



Via Electronic Delivery

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RE: ***Expedited Judicial Review Decision***
24-2564GC Penn State Health CY 2021 Capital DSH CIRP Group
25-0191GC Mayo Clinic CY 2021 Capital DSH CIRP Group

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board (“Board”) has reviewed the **November 5, 2025** consolidated petition for expedited judicial review¹ (“EJR”) for the above-referenced common issue related party (“CIRP”) group appeals. The decision with respect to EJR is set forth below.²

Issue under Dispute

In these group cases, the Providers are challenging:

[T]he validity of the regulation at 42 C.F.R. § 412.320(a)(1)(iii), which bars hospitals that are geographically urban and reclassify as rural under 42 C.F.R. § 412.103 from receiving a capital disproportionate share hospital (“DSH”) add-on payment, known as the capital DSH adjustment. The Providers challenge the validity of 42 C.F.R. § 412.320(a)(1)(iii) on a number of grounds including that the regulation (a) is inconsistent with the controlling Medicare statute, (b) was adopted in violation of the Administrative Procedure Act, and (c) is arbitrary and capricious.³

Background:

Under the inpatient prospective payment system (“IPPS”), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for operating costs (“operating IPPS”) as set forth at § 1395ww(d); and one for capital costs (“capital IPPS”) as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to create incentives for hospitals to operate efficiently, while providing adequate compensation to

¹ Providers’ Petition for Expedited Judicial Review (Nov. 5, 2025) (“Request for EJR”).

² The Request for EJR also encompassed Case Nos. 25-0362GC and 25-0865GC, which were adjudicated on November 25, 2025 under separate cover.

³ Request for EJR at 1.

hospitals.⁴ This case focuses on the capital IPPS.

1. Geographic Reclassification

In 1989, Congress created the Medicare Geographic Classification Review Board (“MGCRB”) which implemented a geographic reclassification system in which IPPS hospitals can be reclassified to a different wage index area⁵ for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.⁶ This includes an IPPS hospital reclassifying from a rural to an urban labor market, or vice versa.

2. Operating DSH Adjustment Under Operating IPPS

Part A of the Medicare Act covers “inpatient hospital services.” Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under operating IPPS.⁷ Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.⁸

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.⁹ One of the adjustments is the hospital-specific Disproportionate Share Hospital (“DSH”) adjustment as set forth at 42 U.S.C. § 1395ww(d)(5)(F), which requires the Secretary to provide an adjustment (*i.e.*, an increase in the operating IPPS payment) to hospitals that “serve [] a significantly disproportionate number of low-income patients.”¹⁰

A hospital may qualify for a DSH adjustment to its operating IPPS payments based on its disproportionate patient percentage (“DPP”).¹¹ As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.¹²

⁴ Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), available at <https://oig.hhs.gov/oas/reports/region1/11700500.pdf> (last visited Oct. 20, 2022) (“*Significant Vulnerabilities*”).

⁵ See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html> (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts “for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.” This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas (“CBSAs”) established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).

⁶ Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). See also *Significant Vulnerabilities* at 4-5.

⁷ See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

⁸ *Id.*

⁹ See 42 U.S.C. § 1395ww(d)(5).

¹⁰ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

¹¹ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

¹² See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

The DSH adjustment provided under operating IPPS is *not* at issue in this case. The DSH adjustment is relevant because certain standards set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment that the Secretary adopted for purposes of capital IPPS.

3. Capital DSH Adjustment Under Capital IPPS

A hospital's *capital* costs are paid separately under capital IPPS (*i.e.*, separate and apart from payment for a hospital's *operating* costs under the operating IPPS). Specifically, on December 22, 1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987 ("OBRA-87") and OBRA-87 § 4006(b) required the Secretary to establish the capital IPPS for cost reporting periods beginning in FY 1992.¹³ OBRA-87 § 4006(b) was codified at 42 U.S.C. § 1395ww(g) which states, in pertinent part:

(g) Prospective payment for capital-related costs; return on equity capital for hospitals

(1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall*, for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .

(B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;

(ii) *may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located;*

(iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

(iv) may provide for suitable adjustment to reflect hospital occupancy rate.

(C) In this paragraph, the term "capital-related costs" has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.¹⁴

¹³ Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).

¹⁴ (Underline and italics emphasis added.)

Significantly, the statute governing capital IPPS does not specifically mandate or address the use of a capital DSH adjustment. Rather, it specifies generally that the Secretary “may provide for an adjustment to account variations in relative costs.” As described below, the Secretary exercised his discretion to establish the *capital* DSH adjustment at issue in this case which is limited in that it **only** applies to *urban* hospitals with 100 or more beds and that serve low income patients.¹⁵

A. Initial Implementation of Capital IPPS and the Capital DSH Adjustment

To the end, the Secretary published a final rule on August 30, 1991 to establish the capital IPPS.¹⁶ In implementing the capital IPPS, the Secretary recognized that he had discretion on whether to apply many of the adjustments statutorily required under operating IPPS to capital IPPS:

We are persuaded by the argument advanced by some commenters, including ProPAC, that in the long run the **same** adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. *While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process), we have the latitude to develop adjustments based on combined costs for the capital prospective payment system.*

We do not believe that it would be appropriate to use the current operating payment adjustments in the capital prospective payment system either permanently or on an interim basis until legislation is enacted changing the operating adjustments to the level appropriate for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME) exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should reflect only the higher Medicare costs associated with teaching activity and treating low income patients.¹⁷

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more

¹⁵ 42 C.F.R. § 412.320(a)(1). See also MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 3 (rev. Nov. 2021), available at https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Jan. 6, 2026).

¹⁶ 56 Fed. Reg. 43356 (Aug. 30, 1991).

¹⁷ *Id.* at 43369-70 (emphasis added).

than 100 beds. The proposal was described as follows:

In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to $(\{1 + \text{DSHP}\}^{0.4176} - 1)$, where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.

Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.¹⁸

In adopting his proposal, the Secretary gave the following justification:

Comment: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.

Response: In the final rule, we are providing that urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level than other hospitals. For FY 1992, the minimum payment level is 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also be eligible for the higher minimum payment level. We are not extending the special protection to other hospitals that receive disproportionate share payments under the operating prospective payment system. In urban areas, we believe that our criteria properly focuses on those hospitals that serve a large

¹⁸ *Id* at 43377.

disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries.**¹⁹

In response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to rural hospitals with 500 or more beds:

As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1, 1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(1){ii} of the regulations.²⁰

Similarly, in response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to other classes of hospitals such as “[a]ll small urban hospitals, hospitals with high Medicare usage, rural hospitals, rural hospitals with at least 100 beds, rural referral centers, or those hospitals with high ‘total government’ usage”:

In developing the capital disproportionate share adjustment for this

¹⁹ *Id.* at 43409-10 (bold and underline emphasis added).

²⁰ *Id.*

final rule, we examined the relationship between the disproportionate share patient percentage and total costs per case for each class of hospital that is currently receiving an operating payment adjustment. We believe that only those hospitals that merit the adjustment according to our regression analysis should receive additional capital payments for serving low income patients. The regression results did not indicate any significant relationship between total costs per case and disproportionate share patient percentage for any of the special groups mentioned above.²¹

In response to comments, the Secretary also looked at setting a threshold DSH percentage to qualify for a capital DSH adjustment but rejected that alternative approach based upon the following explanation:

We examined closely the possibility of using a disproportionate share patient percentage threshold in our total cost regression analysis. We were unable to find any threshold level of disproportionate share percentage below which no payment adjustment was merited, or a threshold above which a higher adjustment was merited. As a result, we believe that it is most equitable to make a capital disproportionate share payment to all qualifying hospitals with a positive patient percentage, rather than penalize some hospitals that have a higher cost of treating low income patients but whose patient percentage is below the artificial level we would set.²²

Further, in response to comments, the Secretary rejected not providing *any* capital DSH adjustment based on the explanation:

We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We believe that it is appropriate for Medicare's payment to recognize these higher Medicare patient care costs.²³

Finally, the Secretary addressed how MGCRB reclassifications, in certain circumstances, affect whether an IPPS hospital qualifies for the capital DSH adjustment:

Comment: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.

²¹ *Id.* at 43378.

²² *Id.* at 43379.

²³ (Emphasis added.)

Response: Any hospital that is reclassified to an urban area by the MGCRB for purposes of its standardized amount is considered to be urban for all prospective payment purposes other than the wage index. As such, if any hospital reclassified by the MGCRB to an urban area for purposes of the standardized amount has at least 100 beds, it would be eligible for capital disproportionate share payments. We note that a rural hospital reclassified for purposes of the wage index only is still considered a rural hospital, and as such, will not be eligible for capital disproportionate share payments.²⁴

The resulting regulations governing capital IPPS were codified at 42 C.F.R. Part 412, Subpart M (§§ 412.300 to 412.374). The regulation governing the capital DSH adjustment was codified at § 412.320 which, at initial implementation, stated:

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).

(b) *Payment adjustment factor.* (1) If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital’s disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.

