHS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? CHS 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 preliminary position paper references "uncompensated care pool."

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

[23] *Id*. at *11.

[24] *Id.*

[25] *Id.*

[26] 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) (available at: https://www.cms.gov/regulations-and-guidance/review-boards/prrbreview/list-of-prrb-jurisdiction-decisions-items/2017-11 (last accessed Mar. 26, 2025)).

* * * * *

Based on the foregoing, the Board has dismissed the remaining issue in this case – (Issue 2 – DSH Payment Medicaid Eligible Days). As no issues remain, the Board hereby closes Case No. 24-0309 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:

2/10/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

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**Via Electronic Delivery**

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RE: ***Board Determination on Provider's Motion for Reinstatement***
Carle Eureka Hospital (Provider Number 14-1309)
FYE: 12/31/2021
Case Number: 25-4676

Dear Mr. Gienko:

The Provider Reimbursement Review Board (the "Board") has reviewed the above-captioned appeal in response the Motion for Reinstatement, filed on February 5, 2026, by Strategic Reimbursement Group, LLC ("Strategic" or "Representative"). In its motion, Strategic requests that the Board find good cause to reinstate the subject appeal and grant an extension to file its preliminary position paper (*hereinafter*, "PPP"). The pertinent facts of the case and the Board's determination are set forth below.

**Pertinent Facts:**

On **June 9, 2025,** Strategic filed an individual appeal on behalf of Carle Eureka Hospital ("Provider"), based on a December 12, 2024 Notice of Program Reimbursement ("NPR") for its fiscal year end ("FYE") 2021 under Case No. 25-4676.

On **June 10, 2025,** the Board issued a "Case Acknowledgement and Critical Due Dates Notice" ("ACCD") setting the Provider's PPP deadline for **February 4, 2025** and the Medicare Contractor's PPP deadline for **June 4, 2026**.

On **February 5, 2026**, the Board dismissed Case No. 25-4676 pursuant to Board Rule 23.4, which indicates the Board will dismiss a case where the Provider fails to timely file its PPP.[1]

On **February 5, 2026**, Strategic filed a Motion for Reinstatement. Strategic explained that the PPP due date was missed due to "an inadvertent clerical error in the calendaring of the due dates" as opposed to an "intent to abandon its appeal." According to Strategic, the deadline for the PPP "was erroneously entered into [its] case management system as February 4, ***2027***, rather than the correct date of February 4, ***2026***." This calendaring error was not discovered until Strategic received the Board's dismissal notice on February 5, 2026, at which time it

[1] Board Rules v 3.2 (Dec. 2023).

immediately requested a reinstatement.[2] Strategic maintains that it is committed to complying with Board deadlines and maintains that it has implemented additional verification steps to prevent such a recurrence. In addition, Strategic contends that, should reinstatement be granted, there would not be any prejudice to the Medicare Contractor as the PPP delay would be minimal and the case has not yet been scheduled for a hearing. Finally, Strategic requested that it be granted a brief 30-day extension to allow it to finalize the substantive arguments and file its PPP since it initially believed the deadline to be a year out.[3]

**Board Determination**:

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

Strategic has filed a *motion* requesting that the Board reinstate the case. Board Rule 47.1 governs motions for reinstatement of an issue or case:

**47.1 Motion for Reinstatement**

> A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s) (*see* 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (*see* Rule 44 governing motions). The Board will ***not*** reinstate an issue(s)/case if the provider was at fault. If an issue(s)/case was remanded pursuant to a CMS ruling (*e.g.*, CMS 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. . . .
>
> ****
>
> **47.3 Dismissals for Failure to Comply with Board Procedures**
>
> *Upon written motion demonstrating good cause*, the Board *may reinstate* a case dismissed for failure to comply with Board procedures. *Generally, administrative oversight*, settlement negotiations or a change in representative *will not be considered good cause to reinstate*. If the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, *the motion for reinstatement must, as a prerequisite, include the*

[2] Motion – Request for Reinstatement and Extension of Time at 1 (Feb. 5, 2026).
[3] *Id.* at 1-2.

*required filing before the Board will consider the motion*.[4]

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

Further, contrary to Board Rule 44 governing motions, Strategic's motion for reinstatement is deficient because it failed to include a statement confirming it had contacted the Medicare Contractor prior to filing the motion to see if the Medicare Contractor would concur or oppose the motion. In addition, Strategic failed to include the missing PPP with its request for reinstatement in accordance with Board Rule 47.3 – and instead, filed a request for an extension to file the missing PPP.

In denying the request, the Board notes that the Critical Due Dates Notice clearly stated that Provider had to file the PPP and that failure to do so would result in dismissal. Specifically, it stated that "[t]he parties must meet the . . . due dates regardless of any outstanding jurisdictional challenges, motions, or subpoena requests" and that "[i]f the provider misses any of its due dates, the Board will dismiss the appeal." Similarly, Board Rule 23.4 states: "The provider's preliminary position paper due date will be set on the same day as the PJSO due date. Accordingly, if neither a PJSO nor the provider's preliminary position paper is filed by the filing due date, *the Board will dismiss the case*."[5] The Board requirements are consistent with 42 C.F.R. § 405.1853(b). Here, the Representative (which is not new to Board procedures) failed to follow the process set forth in the ACDD and Board Rules. A representative is charged with being familiar with Board Rules and deadlines and failure of the representative to carry out his/her responsibilities as a representative is not considered good cause for failing to meet filing deadlines:

> **5.2 Responsibilities**
>
> *The case representative is responsible for being familiar with the following rules and procedures for litigating before the Board*:
>
> - The Board's governing statute at 42 U.S.C. § 1395oo;
> - The Board's governing regulations at 42 C.F.R. Part 405, Subpart R; and
> - These Rules, which include any relevant Orders posted at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-rules-and-board-orders (see Rule 1.1).
>
> *Further, the case representative is responsible for*:
>
> - Ensuring his or her contact information is current with the Board,

[4] (Emphasis added.)
[5] (Emphasis added.)

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 <u>not</u> considered by the Board to be <u>good cause for failing to meet any deadlines</u>*. 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.[6]

In summary, pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b), the Board ***DENIES*** Strategic's request for reinstatement of Case No. 25-4676. The Board finds that the Provider was at fault and failed to establish good cause under Board Rules 47.1 and 47.3 as it admitted fault. Therefore, the Board declines to exercise its discretion to reinstate Case No. 25-4676 and it thereby remains closed. The Board denial is consistent with numerous cases in which federal courts have upheld the Board's authority to dismiss cases for failure of the provider to timely file position papers or other Board filings.[7]

<u>Board Members</u>:

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

For the Board:

2/12/2026

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
Pamela VanArsdale, National Government Services (J-6)

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

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

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RE: ***Board Decision* – DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**
Santa Rosa Medical Center (Provider No. 10-0124)
FYE 05/31/2019
Case No. 23-0253

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. 23-0253***

On **June 6, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2019.

On **November 17, 2022**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

The Provider is commonly owned/controlled by Community Health Systems, Inc. (hereinafter "CHS") and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R.

[1] On June 9, 2023, this issue was transferred to PRRB Case No. 22-1031GC.
[2] On June 9, 2023, this issue was transferred to PRRB Case No. 23-0078GC.
[3] On February 7, 2024, the Board granted Bifurcation of this issue into Issue No. 5 (SSI Fraction – Dual Eligible Days) and Issue No. 6 (Medicaid Fraction – Dual Eligible Days). Subsequently, on February 13, 2024, Issue No. 6 was transferred to PRRB Case No. 23-0079GC and, on May 14, 2024, Issue No. 5 was transferred to PRRB Case No. 22-1006GC.

§ 405.1837(b)(1). For that reason, the Provider transferred Issues 2, 4, 5 and 6 to Community Health groups. As a result, there are two (2) remaining issues in this appeal: Issue 1 (DSH Payment/SSI Percentage (Provider Specific)) and Issue 3 (DSH Payment – Medicaid Eligible Days).

On **November 21, 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]

On **July 5, 2023**, the Provider timely filed its preliminary position paper.

On **September 28, 2023**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 3. 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 **September 29, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **October 20, 2023**, the Medicare Contractor timely filed its preliminary position paper.

### *B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 22-1031GC*

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.
>
> . . .

[4] (Emphasis added).

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

The group issue statement in Case No. 22-1031GC, CHS CY 2019 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
> 6. Failure to adhere to required notice and comment rulemaking procedures.[6]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $20,858.

[5] Issue Statement at 1 (Nov. 17, 2022).
[6] Group Issue Statement, Case No. 22-1031GC.

On July 5, 2023, 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' [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).[7]

### *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 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

[7] Provider's Preliminary Position Paper at 8-9 (Jul. 5, 2023).

> Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 5,6,20,S-D
>
> Estimated Reimbursement Amount: $27,183[8]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the Jewish Hospital case[9] 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.[10] 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).[11]

**MAC's Contentions**

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

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

> The MAC contends that the Provider has abandoned the issue of SSI realignment and, therefore, it should be considered withdrawn.

[8] Appeal Request at Issue 3.
[9] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[10] Provider's Preliminary Position Paper at 9.
[11] *Id.* at 9-10.

> The Provider did not brief this issue within its preliminary position paper PRRB Rule 25.3 addresses issues that are not briefed in a provider's position paper. In relevant part, this rule states:
>
> > Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.[12]

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. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[13]

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.[14]

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."[15] The MAC posits that the Provider "failed to sufficiently develop and set forth the relevant facts and regarding the merits of its claim in its Preliminary Position Paper."[16] Specifically the MAC avers:

> Within its Provider's Preliminary Position Paper, the Provider makes the broad allegation 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.

---

[12] Jurisdictional Challenge at 6 (Sept. 28, 2023).
[13] *Id*. at 6-7.
[14] *Id*. at 4-6.
[15] *Id*. at 7.
[16] *Id*. at 9.

> Yet, the Provider offers no evidence or analysis to demonstrate that CMS calculated its SSI percentage inaccurately. The Providers failed to include any evidence to establish the material facts in this case relating to inaccuracies in the SSI Percentage calculation at issue.[17]

*Issue 3 – DSH Payment – Medicaid Eligible Days*

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

> The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.
>
> Within its Provider's preliminary position paper, the Provider makes the broad allegation, ". . . the Provider contends that the total number of days reflected in its' [sic] 2019 cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats their appeal request.[18]

**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.[19] 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

[17] *Id*.
[18] *Id*. at 11.
[19] Board Rule 44.4.3, v. 3.2 (Dec. 2023).

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 & 3.

### *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. 22-1031GC.

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."[20] 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)."[21] 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."[22]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 22-1031GC 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. 22-1031GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[23], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

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[20] Issue Statement at 1.
[21] *Id.*
[22] *Id.*
[23] PRRB Rules v. 3.1 (Nov. 2021).

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.[24] 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. 22-1031GC.

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. 22-1031GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[25]

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.

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[24] 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).
[25] (Emphasis added).