(2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.²⁵

B. Reclassification of Certain IPPS Urban Hospitals as Rural for Purposes of Operating IPPS Pursuant to BBRA § 401 and Impact on Capital IPPS Adjustments

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (“BBRA”) and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if

²⁴ *Id.*

²⁵ *Id.* at 43452-53.

an application is submitted to the MGCRB and certain criteria are met.²⁶ IPPS hospitals are reclassified per BBRA § 401 are often referred to as “§ 401 hospitals.”

On August 1, 2000, the Secretary published the interim final rule to, in part, implement BBRA § 401 and stated in the preamble that a hospital reclassified as rural pursuant to § 401 is treated as rural for all purposes under operating IPPS, including the DSH adjustment for operating IPPS:

*A hospital that is reclassified as rural under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, is treated as rural for all purposes of payment under the Medicare inpatient hospital prospective payment system (section 1886(d) of the Act), including standardized amount (§§ 412.60 et seq.), wage index (§ 412.63), and disproportionate share calculations (§ 412.106) as of the effective date of the reclassification.*²⁷

On August 1, 2000, the Secretary also published the FY 2001 IPPS Final Rule which included the following discussion on the effect of reclassification of a hospital from urban to rural pursuant to BBRA § 401:

In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. *That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes.* In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.

Consistent with the statutory language, we are providing that a hospital

²⁶ BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).

²⁷ 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added.)

reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. *If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area. Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113.* In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106– 113, which authorizes a 30-percent expansion in a rural hospital’s resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME, which are made under section 1886(h) of the Act.)

Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.

We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification

by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.

We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary. Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify. As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.²⁸

Thus, both the August 1, 2000 interim final rule and the FY 2001 IPPS Final Rule confirmed that urban hospitals reclassified as rural pursuant to BBRA § 401 would be treated as rural for all purposes of operating IPPS, including DSH adjustments. The Secretary memorialized this policy in regulation at 42 C.F.R. § 412.103 (2000) which states in pertinent part:

§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.

(a) *General criteria.* A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:

1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration which is available via the ORHP website at <http://www.nal.usda.gov/orph> or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9-05, Rockville, MD 20857.

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

(3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in §

²⁸ 65 Fed. Reg. 47054, 47088-89 (Aug. 1, 2000).

412.92, if the hospital were located in a rural area.²⁹

Neither the August 1, 2000 interim final rule nor the FY 2001 IPPS Final Rule explicitly discussed the impact on capital DSH adjustments under capital IPPS. However, through operation of the cross-reference in 42 C.F.R. § 412.320(a) to § 412.63(a) in the phrase “the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area”,³⁰ it would appear that hospitals reclassified from urban to rural were *not* eligible for capital DSH adjustments under capital IPPS. In this regard, the Board notes that, following the 2000 rulemaking process, § 412.63(a)-(b) (2001) read, in pertinent part:

(a) *General rule.* (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.

(2) **Each such rate is determined for hospitals located in urban or rural areas** within the United States and within each such region respectively, **as described in paragraphs (b) through (g)** of this section.

(b) *Geographic classifications.* (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, **except that, effective January 1, 2000, a hospital reclassified as rural may mean** a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or **a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103.**³¹

The specific reference in § 412.63(b) to urban to rural reclassifications made under § 412.103 makes clear that capital DSH adjustments would not apply to hospitals reclassified from urban to rural pursuant to BBRA § 401 which as noted above was implemented at § 412.103.

C. Changes to Operating IPPS Required by MMA § 401 and Their Effect on Capital IPPS

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”) and MMA § 401 to equalize operating IPPS payments between urban and rural hospitals.³² Specifically, § 401 specifies that, beginning with FY 2004, all IPPS hospitals are paid on the basis of the large urban standardized amount under operating IPPS.

The Office of Management and Budget publishes information on core-based statistical areas

²⁹ 65 Fed. Reg. 47026, 47048.

³⁰ 56 Fed. Reg. at 43452.

³¹ (Bold and underline emphasis added.)

³² Pub. L. 108–173.

(“CBSAs”) and the Secretary has used this information for purposes of defining labor market areas for use in the wage index for operating IPPS.³³ On June 6, 2003, OMB announced the new CBSAs, comprised of metropolitan statistical areas (“MSAs”) and the new Micropolitan Areas based on Census 2000 data.³⁴

On August 11, 2004, the Secretary published the FY 2005 IPPS Final Rule and this rule finalized revisions to the operating IPPS regulations to both implement MMA § 401 as well as adopt OMB’s new CBSA designations.³⁵ With respect to implementing MMA § 401, the Secretary revised 42 C.F.R. § 412.63 to apply only to years through 2004 and added a new § 412.64 to implement MMA § 401 for federal rates for FYs 2005 forward. Specifically, § 412.64 reads in pertinent part:

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

(a) *General rule.* CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.

(b) *Geographic classifications.* (1) For purposes of this section, the following definitions apply:

(i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.

(ii) The term *urban area* means—

(A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(C) The term *rural area* means any area outside an urban area.

³³ 69 Fed. Reg. 48916, 49026 (Aug. 11, 2004).

³⁴ *Id.*

³⁵ *Id.*

(D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

(2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.

(3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.

(4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result of redesignation of an MSA by the Executive Office of Management and Budget.³⁶

Significantly, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: “A hospital is classified as a ‘disproportionate share hospital’ for the purposes of capital prospective payments if the hospital is located, *for purposes of receiving payment under § 412.63(a)*, in an urban area.”³⁷ As a result of the FY 2005 IPPS Final Rule, § 412.320(a) was updated to reference § 412.64 as it relates to FYs 2005 forward:

³⁶ *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).

³⁷ (Emphasis added.)

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital’s location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64.³⁸

Again, as previously noted, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

Finally, in the preamble to the FY 2005 IPPS Final Rule, the Secretary included the following discussion on the impact of the new CBSAs on geographic reclassifications:

Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB’s new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.

The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed

³⁸ 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.

As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.³⁹

D. August 18, 2006 Revisions to the Capital DSH Adjustment

In the FY 2007 Proposed IPPS Rule, the Secretary⁴⁰ announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.⁴¹

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and Budget's ("OMB's") new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005.⁴²

³⁹ 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004).

⁴⁰ of the Department of Health and Human Services.

⁴¹ 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).

⁴² *Id.*

In the FY 2007 IPPS Final Rule published on August 18, 2006, the Secretary finalized these technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment:

These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.

These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.⁴³

In adopting these changes, the Secretary noted that it did not receive any public comments on the proposed change as published in the proposed rule published on May 17, 2006.⁴⁴

As a result of the FY 2007 IPPS Final Rule, the regulation, subparagraph (iii) was added to 42 C.F.R. § 412.320(a)(1) so that revised § 412.320(a) read, in pertinent part:

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

⁴³ 71 Fed. Reg. 47870, 48104 (Aug. 18, 2006).

⁴⁴ *Id.* at 48105.

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.

(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.⁴⁵

E. Litigation Challenging the Validity of 42 C.F.R. § 412.320(a)(1)(iii) as added by the FY 2007 IPPS Final Rule

The validity of 42 C.F.R. § 412.320(a)(1)(iii) was addressed in *Toledo Hosp. v. Becerra* (“*Toledo*”),⁴⁶ wherein the hospital made the following contentions:

Toledo Hospital contends that the Secretary's 2006 rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to “take into account” relative costs of capital for various hospital types and areas of location, as subsection (g) requires.⁴⁷

In *Toledo*, U.S. District Court for the District of Columbia (“D.C. District Court”) outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.⁴⁸ The Court also noted how Congress enacted legislation in 1999⁴⁹ allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into

⁴⁵ (Bold emphasis added.)

⁴⁶ 621 F.Supp.3d 13 (D.D.C. 2021).

⁴⁷ *Id.* at *25 (citations omitted).

⁴⁸ *Id.* at *18-19.

⁴⁹ 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a “§ 401” hospital.

an urban labor market area for the purposes of fixing its wage index.⁵⁰ The Court also noted the separate IPPS payment for a hospital's *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R. § 412.320 for large urban hospitals (the capital DSH payment).⁵¹ The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.⁵²

The appellants in *Toledo* were geographically located in an urban labor market area but applied to the Secretary (and were approved) to reclassify as rural under § 401. The appellants thereafter applied to the MGCRB to reclassify their wage index to an urban labor market area. The appellants' Medicare Contractor later denied their requests for capital DSH adjustments due to their § 401 rural reclassifications. Before the D.C. District Court, the hospitals argued that 42 C.F.R. § 412.320(a)(1)(iii) violated the plain language of the Medicare Act and that it was promulgated in an arbitrary and capricious manner.⁵³

The D.C. District Court rejected the argument that the capital DSH policy in 42 C.F.R. § 412.320(a)(1)(iii) violated the Medicare Act on its face, finding that the Secretary was not prohibited from treating § 401 reclassified hospitals as rural for operating PPS purposes while denying urban status for the purposes of the capital DSH adjustment.⁵⁴ The Court next examined, however, whether the Secretary's decision to do so was reasonable. The D.C. District Court made the following findings:

1. "if the Secretary had any policy concerning Section 401 reclassifications before 2006, he never announced such a policy, much less explained the basis for it."⁵⁵
2. The Secretary's decision to not provide a capital DSH adjustment was arbitrary because:
 - "The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006."⁵⁶
 - "[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements."⁵⁷
 - "The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp.*, 797 F.3d at 1161 (upholding Secretary's regulation where the Secretary explained why 'added precision' 'would not justify the added

⁵⁰ *Toledo* at *19.

⁵¹ *Id.* at *19-20.

⁵² *Id.* at *21.

⁵³ *Id.* at *22.

⁵⁴ *Id.* at *23-25.

⁵⁵ *Id.* at *29.

⁵⁶ *Id.*

⁵⁷ *Id.*

complication’) (quotation omitted).”⁵⁸

- “The agency cannot ‘entirely fail[] to consider’ the “relevant data” and the factors that Congress directed it to review. *State Farm*, 63 U.S. at 43. 103 S. Ct. 2856. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did he take costs into account at all.”⁵⁹

Notwithstanding these findings, the D.C. District Court declined to vacate 42 C.F.R. § 412.320(a)(1)(iii) because “vacatur of a rule is not an appropriate remedy on review of an adjudication.”⁶⁰ Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants’ eligibility for a capital DSH adjustment.⁶¹

Providers’ Request for EJR

As background, “[e]ach of the Providers is an acute care hospital paid by Medicare pursuant to the inpatient and capital [prospective payment systems]. During the years under appeal, the hospitals were all geographically located in urban areas, operated more than 100 beds, served low-income patients and, for all or part of the year, received [§] 401 rural reclassifications pursuant to 42 C.F.R. § 412.103.”⁶²

The Providers are challenging the validity of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent with the underlying operating PPS statute, in particular 42 U.S.C. § 1395ww(d)(8)(B), which states that hospitals that have undergone a rural reclassification are rural only for purposes of this subsection 1395ww(d). The Providers note that “[t]he capital PPS provisions are located in an entirely different section of the statute, in 42 U.S.C. § 1395ww(g), and therefore a rural reclassification under the subsection (d) operating PPS provisions does not apply for subsection (g) capital PPS purposes.”⁶³

The Providers believe that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(g), and the regulation must be found invalid.⁶⁴ The Providers assert that “the Secretary has implicitly acknowledged that he cannot apply rural status for hospitals that have undergone a rural reclassification to payment provisions outside of subsection (d),” and provides as an example, that “the Secretary has stated with respect to direct graduate medical education (“GME”) that no adjustment to the direct GME cap are available for urban hospitals that have reclassified as rural because subsection (d) reclassification ‘affects only payments under section 1886(d) of the Act,’

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ *Id.* at *30.

⁶¹ *Id.*

⁶² Request for EJR at 7.

⁶³ *Id.* at 1, 7.

⁶⁴ *See id.* at 7-8.

and ‘payment for direct GME are made under section 1886(h) of the Act.’”⁶⁵ Further, the regulation fails to take into account any variation in cost based on location, as the capital PPS statute permits at 42 U.S.C. § 1395ww(g)(1)(B)(ii).⁶⁶

The Providers assert that “[t]he Secretary’s adoption of the regulation was arbitrary and capricious and violates the Administrative Procedure Act” because he “failed to establish that the adoption of the exception to the capital DSH adjustment, for providers that reclassified as rural, took ‘into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located.’”⁶⁷

Though 42 C.F.R. § 412.320(a)(1)(iii) has not been vacated, the Providers argue that the merits of their position were adopted by the D.C. District Court in *Toledo*.⁶⁸ Further, the Providers contend that the Secretary adopted the FY 2024 hospital IPPS proposed rule in which the Secretary, in response to *Toledo*, proposed to amend 42 C.F.R. § 412.320(a)(1)(iii). Specifically, effective for discharges occurring on or after October 1, 2023, an urban hospital that is reclassified as rural under § 412.103 “will no longer be considered rural for purposes of determining capital DSH eligibility. Instead, for purposes of § 412.320, the geographic classifications specified under § 412.64 will apply.”⁶⁹ However, the Providers explain that “for the periods under appeal, CMS and its contractors will continue to apply the 2006 regulation, denying capital DSH to the Providers for these periods.”⁷⁰

The Providers further contend that since the Board is bound by the regulation being challenged,⁷¹ namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), it lacks the authority to decide the legal question presented in the Providers’ Request for EJR. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.⁷²

Board Decision

1. Jurisdiction

Based on its review of the record, the Board finds that it has jurisdiction over each Provider in each case. The Providers have appealed from original NPRs or from the failure of the Medicare Contractor to timely issue an NPR. Each of the participants in these group appeals filed their appeals within 180 days of the issuance of their respective final determinations, or within 180 days after the twelve month period in which the Medicare Contractor was to issue a final determination,⁷³ as required by 42 C.F.R. § 405.1835; the providers in each case appealed the

⁶⁵ *Id.* at 8 (citing 70 Fed. Reg. 47278, 47437 (Aug. 12, 2005)).

⁶⁶ *Id.*

⁶⁷ *Id.* at 8-9.

⁶⁸ *Id.* at 9-10.

⁶⁹ *Id.* at 10 (citing 88 Fed. Reg. 58640, 59117, 59334 (Aug. 28, 2023)).

⁷⁰ *Id.*

⁷¹ *See* 42 C.F.R. § 405.1867.

⁷² Request for EJR at 10-12.

⁷³ Medicare Contractors must issue an NPR within twelve months of receiving a Provider’s perfected cost report. Providers are afforded the right to appeal if this NPR is not timely received pursuant to 42 C.F.R. § 405.1835(c), which states:

issue in their respective appeals; and the Board is not precluded by regulation or statute from reviewing the issue in these appeals. Finally, in each case, the amount in controversy meets the \$50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3).

The Board lacks the authority to decide the legal question presented here because it is a challenge to the validity of a regulation, namely 42 C.F.R. § 412.320(a)(1)(iii).⁷⁴ All of the providers in these two (2) groups, however, are subject to the substantive claim regulations at 42 C.F.R. §§ 413.24 and 405.1873.

2. Jurisdiction – Appropriate Cost Report Claim (FYE beginning on or after to December 31, 2016)

In the November 13, 2015 Final Outpatient Prospective Payment Rule,⁷⁵ the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.⁷⁶ The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement ("NPR") issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). Since all the participants in Cases 24-2564GC and 25-0191GC have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement or the Board's *jurisdiction* is not applicable.

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- (1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's *perfected cost report* or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.
 - (2) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section) . . .

⁷⁴ 42 C.F.R. § 405.1842(f)(1)(ii).

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

⁷⁶ *Id.* at 70555.

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

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

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

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

- (a) *General.* In order to receive or potentially receive reimbursement for a specific item, the provider must include in its cost report an appropriate claim for the specific item (as prescribed

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

These regulations are applicable to the cost reporting periods under appeal for all of the participants in these group appeals, which all have cost reporting periods ending on or after December 31, 2016. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"⁷⁷ 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.⁷⁸

4. Substantive Claim Challenges

In these two (2) group cases, the Providers' Rule 20 certification was filed on **November 5, 2025**, the same day the Request for EJRs was filed. Thus, pursuant to Board Rule 44.6, the Medicare Contractor had five business days (*i.e.*, until **November 12, 2025**) to either file any Substantive Claim Challenges or certify that it would be filing a challenge. On **November 12, 2025**, the Medicare Contractor's designated representative, Federal Specialized Services ("FSS") filed a Response to Providers' EJR Request, noting that substantive claim challenges would be filed in Cases 24-2564GC and 25-0191GC.

Based on this timely certification, the deadline for any Substantive Claim Challenges in these cases was **Tuesday, November 25, 2025**. The Board notes that FSS filed timely Substantive Claim Challenges in both group cases.

Based on the foregoing, and pursuant to Board Rule 44.6, the Board issued a Scheduling Order to set a deadline (**Tuesday, December 16, 2025**) for the Providers' responses to the two (2) Substantive Claim Challenges filed in cases 24-2564GC and 25-0191GC. The Board notes that the Providers filed timely responses in each case on **December 11, 2025**.

⁷⁷ 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."

⁷⁸ See 42 C.F.R. § 405.1873(a).