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.[26]

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."[27]

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 22-1031GC are the same issue.[28] 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 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 §

[26] Last accessed August 14, 2024.
[27] Emphasis added.
[28] 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).

> 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[29]

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.

***B. DSH Payment – Medicaid Eligible Days***

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

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after

[29] (Emphasis added).

> the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[30]

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

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

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

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

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

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must

[30] Individual Appeal Request, Issue 3.

> accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[31]

Similarly, with regard to position papers,[32] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[33] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* 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.[34]

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 November 17, 2022 (over 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

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

Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[35] ***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.[36] 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 dismissal in other cases involving CHS providers.[37]

### *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 November of 2022 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing 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.[38]

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[35] Provider's Preliminary Position Paper at 10.

[36] *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.

[37] 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).

[38] 42 C.F.R. § 405.1835(b).

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.

**A. Disproportionate Share Hospital Payments**

Common examples include, but are not limited to:

- ***Section 1115 waiver days (program/waiver specific). . .***[39]

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.[40]

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 –
>
> . . .

[39] (Bold and italic emphasis added).
[40] *See* 73 Fed. Reg. 30190 (May 23, 2008).

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

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider 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.[41] 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) 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

[41] 65 FR 47054, 47087 (Aug. 1, 2000).

> 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)(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 preliminary position paper 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 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*.[42] 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 . . ."[43] 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."[44] 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.[45] Here, the Board makes the same finding based on similarly *overly generalized language.*

****

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. 22-1031GC 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. The Board also dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider

[42] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[43] *Id*. at *11.
[44] *Id.*
[45] *Id.*

failed to meet the Board requirements for submitting fully developed and complete position papers in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 23-0253 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:

2/18/2026

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: ***Expedited Judicial Review Determination***
Case Numbers: 25-1786GC *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 **January 29 and February 6, 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") groups and individual appeals are all appealing from original and/or revised Notices of Program Reimbursement ("NPRs"/"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 Year Ends ("FYEs") in calendar years spanning 2005 to 2010.

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]

**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. 25-1786GC, Statement of Group Issue at 1 (Jan. 30, 2025).
[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*

[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 file supplemental briefs addressing whether vacatur of the June 9, 2023 Final Rule is the appropriate remedy.[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 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]

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[51] *E.g.,* Case No. 25-1786GC, Appeal Request, Statement of Jurisdiction at 1 (citations omitted).
[52] *E.g.,* Case No. 25-1786GC, Appeal Request, Statement of Group Issue at 1. *Also note*, the Statement of Issue included with each individual appeal is materially identical to the Statement of Group Issue included with each group appeal.
[53] *Id.*
[54] *Id.* (citing to 139 S. Ct. at 1816).
[55] *Id.*

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 Provider[s] 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 in this case, the MAC will not file a substantive claim challenge in this case."[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:

---

[56] *Id.* (citing 4 U.S.C. § 706(2)).
[57] *E.g.*, Case No. 25-1786GC, Provider's Petition for Expedited Judicial Review at 13 (Jan. 29, 2026).
[58] *Id.* at 16-17.
[59] *Id.* at 1-2.
[60] 42 C.F.R. § 405.1867.
[61] *E.g.*, Case No. 25-1786GC, Response to Provider's Request for Expedited Judicial Review at 1 (Feb. 3, 2026).

- 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; [62]
- 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.[63]

For these nine (9) appeals, 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 individual appeals listed in **Appendix A** filed their appeals within 180 days of the issuance of their NPRs and/or RNPRs, and the amount in controversy exceeds $10,000. Likewise, all the providers in the group appeals listed in **Appendix A** were directly added to the groups within 180 days of the issuance of their NPRs and/or RNPRs and the amount in controversy exceeds $50,000 in each case.

The Board finds that the Providers in the nine (9) 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 RNPRs. The Board also finds that the amount in controversy in each individual appeal exceeds $10,000, as required by 42 C.F.R. § 405.1835(a)(2), and for the optional group appeals exceeds $50,000, as required by 42 C.F.R. § 405.1837(a)(3). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

### *B. Board's Decision Regarding the EJR Requests*

The Board finds that:

1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in the 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

---

[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(a) and (b); 42 C.F.R. §§ 405.1835 – 1840.

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 the nine (9) Cases listed in **Appendix A**, the Board hereby closes these nine (9) cases 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:

2/19/2026

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)
Judith Cummings, CGS Administrators (J-15)
Scott Berends, Federal Specialized Services

**Appendix A**

| PRRB Case Number | PRRB Case: Case Name |
|---|---|
| 25-1786GC | Northwell Health CY 2008 Post-Allina II DSH Part C Days CIRP Group |
| 25-4291GC | Kettering Health Network CY 2010 Post-Allina II DSH Part C Days CIRP Group |
| 25-4289GC | Kettering Health Network CY 2008 Post-Allina II DSH Part C Days CIRP Group |
| 25-4290GC | Kettering Health Network CY 2009 Post-Allina II DSH Part C Days CIRP Group |
| 26-0155 | New York Presbyterian Hospital (33-0101), FYE 12/31/2005 |
| 26-0156 | New York Presbyterian Hospital (33-0101), FYE 12/31/2006 |
| 26-0172 | Montefiore Medical Center (33-0059), FYE 12/31/2008 |
| 26-0173 | Montefiore Medical Center (33-0059), FYE 12/31/2009 |
| 26-0174 | Montefiore Medical Center (33-0059), FYE 12/31/2010 |

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Via Electronic Delivery**

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

RE: ***Notice of Dismissal***
Laredo Medical Center (Provider No. 45-0029)
FYE 09/30/2017
Case No. 22-1411

Dear Mr. Summar:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-1411. Set forth below is the decision of the Board to dismiss the 3 remaining issues in this appeal.

**Background:**

**A. *Procedural History for Case No. 22-1411***

On **March 18, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2017.

On **September 2, 2022**, the Board received the Provider's individual appeal request. The Individual Appeal Request contained six (6) issues:

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

The Provider is commonly owned/controlled by Community Health Systems, Inc. (hereinafter "CHS") and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R.

[1] On March 15, 2023, this issue was transferred to PRRB Case No. 20-0997GC.
[2] On March 15, 2023, this issue was transferred to PRRB Case No. 19-2620GC.
[3] On March 15, 2023, this issue was transferred to PRRB Case No. 20-1383GC.
[4] This issue was added to the appeal on October 24, 2022.

§ 405.1837(b)(1). For that reason, on **March 15, 2023**, the Provider transferred Issues 2, 4 and 5 to Community Health groups. As a result, there are three (3) remaining issues in this appeal: Issue 1 (DSH Payment/SSI Percentage (Provider Specific)), Issue 3 (DSH Payment – Medicaid Eligible Days), and Issue 6 (Capital DSH for Rural Hospitals Disallowance).

On **September 7, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[5]

On **September 8, 2022**, the Medicare Contractor filed a Request for DSH Package in connection with Issue 3. In this filing, the Medicare Contractor formally requested that a listing of the Medicaid eligible days at issue plus supporting documentation be provided to the Medicare Contractor on or before October 8, 2022 (*i.e*., within 30 days). Notwithstanding the formal request, the Provider failed to file any response to the Medicare Contractor.

On **March 8, 2023**, the Board issued a Critical Due Dates Notice setting a new filing deadline for the Preliminary Position Papers.

On **April 18, 2023**, the Provider timely filed its preliminary position paper.

On **July 11, 2023**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1, 3 and 6. 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 did not file a response and the time for doing so has elapsed.

On **July 31, 2023**, the Medicare Contractor timely filed its preliminary position paper.

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

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

---

[5] (Emphasis added).

> 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.[6]

The group issue statement in Case No. 20-0997GC, CHS CY 2017 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

[6] Issue Statement at 1 (Sept. 2, 2022).

6. Failure to adhere to required notice and comment rulemaking procedures.[7]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $65,402.

On April 18, 2023, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' [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).[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 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.

[7] Group Issue Statement, Case No. 20-0997GC.
[8] Provider's Preliminary Position Paper at 9 (Apr. 18, 2023).

**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): 5,22,23,26,S-D

Estimated Reimbursement Amount: $36,930[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 [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).[12]

**MAC's Contentions**

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

[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 7.
[12] *Id.* at 8.

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:

> The MAC contends that the Provider has abandoned the issue of SSI realignment and, therefore, it should be considered withdrawn. The Provider did not brief this issue within its preliminary position paper PRRB Rule 25.3 addresses issues that are not briefed in a provider's position paper. In relevant part, this rule states:
>
> > Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.[13]

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. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature **not** necessary because the provider's cost report beginning **10/01/2016 and ending 09/30/2017 is already in alignment with the Federal Fiscal Year. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.**[14]

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.[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 regarding the merits of its claim in its Preliminary Position Paper."[17] Specifically the MAC avers:

> Within its Provider's Preliminary Position Paper, the Provider makes the broad allegation that: "[t]he Provider contends that its' SSI percentage published by the Centers for Medicare and

[13] Jurisdictional Challenge at 7 (Jul. 11, 2023).
[14] *Id*. (Bold emphasis included).
[15] *Id*. at 4-6.
[16] *Id*. at 8.
[17] *Id*. at 9.

> 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," yet offers no evidence or analysis to demonstrate that CMS calculated its SSI percentage inaccurately. The Providers failed to include any evidence to establish the material facts in this case relating to inaccuracies in the SSI percentage calculation at issue or any evidence pertaining to the alleged systemic SSI ratio data match errors like those referenced in the *Baystate* case. The Provider merely repeats their appeal request which itself is a verbatim recitation of the deficiencies that the Board found in the *Baystate* case.[18]

*Issue 3 – DSH Payment – Medicaid Eligible Days*

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

> The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.
>
> Within its Provider's preliminary position paper, the Provider makes the broad allegation, ". . . the Provider contends that the total number of days reflected in its' [sic] 2017 cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats their appeal request.[19]

*Issue 6 – Capital DSH for Rural Hospitals Disallowance*

The MAC's argument reads, in full:

> The Provider added Issue 6: DSH – Capital for Rural [sic] Hospitals, on 10/24/2022. The Provider failed to brief the issue in its Position Paper. Pursuant to Board Rule 25.3, parties should file a complete preliminary position paper with a fully developed

[18] *Id*.
[19] *Id*. at 11.

> narrative, all exhibits, a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. The Provider did not brief or otherwise reference the issue in its preliminary position paper and the Board should consider the issue abandoned.[20]

**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.[21] The Provider failed to file a timely response to the Jurisdictional Challenge. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. 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, 3 and 6.

***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. 20-0997GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security

[20] *Id*. at 13.
[21] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

Income percentage in the Disproportionate Share Hospital calculation."[22] 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)."[23] 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."[24]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-0997GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment 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. 20-0997GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6, the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[25] 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. 20-0997GC.

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

[22] Issue Statement at 1.
[23] *Id.*
[24] *Id.*
[25] 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).