A. Medicare Contractor's Challenges

FSS filed Substantive Claim Challenges over a number of participants in these two (2) cases as outlined below, which will collectively be referred to as “the Challenged Participants.”

i. Case 24-2564GC

FSS asserts the following Provider did not make an appropriate claim for the Rural Capital DSH issue on its cost report:

- Penn State Health St. Joseph; Provider No, 39-0096, Fiscal Year Ending (FYE) 6/30/2021⁷⁹

FSS argues that this Provider filed its relevant cost report identifying a specific amount in Part A Protested Amounts, as well as a Summary of Protested Amounts. These documents, however, indicate that the Provider did not include a protested amount for the Capital DSH issue under dispute, and therefore it failed properly claim a self-disallowed item for the Capital DSH issue and failed to include an appropriate claim for the specific item sought as prescribed in 42 C.F.R. § 413.24(j).⁸⁰

ii. Case 25-0191G

FSS asserts all six (6) Providers in this group did not make an appropriate claim for the Rural Capital DSH issue on their cost reports. This includes the three (3) appeals taken from NPRs:

- Mayo Clinic Health System Eau Claire Hospital (Prov. No. 52-0070, FYE 12/31/2021)⁸¹
- Mayo Clinic Health System Mankato (Prov. No. 24-0093, FYE 12/31/2021)⁸²
- Mayo Clinic Health System Franciscan Medical Center La Crosse (Prov. No. 52-0004, FYE 12/31/2021)⁸³

This also includes the three (3) appeals taken from the failure of the Medicare Contractor to issue a timely final determination:

- Mayo Clinic Hospital Rochester (Prov. No. 24-0010, FYE 12/31/2021)⁸⁴
- Mayo Clinic (Prov. No. 10-0151, FYE 12/31/2021)⁸⁵
- Mayo Clinic Hospital (Prov. No. 03-0103, FYE 12/31/2021)⁸⁶

FSS argues that each Provider filed its relevant cost report identifying a specific amount in Part A Protested Amounts, as well as a Summary of Protested Amounts. These documents, however,

⁷⁹ Case No. 24-2564GC, MAC's Substantive Claim Challenge at 1 (Nov. 19, 2025).

⁸⁰ *Id.* at 4.

⁸¹ Case No. 25-0191GC, MAC's Substantive Claim Challenge at 8 (Nov. 21, 2025).

⁸² *Id.* at 6.

⁸³ *Id.* at 7.

⁸⁴ *Id.* at 5.

⁸⁵ *Id.* at 4.

⁸⁶ *Id.*

indicate that the Providers did not include a protested amount for the Capital DSH issue under dispute, and therefore each provider failed properly claim a self-disallowed item for the Capital DSH issue and failed to include an appropriate claim for the specific item sought as prescribed in 42 C.F.R. § 413.24(j).

For Mayo Clinic Health System Eau Claire Hospital (Prov. No. 52-0070, FYE 12/31/2021) in Case 25-0191GC (“Mayo Eau Claire”), specifically, the Medicare Contractor argues:

Referring to 42 C.F.R. § 413.24(j)(1)(ii) and (j)(2)(i) & (ii) the MAC notes that the Provider filed its FYE 12/31/2021 Medicare Cost Report identifying \$919,796 in Part A Protested Amounts. Along with its cost report, the Provider submitted a Summary of Calculated Protest Amounts which also totaled \$919,796 in Part A Protested Amounts. The MAC notes that the Provider included a protested amount of \$208,308 attributed to “Capital DSH – rural status/urban for wage index”. However, further review of the Summary of Protested Amounts reveals that this item is related to the Provider’s Uncompensated Care reimbursement and is not related to the Capital DSH item that is on appeal in this case. Accordingly, the Provider failed to properly establish a self-disallowed item for the appealed item as required by 42 C.F.R. § 413.24(j)(2).⁸⁷

iii. “Non-Challenged Participants”

For all remaining participants in these two (2) group cases (collectively “the Non-Challenged Participants”), since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,⁸⁸ the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d) for the Non-Challenged Participants.

B. Providers’ Responses

The Providers filed a consolidated response to the Substantive Claim Challenges.⁸⁹ For the Challenged Participants *except for* Mayo Eau Claire, the Providers argue that, while they “did not claim Capital DSH as an allowable cost or protested amount for the year at issue, [they] did self-disallow the issue based on the [Medicare Contractor] being bound by 42 C.F.R. § 412.320(a)(1)(iii).”⁹⁰ They also argue that the substantive claim requirements found in 42 C.F.R. §§ 413.320(j) and 405.1873 are unlawful and seek to challenge their validity.⁹¹ They claim that

⁸⁷ *Id.* at 9 (citations omitted).

⁸⁸ The Board notes that Board Rule 10.2 states: “If the Medicare contractor opposes a provider’s expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44.”

⁸⁹ Providers’ Response to FSS’s Substantive Claim Challenges and Petition for Expedited Judicial Review of the Validity of 42 C.F.R. §§ 413.24(j) and 405.1873 (Dec. 11, 2025) (“Response to Substantive Claim Challenges”).

⁹⁰ *Id.* at 3.

⁹¹ *Id.* at 1, 9.

these regulatory provisions “contravene the Board’s authority as set forth in 42 U.S.C. § 1395oo.”⁹² They cite *Bethesda Hosp. Ass’n v. Bowen*⁹³ and *Banner Heart Hospital v. Burwell*⁹⁴ in support of their position that these regulations are unlawful.⁹⁵

For the Challenged Providers except for Mayo Eau Claire, the Providers concede that “there is no dispute that the Providers did not claim the capital DSH costs at issue either as an allowable cost or a protested amount[.]”⁹⁶

For Mayo Eau Claire, the Provider argues that it did file “a protest item challenging its Capital DSH Reimbursement on its FY 2021 cost report.”⁹⁷ It claims that the protested item support for its appeal

plainly shows that (1) Mayo Eau Claire claimed protested amounts on Worksheet E, Part A, Line 75 and (2) that capital DSH was one of the individual protested issues and amounts on the Summary of Calculated Protest Amounts and the accompanying calculation Mayo Eau Claire submitted with its applicable FY 2021 cost report. Exhibit C-9, Pages 3, 5-6. Thus, regardless of the narrative in Mayo Eau Claire’s Summary of Calculated Protested Amounts, Mayo Eau Claire adequately identified capital DSH as a protested issue included on the protested line of the FY 2021 as-filed cost report and thereby complied with 42 C.F.R. § 413.24(j)(2).⁹⁸

The Providers request the Board grant EJRs for both cases over the Capital DSH issue, as well as the substantive claim regulations for the Challenged Participants except for Mayo Eau Claire since it complied with the substantive claim requirements.⁹⁹

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))”¹⁰⁰ may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement, rather than a jurisdictional one.* Nevertheless, when granting EJRs, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law as to whether an appropriate claim was included.

For the Non-Challenged Participants, the Board need not make any findings of fact or

⁹² *Id.* at 9.

⁹³ 485 U.S. 399 (1988).

⁹⁴ 201 F.Supp.3d 131 (D.D.C. 2016)

⁹⁵ Response to Substantive Claim Challenges at 9-13.

⁹⁶ *Id.* at 9.

⁹⁷ *Id.* at 4.

⁹⁸ *Id.* at 8-9.

⁹⁹ *Id.* at 15-16.

¹⁰⁰ (Emphasis added.)

conclusions of law with regard to whether an appropriate cost report claim was made since no party has raised the question.

Except for Mayo Eau Claire, the Challenged Participants generally do not dispute that they did not claim Capital DSH as an allowable cost or protested amount for the year at issue. They note that they did self-disallow the issue based on the Medicare Contractor being bound by 42 C.F.R. § 412.320(a)(1)(iii),¹⁰¹ but they do not dispute FSS' assertion that there is insufficient support for the allegedly protested items. There were no worksheets describing how the providers calculated the estimated reimbursement for this specific item accompanying the cost report as required by 42 C.F.R. § 413.24(j)(2)(ii). The Board finds that no appropriate claim was made when granting EJRs for these participants.

For Mayo Eau Claire, the relevant cost report lists \$919,796 in protested amounts.¹⁰² The protested items summary accompanying the cost report lists Uncompensated Care Protest Issues for \$25,000, with no narrative following this line item. Immediately following this line item, the support lists Capital DSH – rural status/urban for wage index for \$208,308, with a narrative underneath related to uncompensated care.¹⁰³

The “summary of DSH reimbursement” which immediately follows the summary of protested items, describes the Medicare Capital DSH Adjustment and the figures which illustrate its protest and reimbursement impact.¹⁰⁴

The regulation at 42 C.F.R. § 413.24(j)(1) requires a Provider to *either* claim full reimbursement in its cost report for a specific item *or* self-disallow the specific item by following the procedures set forth in §413.24(j)(2). Those procedures require a Provider to (1) include an estimated reimbursement impact on the cost report, and (2) attach a work sheet for each specific item, *explaining why the provider self-disallowed each specific item* and describing how the provider calculated the estimated reimbursement impact.

Mayo Eau Claire did include an estimated reimbursement impact for its protested items on the cost report. It also attached a work sheet which illustrates how the estimated reimbursement impact for the DSH Capital DSH issue was calculated (*i.e.*, what figures on the cost report should be changed and the impact that would have). The work sheet *does not*, however, “explain[] why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item)” as required by 42 C.F.R. § 413.24(j)(2).

The Board has reviewed the record for Mayo Eau Claire, including Exhibit C-9 to the Substantive Claim Challenge in Case 25-0191GC. Based on the foregoing, the Board finds that Mayo Eau Claire **did not** comply with the regulations requiring it to make an appropriate cost report claim or self-disallow the specific item under appeal.

¹⁰¹ Response to Substantive Claim Challenges at 3-4.

¹⁰² Case No. 25-0191GC, MAC's Substantive Claim Challenge, Ex. C-9 at 3.

¹⁰³ *Id.* at 5.

¹⁰⁴ *Id.* at 6.

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

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that all the participants in Cases 24-2564GC and 25-0191GC are entitled to a hearing before the Board;
- 2) The review process in 42 C.F.R. § 405.1873(a)-(b) has been triggered for the Challenged Participants and the Board specifically finds that, except for Mayo Eau Claire, it is undisputed that these participants 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 on its review of the record, Mayo Eau Claire in Case 25-0191GC **did not** comply with the regulations requiring it to make an appropriate cost report claim or self-disallow the specific item under appeal, specifically 42 C.F.R. § 413.24(j)(2) which required it to “explain[] why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item)”;
- 4) The review process in 42 C.F.R. § 405.1873(a)-(b) has not been triggered for the remaining Non-Challenged Providers and, therefore, there are no findings regarding whether their cost reports included appropriate claims for the specific item at issue in these appeals;
- 5) Based upon the participants’ assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), there are no findings of fact for resolution by the Board;
- 6) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 7) It is without the authority to decide the legal questions of:
 - a. Whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid; and
 - b. For the Challenged Participants, whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid.¹⁰⁵

¹⁰⁵ The Board recognizes that this question relates only to some of the participants in these groups and, as such, does not apply to all the full groups. As a result, it would appear to run afoul of 42 C.F.R. § 405.1837(g) and potentially require bifurcation. However, the Board finds that this is not so in this case. Compliance with 42 C.F.R. § 413.24(j) is substantive in nature (*i.e.*, directly impacts potential reimbursement), but does not affect the issue that is the subject of the appeal. Similar to review under 42 C.F.R. § 405.1840 of jurisdictional or claims-filing requirements, a provider’s compliance with § 413.24(j) relates to the nature of the provider’s *participation* in the group (as set forth in 42 C.F.R. § 405.1873) and is only triggered when, pursuant to § 405.1873(a) *as a procedural matter in the proceedings before the Board*, a party raises their hand and questions the provider’s compliance with § 413.24(j). As a result, the Board finds that potential bifurcation has not been triggered under § 405.1837(f). This situation is akin to the Board denying jurisdiction over one participant in a group but granting EJR relative to the rest of the group. Judicial review remains

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' EJR Request for the issue and the subject years in Cases 24-2564GC and 25-0191GC. The Board also finds that the question of the validity of the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Challenged 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. The Board's jurisdictional determination is subject to review under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. § 405.1875 and 405.1877. Since this is the only issue under dispute in these cases, the Board hereby closes the cases and removes them from the Board's docket.

Board Members Participating:

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

FOR THE BOARD:

1/6/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA

Board Chair

Signed by: Kevin D. Smith -A

Enclosure: Schedules of Providers

cc: Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-L)
Pamela VanArsdale, National Government Services, Inc. (J-6)
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RE: ***Expedited Judicial Review Determination***
Case No. 25-1032GC *et al.* (seven cases – **see Appendix A**)

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (“Board”) has reviewed the Providers’ Petitions for Expedited Judicial Review (“EJR”) filed on **December 11 and 17, 2025** in the above-referenced appeals. The Board’s decision on jurisdiction and EJR is set forth below.

Background and Issue:

In **December, 2024**, the Board received seven (7) requests to establish Common Issue Related Party (“CIRP”) groups. The Providers in all seven (7) groups are appealing from revised Notices of Program Reimbursement (“RNPRs”) which implement the final rule published in the June 9, 2023 Federal Register (“June 2023 Final Rule”)¹ as it pertains to the Providers’ Fiscal Year Ends (“FYE”) in 2007 through 2010.

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 Provider is seeking to challenge the CMS policy adopted in the June 2023 Final Rule to be applied *retroactively* for periods prior to October 1, 2013.³

¹ 88 Fed. Reg. 37772 (June 9, 2023).

² *E.g.*, Case No. 25-1032GC, Statement of Issue at 1 (Dec. 11, 2024).

³ *Id.* at 2-5.

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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 subchapter¹¹

⁴ See 42 U.S.C. § 1395ww(d)(1)-(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. § 412.106(c)(1).

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.)

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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 Secretary¹⁵ 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.

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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:

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).

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. . . 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.

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).

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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

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.

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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”:

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).

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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).

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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 retroactive⁴⁸ 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

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. 25-1032GC, 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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rulemaking.

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

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

B. 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 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 NPRs and RNPRs implementing the retroactive Part C Days policy even if a Provider's SSI Ratio does not change numerically.⁵⁶

On **December 18 and 24, 2025**, the Medicare Contractor's representative, Federal Specialized Services, filed responses to the Requests for EJR simply advising that "a jurisdictional challenge will not be filed, a substantive claim challenge will not be filed and the MAC does not oppose the request [for EJR]."⁵⁷

Decision of the Board:

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

A. Jurisdiction

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

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

⁵⁴ *Id.* at ¶¶ 6-18.

⁵⁵ *E.g.*, Case No. 25-1032GC, Providers' Petition for Expedited Judicial Review at 1-4 (Dec. 11, 2025).

⁵⁶ *Id.* at 11.

⁵⁷ *E.g.*, Case No 25-1032GC, Response to Provider's Request for Expedited Judicial Review at 1 (Dec. 18, 2025).

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their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination;⁵⁸

- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, \$50,000 or more.⁵⁹

For these seven (7) CIRP groups, the providers all appealed from revised NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. All the providers were directly added to their respective groups within 180 days of the issuance of their RNPRs and the amount in controversy exceeds \$50,000 in each case.

The Board finds that the Providers in the seven (7) cases listed in **Appendix A** have filed timely appeals from their revised NPRs concerning the issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these RNPRs. The Board also finds that the amount in controversy exceeds \$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 EJRs 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 seven (7) cases listed in **Appendix A** and that the Providers in each group appeal are entitled to a hearing before the Board;
- 2) Based upon the Providers' assertions regarding the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether the Part C Days policy issue, as adopted on a retroactive basis in the June 9, 2023 Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, properly falls within the provisions of 42 U.S.C.

⁵⁸ 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).

⁵⁹ 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

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§ 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 seven (7) 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:

1/6/2026

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)
Byron Lamprecht, WPS Government Health Administrators (J-5)
Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Scott Berends, Federal Specialized Services

EJR Determination*Blumberg Ribner CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Groups*PRRB Case Nos. 25-1032GC *et al.* (seven cases – see **Appendix A**)

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Appendix A

Case Number	Case Name
25-1032GC	<i>SSM Health CY 2008 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group</i>
25-1042GC	<i>MaineHealth CY 2010 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group</i>
25-1060GC	<i>MaineHealth CY 2009 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group</i>
25-1211GC	<i>LCMC Health CY 2007 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group</i>
25-1214GC	<i>LCMC Health CY 2009 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group</i>
25-1188GC	<i>LCMC Health CY 2008 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group</i>
25-1192GC	<i>East Texas Regional HS CY 2010 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group</i>



Provider Reimbursement Review Board
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Via Electronic Delivery

Daniel Hettich
King & Spalding, LLP
1700 Pennsylvania Avenue NW
Suite 900
Washington, DC 20006

RE: ***EJR Determination***
Covenant Medical Center (Provider Number 45-0040)
Case Number: 26-0715
FYE: 6/30/2024

Dear Mr. Hettich:

The Provider Reimbursement Review Board (“Board”) has reviewed the request for expedited judicial review (“EJR”) filed on **December 19, 2025** for the above referenced case. The decision of the Board is set forth below.

Background:

The Board received an individual appeal request from Covenant Medical Center (“Provider”) on **December 12, 2025**, appealing from the failure of its Medicare Contractor to issue a timely final determination.¹ The Provider’s cost report for its Fiscal Year Ending (“FYE”) June 30, 2024, was received by the Medicare Contractor on **November 27, 2024**, and the Provider asserts that

¹ 42 U.S.C. § 1395oo(a)(1) and (3); *see also* *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986). Medicare Contractors must issue an NPR within twelve months of receiving a Provider’s perfected or amended cost report. Providers are afforded the right to appeal if this NPR is not timely received pursuant to 42 C.F.R. § 405.1835(c), which states:

(1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped “Received” on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.

(2) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section) . . .

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no Notice of Program Reimbursement (“NPR”) had been received at the time of its appeal request. The sole issue in this appeal concerns the exclusion of § 1115 Waiver Days from the Medicare fraction of the disproportionate share hospital (“DSH”) payment formula. The Provider estimates the amount in controversy for this issue to be \$2,020,895. The appeal also contains evidence that the § 1115 Waiver Days in question were protested in its cost report.

The issue statement is framed as follows:

This appeal challenges CMS’s policy—adopted in the inpatient prospective payment system final rule for FY 2024, 88 Fed. Reg. 58640, 59016 (Aug. 28, 2023), and codified at 42 C.F.R. § 412.106(b)(4)(iii)—of excluding the days of “[p]atients whose health care costs, including inpatient hospital services costs, for a given day are claimed for payment by a provider from an uncompensated, undercompensated, or other type of funding pool authorized under section 1115(a) of the Act to fund providers’ uncompensated care costs” from the Medicaid fraction of the Medicare DSH payment formula. The Provider specifically challenges section 412.106(b)(4)(iii) as it applies to the Provider’s DSH payment for the reporting period under appeal.