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

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[26]

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.[27]

[26] (Emphasis added).
[27] Last accessed August 14, 2024.

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[28]

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 20-0997GC are the same issue.[29] 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:

> (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*.[30]

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.

---

[28] Emphasis added.
[29] 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).
[30] (Emphasis added).

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

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

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

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

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

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Furthermore, 42 C.F.R. § 405.1853(b) addresses position papers and specifies in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the*

> *provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[31]

Similarly, with regard to position papers,[32] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[33] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* 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.[34]

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 September 2, 2022 (over 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 preliminary position paper indicated that it would be sending the eligibility listing

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

under separate cover.[35] ***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.[36] 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 dismissal in other cases involving CHS providers.[37]

### *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 September 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 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.[38]

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[35] Provider's Preliminary Position Paper at 8.
[36] *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.
[37] 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).
[38] 42 C.F.R. § 405.1835(b).

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.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include, but are not limited to:
>
> - ***Section 1115 waiver days (program/waiver specific). . .***[39]

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.[40]

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.

[39] (Bold and italic emphasis added).
[40] *See* 73 Fed. Reg. 30190 (May 23, 2008).

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider 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.[41] 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) 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.

[41] 65 FR 47054, 47087 (Aug. 1, 2000).

Because the Provider did not raise the Section 1115 Waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The 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)(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 preliminary position paper 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 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*.[42] 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 . . ."[43] 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."[44] 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.[45] Here, the Board makes the same finding based on similarly *overly generalized language.*

### *D. Capital DSH for Rural Hospitals Disallowance*

Board Rules on Provider's Position Paper read, in pertinent part:

> 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

[42] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[43] *Id*. at *11.
[44] *Id.*
[45] *Id.*

> 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.
>
> . . .
>
> **25.3 Filing Requirements to Board**
>
> [I]f the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn.

The Board finds that the Provider failed to brief Issue No. 6 in their Preliminary Position Paper and therefore, the issue is abandoned and is effectively withdrawn.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 20-0997GC and 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. The Board also dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for submitting fully developed and complete position papers in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. Finally, the Board finds that the Capital DSH for Rural Hospitals Disallowance was not briefed in the Preliminary Position Paper and is therefore, abandoned and withdrawn. As no issues remain pending, the Board hereby closes Case No. 22-1411 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:

2/20/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

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***
Grandview Medical Center (Prov. No. 01-0104), FYE 06/30/2018
Case No. 22-1256

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-1256. 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. 22-1256***

On **February 21, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2018.

On **August 8, 2022**, the Board received the Provider's individual appeal request. The appeal was filed by the parent organization Community Health Systems, Inc. ("CHS") and included five (5) issues:

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

On **August 9, 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:

[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 March 28, 2023, this issue was inadvertently transferred to Case No. 20-2149GC. The transfer was denied on March 31, 2023 and CHS re-effectuated a corrected transfer to Case No. 21-0066GC on April 17, 2023.

> 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 **March 15, 2023, March 28, 2023 and April 17, 2023,** CHS transferred Issues 2, 4 and 5, respectively, to CHS CIRP groups in accordance with the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). As a result, there are two (2) remaining issues in this appeal: Issue 1: DSH Pymt/SSI % (Provider Specific) and Issue 3: DSH Pymt - Medicaid Eligible Days.

On **March 30, 2023**, CHS timely filed the Provider's PPP.

On **April 4, 2023**, a Critical Due Dates letter was issued with updated PPP deadlines.

On **July 14, 2023**, the Medicare Contractor ("MAC") filed a Jurisdictional Challenge over the "DSH Pymt/SSI % (Provider Specific)" and "DSH Pymt - Medicaid Eligible Days" issues.

On **July 20, 2023**, the MAC filed its PPP.

On **July 20, 2023**, CHS requested the representative be changed to Quality Reimbursement Services, Inc. ("QRS"), which the Board effectuated on the following day.

On **December 8, 2025**, the Board issued a Notice of Hearing scheduling the case for a **June 5, 2026** hearing**.**

### *B. Description of Issue 1 in the Individual Appeal Request and the Provider's Participation in Case No. 21-1206GC*

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

[4] (Emphasis added).

> 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 require Medicare Part A payment for days to be counted in the denominator'. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[5]

The Group issue Statement in Case No. 21-1206GC, 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,

[5] Issue Statement at 1 (Aug. 8, 2022).

4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.[6]

On June 1, 2023, the Board received the Provider's PPP in Case No. 22-1256. 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).[7]

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 $100,412.

### *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.

[6] Group Issue Statement, Case No. 21-1206GC.
[7] Provider's PPP at 10 (March 30, 2023).

**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): 2, 13, 16, 17, 19, 20, 21, S-D
>
> Estimated Reimbursement Amount: $63,310

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[8] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[9]

**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 PPP, 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 transferred to Case No. 21-1206GC. 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.[10]

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

The MAC also argued 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

[8] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[9] Provider's PPP at 8-9 (March 30, 2023).
[10] MAC's Jurisdictional Challenge at 2 (July 14, 2023).

expect to be included with their appeal or their preliminary position paper (even though the Provider advised that it would send a listing of additional Medicaid eligible days under separate cover.)[11] In addition, 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 preliminary position paper and because it neglected to include all supporting documentation.[12]

**Provider's Jurisdictional Response**

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[13] The Provider 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. 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 ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[14] Per the appeal

[11] MAC's Jurisdictional Challenge at 11 (July 14, 2023).
[12] MAC's Jurisdictional Challenge at 12 (July 14, 2023).
[13] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[14] Issue Statement at 1.

request, the Provider's legal basis for its SSI Percentage (Provider Specific) issue asserts that the MAC "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[15] The Provider argues that "its'[sic] SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[16]

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. 22-1256 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[17], 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.[18] 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.

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:

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[15] *Id.*
[16] *Id.*
[17] PRRB Rules v. 3.1 (Nov. 2021).
[18] 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).

> **25.2.2 Unavailable and Omitted Documents[19]**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[20]

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

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

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

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[21]

This CMS webpage describes access to DSH data ***from 1998 to 2023*** and instructs providers to send a request via email to access their DSH data."[22]

---

[19] PRRB Rules v. 3.1 (Nov. 2021)
[20] (Italics and underline emphasis added.)
[21] Last accessed Feb. 6, 2026.
[22] Emphasis added.

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. 21-1206GC 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.

*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.

***B. DSH Payment – Medicaid Eligible Days***

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

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

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

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

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

[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).

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*.[24]

Similarly, with regard to position papers,[25] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[26] 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);

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

- if the Board is unable to contact the provider or representative at the last known address; or
- upon failure to appear for a scheduled hearing.

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 8, 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.[27] ***To date, there is no evidence that the 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.[28] 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.

****

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" - Issue 3. As no issues remain, the Board hereby closes Case No. 22-1256 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:

2/25/2026

X Nicole E. Musgrave

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

cc: Cecile Huggins, Palmetto GBA (J-J)
Wilson C. Leong, Esq., Federal Specialized Services

[27] Provider's PPP at 9.

[28] *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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**Via Electronic Delivery**

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Dean Wolfe
Noridian Healthcare Solutions
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RE: ***Board Decision* – Medicaid Eligible Days Issue**
Asante Rogue Regional Medical Center (Provider No. 38-0018)
FYE 09/30/2016
Case No. 22-0056

Dear Mr. Ravindran and Mr. Wolfe,

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. 22-0056***

On **April 28, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2016.

On **October 20, 2021**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained two (2) issues:

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

On **October 21, 2021**, 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.[2]

[1] This issue was withdrawn on August 18, 2022.
[2] (Emphasis added).

On **June 21, 2022**, the Provider timely filed its preliminary position paper.

On **September 29, 2022**, the Medicare Contractor timely filed its preliminary position paper.

On **September 9, 2025**, the Board issued the 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*** *also include* ***any exhibits*** *the Provider will use to support to support its position*. *See* Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.[3]

On **January 6, 2025**, the Provider timely filed its final position paper.

On **January 19, 2026**, the Medicare Contractor filed a Motion to Dismiss, requesting the dismissal of Issue 2. Pursuant to Board Rule 44.3, the Provider had 30 days in which to file a response. However, the Provider ***failed*** to file any response.

On **January 30, 2026**, the Medicare Contractor timely filed its final position paper.

### *C. Description of Issue 2 in the Appeal Request*

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

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation

[3] (Emphasis added.)

> 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): 4,8,9,39,40,s-d
>
> Estimated Reimbursement Amount: $489,336[4]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the *Jewish Hospital* case[5] 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.[6]

**MAC's Contentions**

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

> a. That the Provider has failed to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable.
>
> b. That the Provider has made affirmative statements in its appeal request and [Preliminary Position Paper] that the MAC excluded the days at issue yet supplied no evidence of such exclusion, indicating that the Provider has not yet compiled a listing of such days.
>
> c. That the Provider's failure to furnish such documentation (or describe why such documentation is unavailable) is in violation of of PRRB Rule 7.
>
> d. That the Provider has effectively abandoned its claim for additional Medicaid Eligible Days.
>
> e. That the Provider's claim for additional Medicaid Eligible Days is therefore dismissed.

[4] Appeal Request at Issue 2.
[5] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[6] Provider's Preliminary Position Paper at 7-8 (Jun. 21, 2022).

> f. That as this the only remaining active issue in this individual appeal it is therefore dismissed.[7]

**Provider's Response**

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

**Board Analysis and Decision:**

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

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

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

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[8]

[7] MAC Motion to Dismiss at 4 (Jan. 19, 2026).
[8] Individual Appeal Request, Issue 2.

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

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

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

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

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

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

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

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

> *timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[9]

Similarly, with regard to position papers,[10] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[11] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* 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.[12]

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

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

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

This appeal was initiated on October 20, 2021 (over 4 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 preliminary position paper indicated that it would be sending the eligibility listing

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

under separate cover.[13] ***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.[14] 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.

****

In summary, the Board hereby dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for submitting fully developed and complete position papers in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 22-0056 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:

2/25/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[13] Provider's Preliminary Position Paper at 8.
[14] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**Via Electronic Delivery**

Randall Gienko
Strategic Reimbursement Group, LLC
360 W. Butterfield Road, Suite 310
Elmhurst, IL 60126

RE: ***Notice of Dismissal***
Strategic Reimb Group CY 2015 Unmatched Medicaid Days Group
Case No. 21-1181G

Dear Mr. Gienko:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 21-1181G. Set forth below is the decision of the Board to dismiss the appeal challenging the Provider's Unmatched Medicaid Eligible Days.

## Background

On **April 1, 2021**, Strategic Reimbursement Group, LLC ("SRG") filed a request for a Group Appeal, the representative for the providers in this appeal. The common issue for the participants in this appeal is Unmatched Medicaid Eligible Days. The group issue statement reads:

> **1. Unmatched Medicaid Days (Unpaid Medicaid Eligible Days)**
>
> 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 who were eligible for medical assistance under a Medicaid-approved state plan during their stay ("Medicaid Eligible Days") be included in the Medicaid fraction of the Calculations. Based on prior experience with the Medicaid eligibility data compiled by state Medicaid agencies, the provider believes that the number of Medicaid Eligible Days in its Calculations may be materially

> understated. Among other causes, delays or errors in initial applications for Medicaid recipients can cause the eligibility data utilized in the Calculations to be inaccurate at the time the cost report is filed. The provider seeks to ensure a more accurate count of Medicaid Eligible Days is used to determine the proper amount of DSH reimbursement due to the provider. Based on historical industry experience the provider has estimated the amount of appealed reimbursement to be 2% of eligible DSH days, the reimbursement impact is detailed in the attached calculations.

On **April 1, 2021**, the Board issued the 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 Group Representative regarding the content of its preliminary position paper:

> Group's Preliminary Position Paper – The position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the 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 **April 2, 2022**, SRG notified the Board that the Group was Fully Formed.

On **May 25, 2022**, SRG timely filed the Group's preliminary position paper. The Group 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:

> In accordance with the PRRB's Alert 10 issued on May 23rd, 2014, documentation has been or is being prepared to address each of the PRRB's bulleted requests:
>
> - "A detailed description of the process that the provider used to identify and accumulate the actual Medicaid paid and unpaid eligible days that were reported and filed on the Medicare cost report as issue."

[1] (Emphasis added.)

- "The number of additional Medicaid paid and unpaid eligible days that the provider is requesting to be included in the DSH calculation."
- "A detailed explanation why the additional Medicaid paid and unpaid eligible days at issue could not be verified by the state at the time the cost report was filed. If there is more than one explanation/reason, identify how many of these days are associated with each explanation/reason."[2]

On **August 31, 2022**, the Medicare Contractor filed its preliminary position paper. The Medicare Contractor's position paper noted that to date, the Provider Group had not provided the listings of the days at issue.[3]

On **May 19, 2025**, the Board issued the 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 Group regarding the content of its final position paper:

> Group's Final Position Paper – The final position paper filing should reflect the *refinement* of the issue from the preliminary position paper or proposed joint scheduling order.
>
> . . .
>
> 2. For appeals filed *on or after* August 29, 2018, the final position paper is an *optional* filing, intended to hone/refine the group issue, if necessary, but is not required. *See* 42 C.F.R. § 405.1853(b)(2)-(3) and **Board Rule 27** for more specific content and exhibit requirements. If the Group opts not to file a final position paper, then the arguments and exhibits related to the issue under appeal may be limited to those set forth in the preliminary position paper. *See* **Board Rules 27.4** and **35.3**.*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*** *also include* ***any exhibits*** *the Provider will use to support to support its position*. *See* Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.[4]

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[2] Provider Group's Preliminary Position Paper at 6 (May 25, 2022).
[3] Medicare Contractor's Preliminary Position Paper at 5 (Aug. 31, 2022).
[4] (Emphasis included.)

On **December 1, 2025**, the Provider filed its final position paper. The final position paper is substantively identical to the preliminary position paper.

On **December 31, 2025**, the Medicare Contractor filed its final position paper. In it, the Medicare Contractor states, "[t]he MAC requests that the Group submit a copy of the Group's response to Alert 10 and the referenced Medicaid documentation."[5]

On **January 23, 2026**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Group has failed to comply with Board procedures or filing deadlines under the authority of PRRB Rule 41.2 (Nov. 2021) and 42 C.F.R. § 405.1868(b); (2) That the Group has failed to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable; (3) That the Group has made affirmative statements in both its Preliminary and Final Position Papers that it was developing eligible days listings; (4) That the Group's failure to furnish such documentation (or describe why such documentation is unavailable) is in violation of PRRB Rules 7, 27.2, 25.2.1 and 25.2.2; (5) That the Group effectively abandoned its claim for additional Medicaid Eligible Days; and (5) That the Board dismiss the Group appeal. Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** timely respond to that Motion.

**MAC's Contentions**

The MAC contends that the Providers failed to comply with Board procedures or filing deadlines under the authority of the Board Rules 7, 27.2, 25.2.1 and 25.2.2, and failed to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable. The Medicare Contractor points out that "[t]hat each Provider has essentially abandoned its claim for additional Medicaid Eligible Days."[6] The MAC argues the Group has abandoned its claim and therefore, the case should be dismissed.[7]

**Provider's Jurisdictional Response**

The Group's response to the Motion to Dismiss was due within 30 days but the Group Representative failed to timely file a response. In this regard, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

[5] Medicare Contractor's Final Position Paper at 5 (Dec. 31, 2025).
[6] MAC Motion to Dismiss at 5 (Jan. 23, 2026).
[7] *Id*.

**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.

According to its Appeal Request, the Group asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Group states the issue being appealed as:

> **1. Unmatched Medicaid Days (Unpaid Medicaid Eligible Days)**
>
> 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 who were eligible for medical assistance under a Medicaid-approved state plan during their stay ("Medicaid Eligible Days") be included in the Medicaid fraction of the Calculations. Based on prior experience with the Medicaid eligibility data compiled by state Medicaid agencies, the provider believes that the number of Medicaid Eligible Days in its Calculations may be materially understated. Among other causes, delays or errors in initial applications for Medicaid recipients can cause the eligibility data utilized in the Calculations to be inaccurate at the time the cost report is filed. The provider seeks to ensure a more accurate count of Medicaid Eligible Days is used to determine the proper amount of DSH reimbursement due to the provider. Based on historical industry experience the provider has estimated the amount of appealed reimbursement to be 2% of eligible DSH days, the reimbursement impact is detailed in the attached calculations.

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

> The hospital has the burden of furnishing data adequate to prove

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

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

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

Furthermore, 42 C.F.R. § 405.1853(b) addresses position papers and specifies in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[8]

Similarly, with regard to position papers,[9] Board Rule 25.2.1 (Nov. 2021) requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[10] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;

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

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.[11]

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 1, 2021 (nearly 5 years ago), and at that time, the Providers 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. ***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.[12] 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.

* * * * *

Based on the foregoing, the Board has dismissed the group appeal. The Board hereby closes Case No. 21-1181G 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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[11] (Emphasis added).

[12] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

Board Members Participating:

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

For the Board:

2/25/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Pamela VanArsdale, National Government Services, Inc. (J-6)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**Via Electronic Delivery**

Heather Mogden, Esq.
Hall, Render, Killian, Heath & Lyman, P.C.
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RE: ***Jurisdictional Determination in Part***

PRRB Case No. 16-1626GC - Ascension Health 2014 DSH Medicare/Medicaid Medicare Advantage Days CIRP Group

**Specifically**: Ascension Providence Hospital, Southfield and Novi (Prov. No. 23-0019)

Dear Ms. Mogden:

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the subject group appeal and notes an impediment to jurisdiction over one of the participants that appealed from a revised Notice of Program Reimbursement ("RNPR"). A brief procedural history, the pertinent facts regarding the appeal of this Provider and the Board's Determination are set forth below.

**Procedural History:**

On **May 17, 2016**, Hall, Render, Killian, Heath & Lyman, P.C. ("Hall Render") filed the "Ascension Health 2014 DSH Medicare/Medicaid Medicare Advantage Days CIRP Group" under Case No. 16-1626GC.

On **February 16, 2026**, although the group has not yet been designated to be fully formed, Hall Render requested that the Board remand the group to the Medicare Contractor pursuant to CMS Ruling CMS-1739-R. Case No. 16-1626GC currently includes sixteen participants, and all but the one listed below, were directly added to the group from receipt of their original Notices of Program Reimbursement ("NPRs").

**Pertinent Facts for Ascension Providence Hospital, Southfield and Novi ("APH – Southfield-Novi"/Prov. No. 23-0019), FYE 6/30/2014**

APH – Southfield-Novi's Reopening Request was dated July 29, 2019. The reopening request referenced 42 C.F.R. § 412.106(b)(3), which indicates:

> [i]f a hospital prefers that CMS use its cost reporting period instead of the Federal fiscal year for the first computation (also referred to as

> the SSI ratio) of the hospital's disproportionate percentage, "it must furnish to CMS, through its intermediary, a written request . . . .

In its Request for Reopening, the Provider requested ". . . CMS to provide the SSI listing in order to determine the recalculated SS1% based on the provider's fiscal year end, which is 7/1/2013 to 6/30/2014. Based on the information provided by CMS, the SSI% based using the provider's fiscal year end is 7.987% compared to 7.357% based on the federal fiscal year. The impact of the change is an additional $247,922 in reimbursement to the hospital."

APH – Southfield-Novi was unable to provide a copy of its' Notice of Reopening ("NOR"), but referenced adjustment number 7, which was an adjustment to remove protested amounts.

**Board Determination:**

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 considered in any appeal of the revised determination or decision.[1]

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.[2]

The Board has determined that it does not have jurisdiction over the DSH Medicare/Medicaid Medicare Advantage Days issue that was appealed from the RNPR for APH – Southfield-Novi (Prov. No. 23-0019). The Board finds that the RNPR for this Provider was issued as a result of a SSI Realignment request, and the RNPR did not adjust the DSH Medicare/Medicaid Medicare Advantage Days issue. Thus, the Provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

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[.]"[3] Although the Provider was unable to provide the Notice of Reopening, it is clear from the Provider's Request for Reopening, that it was requesting CMS to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. More specifically, the realignment process

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[1] 42 C.F.R. § 405.1889(b).
[2] (Emphasis added).
[3] 42 C.F.R. § 405.1889(b)(1).

(as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis since CMS does not rerun the data matching process in order to effectuate a realignment.[4] In other words, the determination was only being reopened to include the realigned SSI percentages and CMS' realignment process (as described in the Federal Register) does ***not*** entail re-running of the data matching process (much less revise any of the Part C days included in the underlying month-by-month data).[5] Since the only matters specifically revised in the RNPR for APH – Southfield-Novi were adjustments related to realigning the SSI percentage from federal fiscal year to the provider fiscal year, the Provider does not have a right to appeal under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1) for the DSH Medicare/Medicaid Medicare Advantage Days issue. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[6]

**Conclusion**

The Board finds that it lacks jurisdiction over APH – Southfield-Novi (Prov. No. 23-0019), which appealed from a RNPR because the issue under appeal in the group was not specifically revised in the RNPR which was the basis for the Provider's appeal. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the case.

The Board will issue a determination in response to Hall Render's request for Remand pursuant to CMS Ruling 1739-R under separate cover.

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[4] CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). However, CMS does not utilize or re-run the data match process when it issues a realigned SSI percentage. Rather, when CMS conducts the realignment process, all of the underlying data which has already been gathered on a month-by-month basis through that data matching process remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it based on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[5] *See supra* n. 8.