Effective October 1, 2023, CMS’s new regulation bars hospitals from claiming patient days attributable to individuals whose inpatient hospital services were eligible to be covered in whole or in part by an uncompensated care pool established under a waiver approved by CMS pursuant to Section 1115 of the Social Security Act. This is unlawful because CMS is required to include in the Medicaid fraction all patients it has regarded as eligible for Medicaid under a Section 1115 waiver. 42 U.S.C. § 1395ww(d)(5)(F)(vi). Patients whose care is eligible for coverage under an uncompensated care pool that was established under a CMS-approved Section 1115 waiver are regarded as eligible for Medicaid. *See Forrest General Hospital v. Azar*, 926 F.3d 221, 229 (5th Cir. 2019); *Bethesda Health, Inc. v. Azar*, 389 F. Supp. 3d 32, 47 (D.D.C. 2019) *aff’d*, 980 F.3d 121 (D.C. Cir. 2020).

The Provider in this appeal is a hospital located in the State of Texas. The Texas Medicaid program provides coverage to uninsured patients who receive some or all their hospital services free of charge under the hospital’s charity care policy. Payments for this coverage are drawn from an uncompensated care (UC) pool authorized under the Texas Healthcare Transformation and Quality Improvement Program—a waiver approved by the Secretary of Health and Human Services (the Secretary) pursuant to section 1115(a)(2) of the Social Security Act (the Texas Section

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1115 Waiver). Because the patients covered by the UC pool receive inpatient hospital benefits from a Section 1115 waiver, the Medicare statute regards them as eligible for Medicaid. Accordingly, the statute requires the Secretary to include the inpatient days attributable to these individuals in the Medicaid fraction of the Medicare DSH calculation. CMS's regulation defies this command.

During the cost reporting period under appeal, the Provider treated patients whose care was covered in part or whole by the UC pool approved under the Texas Section 1115(a)(2) waiver. But in accordance with section 412.106(b)(4)(iii), the Provider did not claim the patient days associated with those individuals. Instead, the Provider protested the exclusion of Section 1115 UC Pool days in filing the cost report for the period under appeal.²

On **December 19, 2025**, the Providers' Representative, King & Spalding, LLP, filed a Petition for Expedited Judicial Review ("EJR Request") for the § 1115 Waiver Days issue.

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").³ Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.⁴

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.⁵ This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.⁶

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").⁷ 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.⁸ The DPP is defined as the sum of two fractions expressed as percentages.⁹ Those two

² Case No. 26-0715, Statement of the Issue at 1 (Dec. 12, 2025).

³ See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

⁴ *Id.*

⁵ See 42 U.S.C. § 1395ww(d)(5).

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

⁷ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

⁸ See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

⁹ See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

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fractions are referred to as the “Medicare/SSI fraction” and the “Medicaid fraction.” Both of these fractions consider whether a patient was “entitled to benefits under part A.”

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

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare and Medicaid Services (“CMS”), and the Medicare contractors use CMS’ calculation to compute a hospital’s DSH payment adjustment.¹⁰

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.

In determining under [this subclause] the number of the hospital’s patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under subchapter XI.

The Medicare contractor determines the number of the hospital’s patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.¹¹

¹⁰ 42 C.F.R. § 412.106(b)(2)-(3).

¹¹ 42 C.F.R. § 412.106(b)(4).

Until its recent amendment, the implementing regulation at 42 C.F.R. § 412.106(b)(4) (2022) read, with regard to computing the Medicaid Fraction:

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.*¹²

B. Background on Medicaid State Plans and § 1115 Waivers

Medicaid is a joint Federal and state program, established in Title XIX of the Social Security Act (the "Act").¹³ To participate in the Medicaid program and receive federal matching funds (commonly referred to as federal financial participation or "FFP"), a state must enter into an agreement ("State Plan") with the Federal government, describing the individuals covered, services provided, reimbursement methodologies for providers, and other administrative activities.¹⁴

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

¹² (Italics emphasis added.)

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

¹⁴ *Id.*

¹⁵ 42 U.S.C. § 1315(a)(2)(A).

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

In 2003, however, the Secretary amended the DSH regulation to specify that a patient shall be “deemed eligible for Medicaid on a given day only if the patient is *eligible for inpatient hospital services* under a [State Plan] or under a waiver authorized under section 1115(a)(2).”¹⁹ The rationale was that “certain section 1115 demonstration projects . . . serve expansion populations with benefit packages so limited that the benefits are not similar to the medical assistance available under a Medicaid State plan.”²⁰ The purpose of the refinement was to include in the Medicaid Fraction only days of waiver populations where they were provided inpatient hospital benefits equivalent to the care provided to beneficiaries under a Medicaid State Plan.²¹ To achieve this, the DSH regulation at 42 C.F.R. § 412.106(b)(4)(i) was amended to specify that “a patient is deemed eligible for Medicaid on a given day **only if the patient is eligible for inpatient hospital services** under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day”²²

In 2006, Congress passed the Deficit Reduction Act of 2005, which amended 42 U.S.C. § 1395ww(d)(5)(F)(vi)²³ by adding the following language below subclause (II):

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

The Secretary has interpreted this amendment as confirming that waiver day groups’ days are not automatically “eligible for Medicaid under a State plan,” that he has the discretion to determine

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

¹⁷ 65 Fed. Reg. at 3136.

¹⁸ *Id.* at 3136-3137. *See also* 65 Fed. Reg. 47054, 47086-47087 (Aug. 1, 2000).

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

²⁰ *Id.* at 45420.

²¹ *See* 88 Fed. Reg. 58640, 59014 (Aug. 28, 2023).

²² (2022) (emphasis added).

²³ Pub. L. 109-171, § 5002, 120 Stat. 4, 31 (2006).

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the extent to which patients are “not so eligible,” and to what extent, if any, they may be “regarded as eligible” and thus included in the Medicaid fraction.²⁴

To this end, the Secretary has noted a rise in § 1115 waiver demonstrations which authorize funding a limited and narrowly circumscribed set of payments to hospitals, such as § 1115 demonstrations which include funding for uncompensated/undercompensated care pools. These pools do not extend health insurance to individuals or benefits similar to Medicaid beneficiaries under a State plan. Instead, they provide funds directly to hospitals to offset treatment costs for uninsured and underinsured patients.²⁵ As such, these days have been typically excluded from the Medicaid fraction of the DSH calculation because the days associated with these § 1115 demonstrations do not create inpatient hospital eligibility.

In the FY 2022 IPPS/LTCH proposed rule,²⁶ the Secretary acknowledged that several court decisions have disagreed with this approach and ruled that 42 C.F.R. § 412.106(b)(4) requires the inclusion of days “for which hospitals have received payment from an uncompensated care pool authorized by a [§] 1115 demonstration.”²⁷ Thus, in the same FY 2022 IPPS/LTCH PPS proposed rule, the Secretary proposed to revise the regulation “to ensure that the only section 1115 days that may be counted in the numerator of the Medicaid fraction are the days of patients for whom a section 1115 waiver provides inpatient hospital insurance coverage benefits directly to that patient on that day.”²⁸ After reviewing comments on the proposal, the Secretary proposed different revisions to the regulations in the FY 2023 IPPS/LTCH PPS proposed rule,²⁹ but opted not to finalize them after reviewing comments on the proposal.³⁰

Finally, in a proposed rule published on February 28, 2023,³¹ the Secretary proposed revisions to the regulations “on the counting of days associated with individuals eligible for certain benefits provided by section 1115 demonstrations[.]”³² Thereafter, in the FY 2024 Final Rule, he announced that “we are modifying our regulations to explicitly state our long-held view that only patients who receive health insurance through a section 1115 demonstration where State expenditures to provide the insurance may be matched with funds from title XIX can be ‘regarded as’ eligible for Medicaid.”³³ He also finalized a proposed amendment “to state specifically that patients whose inpatient hospital costs are paid for with funds from an uncompensated/undercompensated care pool authorized by a section 1115 demonstration are not patients ‘regarded as’ eligible for Medicaid, and the days of such patients may not be included in the DPP Medicaid fraction numerator.”³⁴

²⁴ 88 Fed. Reg. at 59014.

²⁵ *Id.* at 59015.

²⁶ 86 Fed. Reg. 25070 (May 10, 2021).

²⁷ *Id.* at 25458-59 (citing *Bethesda Health, Inc. v. Azar*, 980 F.3d 121 (D.C. Cir. 2020); *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. 2018)).

²⁸ *Id.* at 25459.

²⁹ 87 Fed. Reg. 28108 (May 10, 2022).

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

³¹ 88 Fed. Reg. 12623 (Feb. 28, 2023).

³² *Id.* at 12623.

³³ 88 Fed. Reg. at 59016.

³⁴ *Id.*

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Thus, effective October 1, 2023, 42 C.F.R. § 412.106(b)(4) (2023) now reads:

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 patients who were not entitled to Medicare Part A, and who were either eligible for Medicaid on such days as described in paragraph (b)(4)(i) of this section or who were regarded as eligible for Medicaid on such days and the Secretary has determined to include those days in this computation as described in paragraph (b)(4)(ii)(A) or (B) of this section. The fiscal intermediary then 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 eligible for Medicaid on a given day if the patient is eligible on that day for inpatient hospital services under a State Medicaid plan approved under title XIX of the Act, regardless of whether particular items or services were covered or paid for on that day under the State plan.

(ii) For purposes of this computation, a patient is regarded as eligible for Medicaid on a given day if the patient receives health insurance authorized by a demonstration approved by the Secretary under section 1115(a)(2) of the Act for that day, where the cost of such health insurance may be counted as expenditures under section 1903 of the Act, or the patient has health insurance for that day purchased using premium assistance received through a demonstration approved by the Secretary under section 1115(a)(2) of the Act, where the cost of the premium assistance may be counted as expenditures under section 1903 of the Act, and in either case regardless of whether particular items or services were covered or paid for on that day by the health insurance. Of these patients regarded as eligible for Medicaid on a given day, only the days of patients meeting the following criteria on that day may be counted in this second computation:

(A) Patients who are provided by a demonstration authorized under section 1115(a)(2) of the Act health insurance that covers inpatient hospital services; or

(B) Patients who purchase health insurance that covers inpatient hospital services using premium assistance provided by a demonstration authorized under section 1115(a)(2) of the Act and the premium assistance accounts for 100 percent of the premium cost to the patient.

(iii) Patients whose health care costs, including inpatient hospital services costs, for a given day are claimed for payment by a provider from an uncompensated, undercompensated, or other type of funding pool authorized under section 1115(a) of the Act to fund providers' uncompensated care costs are not regarded as eligible for Medicaid for purposes of paragraph (b)(4)(ii) of this section on that day and the days of such patients may not be included in this second computation.

Provider's Request for EJR:

The Provider is seeking EJR to challenge the validity of the regulatory amendments to 42 C.F.R. § 412.106(b)(4)(iii) which were finalized in the Federal Register published August 28, 2023.³⁵ The EJR Request restates the same arguments and supporting facts set forth in the Issue Statement,³⁶ and alleges that the Secretary's new regulation violates the Medicare Statute.³⁷ The Provider argues that if a patient underlying a given day were Medicaid-eligible or received benefits under a § 1115 demonstration project, that day should be included in the numerator of the Medicare Fraction without any exceptions or qualifications.³⁸

The Provider argues the "determination is unlawful because the Medicare statute does not afford the Secretary the discretion to exclude certain patients once he has conferred a benefit upon them by approving a section 1115 waiver."³⁹ The Provider claims that the justifications set forth by the Secretary to "carve[] out a sub-population of patients who receive inpatient benefits through an approved section 1115 uncompensated care pool" have been rejected by federal courts.⁴⁰ It argues the amended regulations "flout[] prior contrary and binding interpretations of the very statute [the Secretary] believes gives him the discretion to exclude certain categories of section 1115 beneficiaries from calculating the Medicaid fraction."⁴¹ Since the Board is bound by these new regulations, it therefore cannot provide the relief sought by the Provider and, as a result, the Provider is requesting EJR in order to challenge them.

Medicare Contractor's Response to Request for EJR:

The Medicare Contractor's designated representative, Federal Specialized Services ("FSS"), filed a Response to Provider's EJR Request on **December 24, 2025**. The response simply stated that "a jurisdictional challenge will not be filed, a substantive claim challenge will not be filed and the MAC does not oppose the request."⁴²

³⁵ Petition for Expedited Judicial Review at 1 (Dec. 19, 2025) ("EJR Request").

³⁶ *Id.* at 1-8.

³⁷ *Id.* at 8-10.

³⁸ *Id.* at 8-9 (citing *Forrest General Hospital v. Azar*, 926 F.3d 221, 228-229 (5th Cir. 2019)).

³⁹ *Id.* at 7 (citing *Forrest General Hospital*, 926 F.3d at 224 ("Once the Secretary authorizes a demonstration project, no take-backs.")).

⁴⁰ *Id.* at 9 (citing *Bethesda Health*, 389 F. Supp. 3d at 46-47; *Forrest Gen. Hosp.*, 926 F.3d at 229).

⁴¹ *Id.* at 10.

⁴² Response to Provider's Request for Expedited Judicial Review at 1 (Dec. 24, 2025).

Decision of the Board:

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

A. Jurisdiction

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

- It is dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a “final determination” related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination;⁴³ and
- The amount in controversy is \$10,000 or more.⁴⁴

The Board finds that the Provider filed an appeal from the failure of its Medicare Contractor to issue a timely final determination. The appeal was filed within 180 days of the expiration of the period in which the Medicare Contractor was to issue the Provider’s NPR and the amount in controversy exceeds \$10,000. The appeal challenges the validity of 42 C.F.R. § 412.106(b)(4) (2023) as published in the August 28, 2023, Final Rule. The Board, however, is without the authority to grant the relief requested: to declare this newly amended regulation substantively invalid because it violates the Medicare Statute.

B. Board’s Decision Regarding the EJR Requests

The Board finds that:

- 1) It has jurisdiction over the § 1115 Waiver Days issue, as set forth in the August 28, 2023 Federal Register, for the subject year in Case 26-0715 and that the Provider is entitled to a hearing before the Board;
- 2) Based upon the Provider’s assertions regarding the amendments to 42 C.F.R. § 412.106(b)(4) (2023) and the § 1115 Waiver Days issue, as set forth in the August 28, 2023 Federal Register, there are no findings of fact for resolution by the Board;

⁴³ 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).

⁴⁴ 42 U.S.C. § 1395oo(a)(2); 42 C.F.R. §§ 405.1835 – 1840.

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- 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 42 C.F.R. § 412.106(b)(4) (2023) and the § 1115 Waiver Days issue, as set forth in the August 28, 2023 Federal Register, is substantively valid.

Accordingly, the Board finds that the question of the validity of the § 1115 Waiver Days issue, as set forth in the August 28, 2023 Federal Register, 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 26-0715 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:

1/13/2026

X Kevin D. Smith, CPA

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

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



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RE: ***Expedited Judicial Review Determination***

25-1113GC *Northwell Health CY 2009 Post-Allina II DSH Part C Days CIRP Group*
25-4079GC *Univ of Florida Health CY 2013 Post-Allina II DSH Part C Days CIRP Group*
25-4084GC *Univ of Florida Health CY 2014 Post-Allina II DSH Part C Days CIRP Group*

Dear Ms. Webster:

The Provider Reimbursement Review Board (“Board”) has reviewed the Providers’ Petitions for Expedited Judicial Review (“EJR”) filed on **December 19, 2025** in the above-referenced appeals. The Board’s decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Board received requests to establish Common Issue Related Party (“CIRP”) groups for these three (3) cases in **December, 2024 and March, 2025**. The Providers 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 (“FYE”) spanning from 2009 to 2014.

The issue in these appeals is “the proper treatment in the Medicare disproportionate share hospital (“DSH”) calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute (“part C days”) in the aftermath of the *Allina II* litigation. The Providers 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. 25-1113GC, Statement of Group Issue at 1 (Dec. 19, 2024).

³ *Id.* at 2-3.

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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 subchapter¹¹

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

⁴ See 42 U.S.C. § 1395ww(d)(1)-(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. § 412.106(c)(1).

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).

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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 Secretary¹⁵ 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

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).

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

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

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

... We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days

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).

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*associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*²⁴

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

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

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

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

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* (“*Allina I*”),²⁹ vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005

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).

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IPPS rule.³⁰ In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.³¹ However, the Secretary has not acquiesced to that decision.

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

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.³⁹ On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as “CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in *Allina II*”:

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

³⁰ *Id.* at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

³¹ *Id.* at 2011.

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

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

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

³⁵ 139 S.Ct. 1804 (2019).

³⁶ *Id.* at 1817.

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

³⁸ 139 S.Ct. at 1814.

³⁹ 85 Fed. Reg. 47723 (Aug. 6, 2020).

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

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.⁴¹ The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

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

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

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

⁴⁰ CMS Ruling 1739-R at 1-2.

⁴¹ 88 Fed. Reg. 37772 (June 9, 2023).

⁴² 88 Fed. Reg. at 37788 (emphasis in original).

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

2. “We do not agree that it is arbitrary or capricious to treat hospitals’ Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II*. It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital’s appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary’s interpretation set forth in this final action.**⁴⁴
3. “Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions contained in the NPRs or revised NPRs.* Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights.* Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised NPRs will provide hospitals with a vehicle to appeal the new final action* even if the Medicare fraction or DSH payment does not change numerically.⁴⁵
4. “*When the Secretary’s treatment of Part C days in this final action is reflected in NPRs and revised NPRs, providers, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], will be able to challenge the agency’s interpretation by appealing those NPRs and revised NPRs.* While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings.”⁴⁶

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

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are “entitled to [Part A] benefits” within the context of 42 U.S.C. § 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.⁴⁷ It ruled,

⁴³ 88 Fed. Reg. at 37774-75 (emphasis added).