[6] *See St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

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

For the Board:

2/26/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

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**Via Electronic Delivery**

James Ravindran
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Arcadia, CA 91006

RE: **Board Determination on Response to Show Cause Order**

Case Number: 25-1509GC – Quorum Health CY 2011 Part C Days Retroactive Final Rule CIRP Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the response to the Board's Show Cause Order submitted by Quality Reimbursement Services, Inc. ("QRS") in the subject common issue related party ("CIRP") group appeal. A summary of the pertinent facts and the Board's determination are set forth below.

**Pertinent Facts**:

On **January 22**, **2025**, QRS formed the "Quorum Health CY 2011 Part C Days Retroactive Final Rule CIRP Group" under Case No. 25-1509GC.[1]

On **January 22**, **2025**, the Board acknowledged the case in a Case Acknowledgement and Critical Due Dates notification ("ACDD"). The Board's ACDD notice gave the Group Representative a **January 22, 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."[2]

On **January 29, 2026**, a week after the deadline had passed, the Board issued a determination deeming the group to be fully formed and ordering QRS to show cause why the group should not be dismissed for having missed the "Comments Regarding Full Formation" deadline.[3]

[1] The group includes one participant: Crossroads Community Hospital (Provider Number 14-0294).
[2] (Emphasis added.) 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."
[3] Because the group was deemed fully formed with only a single participant, in accordance with Board Rule 18, the Board also requested the Representative's comments regarding a proposal to expand a later year group into which to

On **February 12, 2026**, QRS responded to the Show Cause Order and maintained that dismissal is not appropriate for this case on the grounds that:

- In January 2025, QRS headquarters was subject to emergency evacuation orders due to the Eaton fire disaster. This period coincided with the issuance of the ACDD notice in this case;
- Due to the emergency conditions created by the fire and its impact on operations, several Board issued notifications were lost, including the ACDD in the subject appeal;
- Dismissal would be an extreme remedy considering there would be no prejudice to the Board or MAC if the case were allowed to proceed;
- Dismissal based on an error or minor procedural misstep undermines and conflicts with the purpose of the Board, which is to serve as an objective arbiter of disputes between providers and MACs. It also conflicts with the "spirit of the governing statutes and the regulations;"
- Although QRS recognizes that dismissal is permitted, it is not required. Here dismissal is not appropriate because the error occurred due to circumstances outside of QRS' control, and, therefore, the Board's discretion should be exercised.[4]

**Board Determination**:

After a review of the facts in this case, the Board finds dismissal of the group to be appropriate based on QRS' failure to timely respond to the "Comments Regarding Full Formation" by the deadline.

QRS 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 states 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."

As representative of Case No. 25-1509GC, QRS had full access to the details of this case in the Office of Hearings Case & Document Management System ("OH CDMS"), including pending deadlines. Additionally, those deadlines were solely issued electronically and would have been delivered to an email mailbox. The Eaton fire may have had an impact on QRS' operations, but the email would have still been delivered. In addition, the fire was over a year ago.[5] At any time during the year, QRS could have verified in OH CDMS that it had an upcoming due date in this case. In that regard, if QRS maintains its own separate tracking system, the absence of a due date in this case, which was filed more than a year ago, should also have raised a question.

See Board Rule 19.2 regarding mandatory groups (i.e., CIRP groups) which states, "Within the Board's Acknowledgement of a CIRP group appeal, the providers are notified that, **at the one year mark** (if they had not previously done so), **they must notify the Board if the group is complete** and, if not, which providers have not yet received a final determination for the

consolidate Case No. 25-1509GC.
[4] Provider's Response to Board Determination & Request for Information at 1-2 (Feb. 12, 2026).
[5] The Board has not considered the fire issue to be good cause in numerous past cases.

specified fiscal year and intend to join the group."[6] Plainly stated, QRS should be aware that the one-year mark triggers a requirement for a response regarding the group's full formation in all CIRP groups (that have not already been marked "complete."). QRS represents numerous CIRP and Optional group cases and should be well-familiar with the rules in such cases.

Finally, the Board is aware that this is not the first instance where QRS has failed to meet the "Comments Regarding Full Formation" deadline in a group due to its own oversight.[7] The Board has a docket of over 12,000 cases, and it is imperative that it is able to set its own deadlines, and that the parties adhere to those deadlines. The Board has clearly set forth in its Board Rules and its Notices to the Parties the details of the ramifications if deadlines are missed.

Therefore, given its discretionary authority in 42 C.F.R. § 405.1868 and Board Rule 41.2, which states the Board may dismiss a case upon failure of the group to comply with Board procedures or filing deadlines, the Board dismisses Case No. 25-1509GC.

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:

2/26/2026

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 C. Leong, FSS

[6] (Emphasis added.)
[7] On July 22, 2025, the Board issued a decision dismissing Case Nos. 24-1484GC, 24-1549GC, 24-1366GC, 24-1406GC, 24-1367GC and 24-1409GC for failure to timely respond to the "Comments Regarding Full Formation." On December 16, 2025, it dismissed Case No. 25-0856GC for the same infraction.

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**Via Electronic Delivery**

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RE: ***Notice of Dismissal***
University of Kansas Hospital, Prov. No. 17-0040, FYE 06/30/2017
Case No. 21-0291

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 21-0291. Set forth below is the decision of the Board to dismiss the sole remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for Medicaid Eligible Days payments.

## Background

### A. *Procedural History for Case No. 21-0291*

On **June 5, 2020**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2017.

On **November 24, 2020**, the Provider filed this individual appeal request. The initial Individual Appeal Request contained two (2) issues:

1. SSI Percentage (Provider Specific) – ***withdrawn on December 30, 2025***
2. Medicaid Eligible Days

On **November 25, 2020**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

> made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[1]

On **August 10, 2021**, the Provider filed its Preliminary Position Paper.

On **September 13, 2021**, the Medicare Contractor filed a Jurisdictional Challenge over Issue 1.

On **October 8, 2021**, the Medicare Contractor filed a Substantive Claim Challenge over Issues 1 and 2.

On **October 26, 2021**, the Medicare Contractor timely filed its Preliminary Position Paper.

On **January 18, 2023**, the Medicare Contractor filed a Request for Documentation to substantiate the Medicaid Eligible Days issue.

On **May 19, 2025**, the Board issued the 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*** *also include* ***any exhibits*** *the Provider will use to support to support its position*. *See* Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.[2]

On **November 25, 2025**, the Provider filed its Final Position Paper and a Redacted Section 1115 and Medicaid Eligible Days Listing

On **December 8, 2025**, the Medicare Contractor filed a second Jurisdictional Challenge over Issue 2.

On **December 17, 2025**, the Medicare Contractor filed its Final Position Paper.

On **December 29, 2025**, the Provider filed a Response to the Jurisdictional Challenge.

On **December 30, 2025**, the Provider withdrew Issue 1.

### *B. Description of Issue 1 in the Appeal Request – 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 calculations. The Provider describes Issue 2 as:

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[1] (Emphasis added.)
[2] (Emphasis added.)

**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): 5, 9, 10, 11, 44, 45, s-d

Estimated Reimbursement Amount: $965,091[3]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the *Jewish Hospital* case[4] 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.[5]

**MAC's Contentions – Issue 2 – Medicaid Eligible Days**

The MAC requests that the Board dismiss the DSH – Medicaid Eligible Days issue arguing this issue should be dismissed because the Provider failed to file a complete preliminary position paper including all supporting exhibits to document the merits of its argument in accordance with 42 C.F.R. §405.1853(b)(2) and Board Rule 25.3.[6]

The Medicare Contractor notes that position papers must include a fully developed narrative and all exhibits, but the preliminary position paper in this case did not contain a finalized eligibility day listing.[7] It also argues that, while a list of days was submitted by the Provider on November 25, 2025, the list included a caveat of "Listing pending finalization up on receipt of State

[3] Appeal Request at Issue 2.
[4] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[5] Provider's Preliminary Position Paper, 7-8 (July 22, 2021).
[6] Jurisdictional Challenge at 2, 7-9 (Dec. 8, 2025).
[7] *Id.* at 7-9.

eligibility data" and is thus not a final list. The list also lacked any documentation to support the patients' Medicaid eligibility.[8]

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

**Provider's Jurisdictional Response**

The Provider filed a Jurisdictional Response on December 29, 2025. The response only argues that the Section 1115 Waiver Days currently claimed were not untimely added. It claims the issue statement in the appeal argued that the Medicare Contractor "failed to include all Medicaid eligible days, *including but not limited to* Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation."[10]

It also cites to the Board Rule 7.2.1, arguing that an issue in a Board appeal must only identify the following:

- An issue title and a concise issue statement describing:
  - The adjustment, including the adjustment number,
  - The controlling authority,
  - Why the adjustment is incorrect,
  - How the payment should be determined differently,
  - The reimbursement effect, and
  - The basis for jurisdiction before the PRRB

The Provider argues that adjustments for Medicaid eligible days inherently affect section 1115 waiver days, and claim "the regulations consider an 'issue' to be a specific cost report adjustment" without quoting or citing to any particular regulation that supports this notion.[11] The Provider claims the Board's Rules are circular and confusing, and that it improperly labels "components" of issues as separate issues, while failing to acknowledge that Board Rule 8 (2018) ***specifically and clearly*** notifies Providers that, for issues with multiple components, "each contested component must be appealed as a separate issues and described as narrowly as possible." Indeed, the Rule goes on to ***specifically*** identify Section 1115 waiver days as a separate component of Disproportionate Share Hospital Payment issues:

> **8.1 General**
>
> Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described

[8] *Id.* at 9.
[9] *Id.* at 10-13.
[10] Jurisdictional Challenge Response, 1 (Dec. 29, 2025) (emphasis in original).
[11] *Id.* at 2.

> as narrowly as possible using the applicable format outlined in Rule 7. Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: dual eligible Medicare Part A/Medicaid, dual eligible Medicare Part C/Medicaid, SSI data matching, state/program specific general assistance days, Section 1115 waiver days (program/waiver specific), and observation bed days.

The Jurisdictional Response does not address the failure to include an eligibility listing with its preliminary position paper and merely notes the Provider submitted a redacted listing in its Final Position Paper, and an unredacted listing to the MAC, both on November 25, 2025.[12] Nor does the Provider address the fact that the listing submitted was still not finalized, but "pending finalization upon receipt of State eligibility data."

**Decision of the Board**

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2020), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

***A. DSH Payment – Medicaid Eligible Days***

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

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

[12] *Id.* at 4.

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[13]

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

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

> **Rule 25 Preliminary Position Papers**[14]
>
> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the following sub-sections.
>
> **25.1.1 The Provider's Position Paper**
>
> A. Identify any issues that were raised in the appeal but are

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

already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.

B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

**25.2 Position Paper Exhibits**

**25.2.1 General**

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

**25.2.2 Unavailable and Omitted Documents**

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

**25.2.3 List of Exhibits**

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

**25.3 Filing Requirements to the Board**

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

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

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on **November 25, 2020** included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 2, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[15]

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

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

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

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

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

[15] (Emphasis added.)

- upon failure to appear for a scheduled hearing.

On **July 22, 2021**, 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.[16] 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 $965,091 based on an estimated 2,062 days). The Provider's complete briefing of this issue in its preliminary 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, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number

[16] Provider's Preliminary Position Paper at 11 (July 22, 2021).

> of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[17]

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 challenge requests dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to timely furnish documentation (*e.g.*, a full and final listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish the list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2. The Medicare Contractor thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the regulations and the Board Rules.[18]

The Provider's Jurisdictional Response filed on **December 29, 2025** does not address the failure to include an eligibility listing with its preliminary position paper and merely notes the Provider submitted a redacted listing in its Final Position Paper, and an unredacted listing to the MAC, both on **November 25, 2025**.[19] Nor does the Provider address the fact that the listing submitted was still not finalized, but "pending finalization upon receipt of State eligibility data."

The Redacted Listing was 44 pages with hundreds of Medicaid eligible days. QRS' filing did not explain why the listing of so many days was being submitted at this late date. The Board notes that this filing was submitted ***more than four years past the deadline for including it with its preliminary position paper*** since the position paper deadline was **July 22, 2021**.

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).

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[17] *Id.* at 7-8.
[18] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.
[19] *Id.* at 4.

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

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

### *B. 1115 Waiver Days*

The Board finds that the section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added. The Provider failed to include section 1115 Waiver days as a cost issue in its appeal request and failed to timely and properly add this additional issue to the 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 2020 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…

[20] (Emphasis added.)

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

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

> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[22]

Board Rule 7.2.1 (2018) elaborated on this regulatory requirement, instructing providers:

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>   - the adjustment, including the adjustment number,
>   - the controlling authority,
>   - why the adjustment is incorrect,
>   - how the payment should be determined differently,
>   - the reimbursement effect, and
>   - the basis for jurisdiction before the [Board].

Board Rule 8 (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 are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[23]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[24]

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

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[22] 42 C.F.R. § 405.1835(b).
[23] (Bold and italic emphasis added).
[24] *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.[25] 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) (2019) states in pertinent part:

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

[25] 65 FR 47054, 47087 (Aug. 1, 2000).

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

Because the Provider did not raise the Section 1115 Waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The 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). As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* § 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 in that it only makes perfunctory conclusions.[26] 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.

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

The Board's finding that neither the appeal request nor final position paper met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[27] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[28] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[29] The Court found that this 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.[30] Here, the Board makes the same finding based on similarly *overly generalized language.*

* * * * *

Based on the foregoing, the Board has dismissed the sole remaining issue in this case – (Issue 2). As no issues remain, the Board hereby closes Case No. 21-0291 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:

2/26/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[27] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[28] *Id*. at *11.
[29] *Id.*
[30] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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**Via Electronic Delivery**

Daniel Hettich, Esq.
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Washington, DC 20006

RE: ***Expedited Judicial Review Determination***
Case Number: 22-0734GC - *Steward Health Care FFY 2022 IPPS Section 401 Hospitals Rural Floor CIRP Group*

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Consolidated[1] Request for Expedited Judicial Review ("EJR") filed on **January 5, 2026** concerning the above referenced common issue related party ("CIRP") group appeal. The Board's decision on jurisdiction and EJR for this case are set forth below.

**Issue:**

The Petition for EJR describes the issue as follows:

> The Medicare statute provides that "Section 401" hospitals must be treated as being located in a rural area for all purposes under the IPPS system, *see* 42 U.S.C. § 1395ww(d)(8)(E), and that no urban hospital can be assigned a wage index that is lower than the wage index assigned to rural hospitals in the same state, *see* 42 U.S.C. § 1395ww note. In its rulemaking for the Inpatient Prospective Payment System for fiscal year 2020, and carried forward to FFY 2022, however, CMS announced a new rule that violates both of these statutory directives. Specifically, under CMS's new policy, Section 401 hospitals would not be treated as rural in calculating the rural floor, and urban hospitals will be assigned a lower wage index than the one applicable to rural hospitals in the state. The issue presented in these appeals is whether CMS's new wage index rule is unlawful because it conflicts with the unambiguous requirements of the Medicare statute.[2]

[1] The petition also included Case Nos. 22-0732GC, 22-0733GC, 22-0735GC, 22-0740GC, and 23-1393G, which were addressed under separate cover.
[2] Case Nos. 22-0732GC *et al.*, Consolidated Petition for Expedited Judicial Review at 1 (Jan. 5, 2026).

The Providers are requesting "that the Board grant EJR of the Providers appeals challenging the validity of CMS's rule excluding Section 401 hospitals from the calculation of the rural floor."[3]

**Statutory and Regulatory Background:**

*1. Wage Index; Rural and Urban Classification*

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[4] known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs"). The base payment rate is comprised of a standardized amount[5] for all subsection (d) hospitals located in an "urban" or "rural" area.[6]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[7] adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).[8]

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives "an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the

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[3] *Id.* at 10.
[4] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).
[5] The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27708, 27765-27766 (May 27, 1994). Section 1395ww(d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).
[6] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[7] of the Department of Health and Human Services.
[8] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index (last visited January 30, 2026).

nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts."[9]

In 1999, Congress recognized that in some cases, a hospital in one geographical area may compete for the same labor pool as hospitals in a nearby, larger urban area but receive lower reimbursement because they are geographically located in a lower wage index area. This resulted in some hospitals being underpaid for their labor costs. As a result, "Congress amended the Medicare Act in order to allow a hospital to seek reclassification from its geographically-based wage area to a nearby wage area for payment purposes if it met certain criteria"[10] and established the Medicare Geographic Review Board (MGCRB) to administer the reclassification process.[11,12]

Ten years after the MGCRB was established, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106-113).[13] This legislation instructed the Secretary that urban hospitals that applied to the MGCRB for redesignation as rural were to be treated as such. Hospitals that receive these redesignations are sometimes known as "Section 401," hospitals. Codified at 42 U.S.C. § 1395ww(d)(8)(E), the statute states that:

> (E)(i) For purposes of this subsection, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital described in clause (ii), the Secretary ***shall treat the hospital as being located in the rural area*** (as defined in paragraph (2)(D)) of the State in which the hospital is located.
> (ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban area (as defined in paragraph (2)(D)) and satisfies any of the following criteria:
> (I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).
> (II) The hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).
> (III) The hospital would qualify as a rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.
> (IV) The hospital meets such other criteria as the Secretary may specify.[14]

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[9] *Id.*
[10] *Robert Wood Johnson University Hosp. v. Thompson,* 297 F. 3d. 273, 276 (3d Cir. 2002).
[11] *Id.*
[12] 42 U.S.C. § 1395ww(d)(10)(D)(v).
[13] *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Public L. 106-113, app. F. § 401, 113, Stat. 1501, 1501A-321 (Nov. 29, 1999). Codified as 42 U.S.C. § 1395ww(d)(8).
[14] *Id.* (emphasis added).

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

> Hospitals qualifying under this section shall be eligible to qualify for all categories and designations available to rural hospitals, including sole community, Medicare dependent, critical access, and referral centers. Additionally, qualifying hospitals shall be eligible to apply to the [MGCRB] for geographic reclassification to another area. The [MGCRB] shall regard such hospitals as rural and as entitled to the exceptions extended to referral centers and sole community hospitals, if such hospitals are so designated.[15]

### *2. Rural Floor Adjustment*

In 1997, Congress observed that the calculation of the wage index for all regions of a state can sometimes result in "some urban hospitals being paid less than the average rural hospital in their state."[16] To correct this problem, in the Balanced Budget Act of 1997, Congress provided that the wage index assigned to a hospital in an urban area must be at least as great as the wage index assigned to rural hospitals within the same state. The statute provides that:

> For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)) may not be less than the area wage index applicable under such section to hospitals located in rural areas in the State in which the hospital is located.[17]

This provision is commonly referred to as the "rural floor."

### *3. Changes to the Wage Index Calculation*

In the FFY 2019 IPPS proposed rule,[18] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information ("RFI") as part of the FFY 2020 IPPS proposed rule.[19] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[20] In the

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[15] H.R. Conf. Rep. No. 106-479, 512 (1999).
[16] H.R. Rep. No. 105-149, at 1305 (1997).
[17] 42 U.S.C. § 1395ww note (Floor on Area Wage Index).
[18] 83 Fed. Reg. 20164 (May 7, 2018).
[19] 84 Fed Reg 19158, 19393-94 (May 3, 2019).
[20] *Id.*

FFY 2020 IPPS Final Rule, the Secretary proposed several policies to address wage index disparities.[21] Relevant to the issue under appeal here are the Secretary's proposals to prevent allegedly inappropriate payment increases due to rural reclassifications made under the provisions of 42 C.F.R. § 412.103.[22],[23] The Secretary finalized without modification the proposals

- to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103); and
- for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . .(as implemented at § 412.103) from the calculation of ''the wage index for rural areas in the State in which the county is located'' referred to in section [1395ww](d)(8)(C)(iii). . . .[24]

The Secretary contends that this policy "is necessary and appropriate to address the unanticipated effects of rural reclassification on the rural floor and resulting wage index disparities, including the effects of the manipulation of the rural floor by certain hospitals."[25] The Secretary concludes that "the inclusion of reclassified hospitals in the rural floor calculation has had the unforeseen effect of exacerbating the wage index disparities between low and high wage index hospitals."[26]

Under the 2020 IPPS Final Rule, the Secretary "would continue to calculate the rural floor based on the physical non-MSA area of the state, which is the same rural area to which a hospital is reclassified under section [1395ww](d)(8)(E). However, for purposes of calculating the rural

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[21] *See generally* 84 Fed. Reg. 42044, 42336-42339 (Aug. 16, 2019).
[22] 42 C.F.R. § 412.103 states in relevant part that:

> (a) General criteria. A prospective payment hospital that is located in an urban area (as defined in subpart D of this part) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
> (1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification, the Rural–Urban Commuting Area codes, . . . .
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.
> *****
> (7) For a hospital with a main campus and one or more remote locations under a single provider agreement where services are provided and billed under the inpatient hospital prospective payment system and that meets the provider-based criteria at § 413.65 of this chapter as a main campus and a remote location of a hospital, the hospital is required to demonstrate that the main campus and its remote location(s) each independently satisfy the location conditions specified in paragraphs (a)(1) and (2) of this section.

[23] 84 Fed. Reg. at 42332.
[24] *Id.* at 42336.
[25] *Id.* at 42333.
[26] *Id.*

floor wage index for a state, [the Secretary] would not include in the rural area the data of hospitals that have reclassified as rural under section [1395ww](d)(8)(E)."[27] The Secretary pointed out that the "legislative intent of the rural floor was to correct the 'anomaly' of 'some urban hospitals being paid less than the average rural hospital in their States.'"[28]

The Secretary found that "[u]nder the current rural floor wage index calculation, rather than raising the payment of some urban hospitals to the level of the average rural hospital in their State, urban hospitals may have their payments raised to the relatively high level of one or more geographically urban hospitals reclassified as rural."[29] The Secretary explained that "[w]hile urban hospitals in mostly rural states may benefit from an increase in the rural floor due to urban to rural reclassification . . . other states with high wage urban hospitals using [42 C.F.R.] § 412.103 reclassifications to raise the rural floor can mitigate those gains for mostly rural states, due to budget neutrality."[30] The Secretary believes that "excluding the data of hospitals that reclassify as rural under section [1395ww](d)(8)(E) from the rural floor wage index is necessary and appropriate to address these unanticipated effects of rural reclassifications on the rural floor and the resulting wage index disparities."[31]

The Secretary contends that his reimbursement calculation "is permissible under [42 U.S.C. § 1395ww](d)(8)(E) (as implemented by [42 C.F.R.] § 412.103) and the rural floor statute [42 U.S.C. § 1395ww(d) note]" and notes that the statute "does not specify where the wage data of reclassified hospitals must be included."[32] Therefore, the Secretary believes that he has the "discretion to exclude the wage index data of such hospitals from the calculation of the rural floor. Furthermore, the rural floor statute does not specify how the rural floor wage index is to be calculated or what data are to be included in the calculation."[33] Consequently, the Secretary believes that he has the "discretion under the rural floor statute to exclude the wage data of hospitals reclassified under section [1395ww](d)(8)(E) from the calculation of the rural floor."[34]

CMS has adopted the FY 2020 IPPS Final Rule's policy in its FY 2022 IPPS Final Rule, meaning for FFY 2022 it will calculate the rural floor in a state without reference to the wage index that applies for any hospitals in that state which were reclassified as rural pursuant to Section 401.[35]

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[27] *Id.* at 42334.
[28] *Id.*
[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] *Id.*
[34] *Id.*
[35] 86 Fed. Reg. 44774, 45175 (Aug. 13, 2021).

**Positions of the Parties:**

***1. Providers' Appeal Requests***

The Providers describe the appealed issue as follows:

> The Providers in this group appeal challenge the Secretary's calculation of the rural floor for federal fiscal year (FFY) 2022. The Secretary's calculation violates the plain meaning of the rural floor provision of the statute and the requirement to treat reclassified rural hospitals as rural hospitals for all purposes of the prospective payment system.
>
> ****
>
> For wage index purposes, there are two types of geographic areas: urban and rural.
>
> ***
>
> When a hospital reclassifies as rural, its wage and hour data is included in the calculation of the state rural wage index adjustment in the next federal fiscal year.
> The Medicare statute contains a provision requiring that no urban hospital can be assigned a wage index adjustment that is lower than the wage index assigned to rural hospitals in the state.
>
> ***
>
> In the Inpatient Prospective Payment System Rulemaking for FFY 2020, the . . . . rural wage index will continue to be calculated based on the average hourly wage of all rural hospitals and all urban hospitals that have reclassified as rural. The rural floor, however, will not include the wage and hour data of reclassified rural hospitals; it will be based solely on the wage data of naturally rural hospitals. The Secretary continued this policy in FFYs 2021 and 2022.
>
> ***
>
> As a direct result of this policy, in FFY 2022, urban hospitals in some states have been assigned a wage index that is lower than the wage index assigned to rural hospitals in those states.
>
> ***
>
> This result violates the rural floor, which expressly prohibits the Secretary from assigning a wage index to urban hospitals that is lower than the wage index of rural hospitals in the same state. *See* 42 U.S.C. § 1395ww note. Even if this result did not violate the rural floor (it does), the Secretary's policy would separately violate 42 U.S.C. § 1395ww(d)(8)(E)(i), which requires the Secretary to treat a hospital that has elected to reclassify as rural as rural for the purposes of the prospective payment system.

> For the forging reasons, the Providers in this group appeal are seeking reversal of CMS's policy of divorcing the rural floor from the rural wage index.[36]

### *2. Providers' Request for EJR*

The Providers filed their Petition for EJR to challenge CMS' new wage index rules as unlawful because it conflicts with the Medicare statute.[37] They argue that the FY 2020 rulemaking (1) does not treat reclassified "Section 401" hospitals as being located in a rural are as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[38]

They seek to have their wage indices recalculated in compliance with the requirements of the Medicare statute.[39] The Providers are specifically seeking the Board hold that:

> CMS's calculation of the FFY 2022 rural floor is unlawful because CMS does not have statutory authority to exclude data of Section 401 hospitals from the calculation of the rural floor and CMS cannot assign a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state, and to compel CMS to pay the Providers reimbursement that was withheld as a result of that regulation during the years under appeal.[40]

The Providers insist they have met the criteria set forth in 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), namely that the Board has jurisdiction over the appeal but lacks the authority to grant the relief the Provider seeks.[41]

### *3. Medicare Contractor's Position*

On **January 12, 2026**, the Medicare Contractor's designated representative, Federal Specialized Services, filed a response to the Consolidated Request for Expedited Judicial Review. It took no position on the Request for EJR but noted "that the MAC will file substantive claim challenges for 22-0733GC, 22-0740GC and 23-1393G."[42]

A Substantive Claim Challenge was filed in Case 22-0734GC on **January 26, 2026**. The Substantive Claim Challenge is addressed below.

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[36] Statement of the Issue (Feb. 9, 2022).
[37] Consolidated Petition for Expedited Judicial Review at 1 (Jan. 5, 2026).
[38] *Id.* at 1, 5-6.
[39] *Id.* at 1-2.
[40] *Id.* at 7.
[41] *Id.* at 6-10.
[42] Response to Provider's Request for Expedited Judicial Review at 1 (Jan. 12, 2026).

**Decision of the Board:**

The participants that comprise the group appeal filing this EJR request have filed an appeal involving FFY 2022 based on their appeal from policies the FFY 2022 IPPS Final Rule published in the Federal Register.

***1. Jurisdiction and Request for EJR***

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

As previously noted, all of the participants in this group case appealed from the FFY 2022 IPPS Final Rule.[43] The Board has determined that (1) the participants' documentation in the group appeal shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal;[44] (2) the appeals were timely filed; and (3) Board review of the matter in this appeal is not precluded by statute or regulation. In finding that the group meets the $50,000 amount in controversy, the Board recognizes that the filed amounts in controversy illustrate the reimbursement difference between the "current rural floor calculation" and "if [the] rural floor were calculated correctly."[45] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractors for the actual final amounts.

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

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

> (1) *General Requirement*. In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in

[43] 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.
[44] *See* 42 C.F.R. § 405.1837.
[45] *E.g.,* Impact Calculation, (Steward) Carney Hospital (Prov. No. 22-0017).

> paragraph (j)(3) of this section), **must include an appropriate claim for the specific item**, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **and describing** how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[46]

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.

[46] (Bold and underline emphasis added.)

> (b) *Summary of Procedures*.
>
> ***
>
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ***
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ***
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> (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**.[47]

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

> give the parties an adequate opportunity to submit factual evidence and legal arguments regarding the question of whether the provider's cost report included an appropriate claim for the specific item under

[47] (Bold and underline emphasis added.)

> 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.

Board Rule 44.5.2 (2021) governs the timing for filing substantive claim challenges pursuant to 42 C.F.R. § 405.1873(a) and reads:

> A party that questions whether the one or more participants in a group case (CIRP or optional) included an appropriate claim *on the cost report at issue* for the common issue being appealed in the group ***must file a Substantive Claim Challenge sixty (60) days after the group files its final Schedule of Providers (SOP) unless the moving party's filing demonstrates good cause***.[48] The moving party must summarize in its Substantive Claim Challenge the efforts that it made to contact the opposing party to discuss the merits of the Substantive Claim Challenge. If the moving party has attempted to confer but has been unsuccessful, briefly describe the attempts made. *See* sample language in Rule 44.2. The opposing party(ies) has thirty (30) days to respond (including in the context of an EJR filing).
>
> - *Expedited Challenge Filing Deadline When an EJR Request Is Filed per Board Rule 42.---If the final SOP is filed concurrent with an EJR request or 60 days has not yet transpired between the filing of the final SOP and the EJR request, then refer to Rule 44.6 for special instructions on deadlines for filing Substantive Claim Challenges and any response thereto.*

In Case 22-0734GC, the Providers notified the Board that the case was fully formed on **February 11, 2022**, and also filed a "Request to Change Lead MAC and Certification that Group is Complete and Fully Populated on OH CDMS."

FSS filed a Substantive Claim Challenge on **January 26, 2026** and argued that Providers had ***not*** submitted a final Schedule of Providers or Rule 20 certification, meaning "the timeline for filing a Substantive Claim Challenge has not yet begun, making this challenge timely."[49]

On **February 3, 2026**, the Board issued a Request for Information which set a deadline for the Providers to file a Response to the Substantive Claim Challenge. The Providers filed their Response on **February 6, 2026**, explaining that their Rule 20 certification was included within their **February 11, 2022** request to change the lead Medicare Contractor. The Providers are correct, and since a Substantive Claim Challenge was not filed until **January 26, 2026**, well beyond the sixty (60) day timeframe for filing the challenge mandated by Board Rule 44.5.2 (2021), this challenge was not timely and the Board declines to consider it.

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[48] (Emphasis added.)
[49] Medicare Administrative Contractor's Substantive Claim Challenge at 1 (Jan. 26, 2026).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[50] 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.[51] In this group case, the Medicare Contractor has failed to file a Substantive Claim Challenge[52] in accordance with Board Rules 44.5.2 and 44.6 (2021) for any of the Providers with FYEs December 31, 2016.

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[53] 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).

### *3. Analysis Regarding Appealed Issue*

As set forth below, the Board finds that the Secretary's determination to (1) "calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103)"; and (2) "for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . . (as implemented at § 412.103) from the calculation of 'the wage index for rural areas in the State in which the county is located' referred to in section [1395ww](d)(8)(C)(iii). . . ."[54] was made through notice and comment in the form of an uncodified regulation.[55]

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

> After consideration of the public comments we received, for the reasons discussed in this final rule and in the proposed rule, we are finalizing without modification our proposal to calculate the rural

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[50] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[51] *See* 42 C.F.R. § 405.1873(a).
[52] 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."
[53] 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."
[54] 84 Fed. Reg. 42044 at 42336.
[55] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals."

> floor without including the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103). Additionally, we are finalizing without modification our proposal, for purposes of applying the provisions of section 1886(d)(8)(C)(iii) of the Act, to remove the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103) from the calculation of "the wage index for rural areas in the State in which the county is located" referred to in section 1886(d)(8)(C)(iii) of the Act.[56]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as the "Uncodified Regulations on Rural Floor Calculation and Wage Index." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation.[57]

While this appeal involves the FFY 2022 IPPS Final Rule, the continuation of this policy was implemented in the same way as it was initially for FFY 2020.[58] The FY 2022 IPPS Final Rule did not make any changes to this policy. Therefore, the Board finds that this policy continues to be a binding but uncodified regulation for FFY 2022.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2022 IPPS Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulations on Rural Floor Calculation and Wage Index which they allege (1) does not treat reclassified "Section 401" hospitals as being located in a rural area, as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[59] As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in Case 22-0734GC.

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[56] 84 Fed. Reg. at 42336.
[57] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."
[58] 86 Fed. Reg. 44774, 45175 (Aug. 13, 2021).
[59] Consolidated Petition for Expedited Judicial Review at 1, 5-6.

***D. Board's Decision Regarding the EJR Request***

The Board finds that:

1) It has jurisdiction over the Uncodified Regulations on Rural Floor Calculation and Wage Index Issue for the subject year in Case 22-0734GCand that the Providers in this group appeal are entitled to a hearing before the Board;

2) While the Providers appealed cost reporting periods beginning after January 1, 2016, no substantive claim challenges[60] have been filed pursuant to 42 C.F.R. § 405.1873(a) and in accordance with the Board's Rules to trigger either Board review under § 405.1873(b) or reporting under § 405.1873(d)(2);

3) Based upon the Providers' assertions regarding the FFY 2022 IPPS 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 codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2022 IPPS Final Rule is valid.

Accordingly, the Board finds that the question of the validity of the codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2022 IPPS Final Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject 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 this group case, the Board hereby closes Case 22-0734GC and removes it from its docket.

[60] As the Board explained in Board Rule 44.5, "[t]he Board adoption of the term "Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

Board Members Participating:

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

FOR THE BOARD:

2/26/2026

X Kevin D. Smith, CPA

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

Enclosure: Schedule of Providers

cc: Dean Wolfe, Noridian Healthcare Solutions (J-F)
Scott Berends, Esq., Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Via Electronic Delivery**

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

RE: ***Notice of Dismissal***
Porter Regional Hospital (Prov. No. 15-0035), FYE 12/31/2018
Case No. 23-0026

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0026. 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. 23-0026***

On **April 15, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2018.

On **October 5, 2022**, the Board received the Provider's individual appeal request. The appeal was filed by the parent organization Community Health Systems, Inc. ("CHS") and included five (5) issues:

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

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 (*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,

[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.

> 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 **March 16, 2023**, a Critical Due Dates letter was issued with updated PPP deadlines.

On **May 30, 2023,** CHS transferred Issues 2, 4 and 5 to CHS common issue related party ("CIRP") groups in accordance with the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). As a result, there are two remaining issues in this appeal: Issue 1: "DSH Pymt/SSI % (Provider Specific)" and Issue 3: "DSH Pymt - Medicaid Eligible Days."

On **June 1, 2023**, CHS timely filed the Provider's PPP.

On **August 14, 2023**, the Medicare Contractor ("MAC") filed a Jurisdictional Challenge over the "DSH Pymt/SSI % (Provider Specific)" and "DSH Pymt - Medicaid Eligible Days" issues.

On **August 16, 2023**, CHS requested the representative be changed to Quality Reimbursement Services, Inc. ("QRS"), which the Board effectuated on the same day.

On **September 5, 2023**, the MAC filed its PPP.

On **February 2, 2026**, the Board issued a Notice of Hearing scheduling the case for a **September 14, 2026** hearing**.**

### *B. Description of Issue 1 in the Individual Appeal Request and the Provider's Participation in Case No. 21-1206GC*

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.

[4] (Emphasis added).

> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator'. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[5]

The Group issue Statement in Case No. 21-1206GC, 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

[5] Issue Statement at 1 (Oct. 5, 2022).

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

On June 1, 2023, the Board received the Provider's PPP in Case No. 23-0026. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[7]

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 $68,823.

### *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.

[6] Group Issue Statement, Case No. 21-1206GC.
[7] Provider's PPP at 9 (June 1, 2023).

**Statement of the Legal Basis**

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

The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
Audit Adjustment Number(s): 7, 8, 10, 28, S-D

Estimated Reimbursement Amount: $47,953

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[8] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[9]

**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 PPP, 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 transferred to Case No. 21-1206GC. 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.[10]

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

With regard to Medicaid Eligible Days, 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.)[11] 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.[12] Therefore, since the issue

[8] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[9] Provider's PPP at 7 (June 1, 2023).
[10] MAC's Jurisdictional Challenge at 2 (Aug. 14, 2023).
[11] MAC's jurisdictional challenge at 11 (Aug. 14, 2023).
[12] *Id*. at 12.

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.[13]

**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. 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 ("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

[13] *Id* at 13.
[14] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[15] Issue Statement at 1.

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 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. 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. 23-0026 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[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. 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.

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:

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[16] *Id.*
[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).

> **25.2.2 Unavailable and Omitted Documents[20]**
>
> 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]

This CMS webpage describes access to DSH data ***from 1998 to 2023*** and instructs providers to send a request via email to access their DSH data."[23]

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[20] PRRB Rules v. 3.1 (Nov. 2021)
[21] (Italics and underline emphasis added.)
[22] Last accessed Feb. 6, 2026.
[23] Emphasis added.

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. 21-1206GC 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 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.

***B. DSH Payment – Medicaid Eligible Days***

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

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

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

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

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

[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 CHS CIRP group per 42 C.F.R. § 405.1837(b)(1).

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]

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);

[25] (Emphasis added).
[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).

- if the Board is unable to contact the provider or representative at the last known address; or
- upon failure to appear for a scheduled hearing.

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

This appeal was initiated on October 5, 2022 (more than 3 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.[28] ***To date, there is no evidence that the listing has been provided—even after the MAC requested the listing***.[29] 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.[30] 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.

****

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" - Issue 3. As no issues remain, the Board hereby closes Case No. 23-0026 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:

2/27/2026

X Nicole E. Musgrave

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

cc: Byron Lamprecht, WPS Government Health Administrators (J-8)

[28] Provider's PPP at 8.
[29] MAC PPP at 13 (Sept. 5, 2023)
[30] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

Wilson C. Leong, Esq., Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Via Electronic Delivery**

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

RE: ***Notice of Dismissal***
Fannin Regional Hospital (Prov. No. 11-0189), FYE 12/31/2018
Case No. 23-0032

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0032. Set forth below is the decision of the Board to dismiss the two (2) issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") SSI (Provider Specific) and Medicaid Eligible Days issues.

**Background:**

**A. *Procedural History for Case No. 23-0032***

On **April 15, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2018.

On **October 6, 2022**, Quality Reimbursement Services, Inc. ("QRS") filed an appeal on behalf of the Provider which included five (5) issues:

1. SSI (Provider Specific)
2. SSI Systemic Errors
3. Medicaid Eligible Days
4. SSI MCD PT C
5. SSI MCD Dual

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.[1]

On **March 10, 2023,** QRS transferred Issues 2, 4, and 5 to Quorum Health common issue related party "CIRP" groups in accordance with the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). As a result, there are two (2) remaining issues in this appeal: Issue 1: SSI (Provider Specific) and Issue 3: Medicaid Eligible Days.

On **March 16, 2023** an updated Critical Due Dates notice was issued, with revised PPP due dates.

On **June 1, 2023**, QRS filed the Provider's PPP.

On **August 11, 2023**, the MAC filed a Jurisdictional Challenge over the SSI (Provider Specific) and Medicaid Eligible Days issues.

On **September 21, 2023**, the Medicare Contractor ("MAC") filed its PPP.

On **December 8, 2025**, the Board issued a Notice of Hearing, scheduling the case for a June 11, 2026 hearing.

### *B. Description of Issue 1 in the Individual Appeal Request and the Provider's Participation in Case No. 22-0977GC*

In its Individual Appeal Request, the Provider summarizes its 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. *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'.

[1] (Emphasis added.)

> 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. 22-0977GC, 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]

In the Provider's June 1, 2023 PPP in Case No. 23-0032, the following is the Provider's ***complete*** position on Issue 1 set forth therein:

[2] Issue Statement at 1 (Oct. 6, 2022).
[3] Group Issue Statement, Case No. 22-0977GC.

> **Provider Specific**
>
> The Provider contends that its' [sic] SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the 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. [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 $7,439.

### *C. Description of Issue 3 in the Individual Appeal Request*

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

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation

[4] Provider's PPP at 10 (June 1, 2023).

> of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 7, 8, 22, S-D
>
> Estimated Reimbursement Amount: $21,957[5]

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 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 PPP, 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 transferred to Case No. 22-0977GC. 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. Finally, 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.[8]

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

The MAC also 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 indicated a listing would be sent under separate cover. In addition, the MAC requested a listing on March 21, 2023 to which the Provider did not respond.[9] Again with this issue, 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.[10] Therefore, since the issue was not properly developed, the Provider did not provide a list of additional Medicaid

[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 8 (June 1, 2023).
[8] MAC's Jurisdictional Challenge at 2 (Aug. 11, 2023).
[9] MAC's PPP at 13. (Sept. 21, 2023).
[10] *Id*. at 11.

days, nor did it explain why it could not produce the documentation, the MAC contends the Provider has abandoned the issue.[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 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 (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. 22-0977GC.

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."[13] 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)."[14] The Provider argues that "its'[sic] SSI

[11] *Id* at 13.
[12] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[13] Issue Statement at 1.
[14] *Id.*

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.”[15]

The Provider’s SSI Percentage (*Systemic Errors*) issue in group Case No. 22-0977GC 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. 23-0032 is duplicative of the DSH/SSI Percentage (*Systemic Errors*) issue in Case No. 22-0977GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[16], 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.[17] 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. 22-0977GC.

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. 22-0977GC 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:

---

[15] *Id.*

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

[17] 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).

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[18]

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.[19]

This CMS webpage describes access to DSH data ***from 1998 to 2023*** and instructs providers to send a request via email to access their DSH data."[20]

---

[18] (Italics and underline emphasis added.)
[19] Last accessed February 6, 2026.
[20] Emphasis added.

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. 22-0977GC are the same issue.[21] 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.

***B. DSH Payment – Medicaid Eligible Days***

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

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

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

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

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

[21] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Quorum CIRP group per 42 C.F.R. § 405.1837(b)(1).

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*.[22]

Similarly, with regard to position papers,[23] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[24] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides instruction on the content of position papers as it relates to unavailable documentation/exhibits, as discussed *supra*.

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

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

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

- upon failure to appear for a scheduled hearing.

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

This appeal was initiated on October 6, 2022 (more than 3 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.[25] ***To date, there is no evidence that the listing has been provided—even after the MAC requested the listing in March 2023***.[26] 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.[27] 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.

****

Based on the foregoing, the Board is dismissing the two (2) remaining issues in this case: SSI (Provider Specific) - Issue 1 and Medicaid Eligible Days - Issue 3. As no issues remain, the Board hereby closes Case No. 23-0032 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:

2/27/2026

X Nicole E. Musgrave

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

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

[25] Provider's PPP at 9 (June 1, 2023).
[26] MAC PPP at 13.
[27] *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.