⁴⁴ *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).

⁴⁵ *Id.* at 37788 (emphasis added).

⁴⁶ *Id.* (emphasis added).

⁴⁷ *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).

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however, that the June 9, 2023 Final Rule is both impermissibly retroactive⁴⁸ 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 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

⁴⁸ *Id.* at *12-19.

⁴⁹ *Id.* at *19-22.

⁵⁰ *Id.* at *23.

⁵¹ *E.g.*, Case No. 25-1113GC, Appeal Request, Statement of Jurisdiction at 1 (citations omitted).

⁵² *E.g.*, Case No. 25-1113GC, Statement of Group Issue at 1.

⁵³ *Id.*

⁵⁴ *Id.* (citing to 139 S. Ct. at 1816).

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vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.⁵⁵

Based on the above, the Providers maintain that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule “is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, exceeds the agency’s statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence.”⁵⁶

B. Providers’ Petitions for EJR

The Providers have requested EJR over the “post-*Allina* retroactive Part C policy issue” because they believe they have met the requirements for a hearing before the Board, but the Board lacks the authority to decide the substantive and procedural validity of CMS’ final rule published in the Federal Register on June 9, 2023.⁵⁷ They seek a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.⁵⁸ “The Providers contend that the new, post-*Allina* retroactive part C days rule, applied in the [NPRs] appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency’s statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence.”⁵⁹ Since the Board is bound by this regulation,⁶⁰ it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

On **December 24, 2025**, the Medicare Contractor’s representative, Federal Specialized Services, filed timely responses to the Requests for EJR in all three (3) cases. It simply advised that, in each case, “a jurisdictional challenge will not be filed, a substantive claim challenge will not be filed, and the MAC does not oppose the request.”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.

⁵⁵ *Id.*

⁵⁶ *Id.* (citing 4 U.S.C. § 706(2)).

⁵⁷ *E.g.*, Case No. 25-1113GC, Provider’s Petition for Expedited Judicial Review at 13 (Dec. 19, 2025).

⁵⁸ *Id.* at 16-17.

⁵⁹ *Id.* at 1-2.

⁶⁰ 42 C.F.R. § 405.1867.

⁶¹ *E.g.*, Case No. 25-1113GC, Response to Provider’s Request for Expedited Judicial Review at 1 (Dec. 24, 2025).

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A. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a “final determination” related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination;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, \$50,000 or more for a group of providers.⁶³

For these three (3) CIRP group 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 Cases 25-1113GC, 25-4079GC, and 25-4084GC 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 Cases 25-1113GC, 25-4079GC, and 25-4084GC have all filed timely appeals from their original and 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 NPR and RNPRs. The Board also finds that the amount in controversy for each CIRP group appeal exceeds \$50,000 as required by 42 C.F.R. § 405.1837(a)(3). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

B. Board’s Decision Regarding the EJRs 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 Case Nos. 25-1113GC, 25-4079GC, and 25-4084GC, 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;

⁶² 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).

⁶³ 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

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- 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 Cases 25-1113GC, 25-4079GC, and 25-4084GC, the Board hereby closes these three (3) 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:

1/13/2026

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)
Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)
Scott Berends, Federal Specialized Services



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RE: *Expedited Judicial Review Determination*

Case Number: 25-1096GC *MaineHealth CY 2013 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*

Case Number: 25-1069GC *MaineHealth CY 2008 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*

Case Number: 25-1063GC *MaineHealth CY 2012 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*

Case Number: 25-1066GC *MaineHealth CY 2011 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (“Board”) has reviewed the Providers’ Petitions for Expedited Judicial Review (“EJR”) filed on **December 26, 2025** in the above-referenced appeals. The Board’s decision on jurisdiction and EJR is set forth below.

Background and Issue:

In **December, 2024**, the Board received four (4) requests to establish Common Issue Related Party (“CIRP”) groups. The Providers in all four (4) groups are appealing from revised Notices of Program Reimbursement (“RNPRs”) which implement the final rule published in the June 9, 2023 Federal Register (“June 2023 Final Rule”)¹ as it pertains to the Providers’ Fiscal Year Ends (“FYE”) in 2008, 2011, 2012 and 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 Provider is seeking to challenge the CMS policy adopted in the June 2023 Final Rule to be applied

¹ 88 Fed. Reg. 37772 (June 9, 2023).

² E.g., Case No. 25-1096GC, Statement of Issue at 1 (Dec. 18, 2024).

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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 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 subchapter¹¹

³ *Id.* at 2-5.

⁴ *See* 42 U.S.C. § 1395ww(d)(1)-(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. § 412.106(c)(1).

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.)

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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 Secretary¹⁵ 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.

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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:

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).

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. . . 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.

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).

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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

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.

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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”:

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).

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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).

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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 retroactive⁴⁸ 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

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. 25-1096GC, 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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rulemaking.

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

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

B. Providers' Petitions for EJ R

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

On **January 5, 2026**, the Medicare Contractor's representative, Federal Specialized Services, filed responses to the Requests for EJ R simply advising that "a jurisdictional challenge will not be filed, a substantive claim challenge will not be filed, and the MAC does not oppose the request [for EJ R]."⁵⁷

Decision of the Board:

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

A. Jurisdiction

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

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

⁵⁴ *Id.* at ¶¶ 6-18.

⁵⁵ *E.g.*, Case No. 25-1096GC, Providers' Petition for Expedited Judicial Review at 1-4 (Dec. 26, 2025).

⁵⁶ *Id.* at 11.

⁵⁷ *E.g.*, Case No. 25-1096GC, Response to Provider's Request for Expedited Judicial Review at 1 (Jan. 5, 2025).

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their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination;⁵⁸

- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, \$50,000 or more.⁵⁹

For these four (4) CIRP groups, the providers all appealed from revised NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. All the providers were directly added to their respective groups within 180 days of the issuance of their RNPRs and the amount in controversy exceeds \$50,000 in each case.

The Board finds that the Providers in Cases 25-1096GC, 25-1069GC, 25-1063GC, and 25-1066GC have filed timely appeals from their revised NPRs concerning the issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these RNPRs. The Board also finds that the amount in controversy exceeds \$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 EJRs Requests

The Board finds that:

- 1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in Cases 25-1096GC, 25-1069GC, 25-1063GC, and 25-1066GC and that the Providers in each group appeal are entitled to a hearing before the Board;
- 2) Based upon the Providers' assertions regarding the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether the Part C Days policy issue, as adopted on a retroactive basis in the June 9, 2023 Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, properly falls within the provisions of 42 U.S.C.

⁵⁸ 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).

⁵⁹ 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

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§ 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 25-1096GC, 25-1069GC, 25-1063GC, and 25-1066GC 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:

1/15/2026

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)
Scott Berends, Federal Specialized Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Jurisdictional Decision***

BJC Healthcare CY 2010 Improper Rulemaking SSI Fraction Dual Eligible Days CIRP Group, Case Number: 26-0520GC

BJC Healthcare CY 2010 DSH SSI Unduly Narrow Definition of SSI Entitlement CIRP Group, Case Number: 26-0519GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“PRRB” or “Board”) has reviewed the above-referenced common issue related party (“CIRP”) group appeals filed by Quality Reimbursement Service, Inc. (“QRS”) on its own motion. The pertinent facts and the Board’s determination are set forth below.

Pertinent Facts:

On **May 30, 2025**, the initiating provider in the subject groups, Boone Hospital Center (“Boone”/Provider Number 26-0068) was issued a Revised Notice of Program Reimbursement (“RNPR”) for fiscal year end (“FYE”) December 31, 2010.

On **November 24, 2025**, the Board received the BJC common issue related party (“CIRP”) groups:¹

- BJC Healthcare CY 2010 DSH SSI Unduly Narrow Definition of SSI Entitlement CIRP (“Unduly Narrow”) Group , Case No. 26-0519GC

AND

- BJC Healthcare CY 2010 Improper Rulemaking SSI Fraction Dual Eligible Days (“Improper Rulemaking”) CIRP Group, Case No. 26-0520GC

¹ QRS also filed a BJC Healthcare CIRP for the CY 2010 Improper Recalculation of SSI, under Case No. 26-0521GC.

In the **Unduly Narrow Group (Case No. 26-0519GC)**, the issue was summarized as follows:

The Provider(s) protest(s) CMS's policy of excluding unpaid SSI days from the numerator of the Medicare fraction. Despite CMS's seemingly contrary policy of treating unpaid Part A days as days entitled to benefits under Part A, CMS requires that a beneficiary be paid SSI benefits (or "covered" by SSI) during the period of his or her hospital stay in order for such days to be considered "entitled to supplemental security income benefits" and included in the numerator of the SSI fraction.

CMS's policy of applying different interpretations to the same term, "entitled," used in the same sentence of the statute is the epitome of arbitrary and capricious agency action and must be reversed. *See Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 20 n.1 (D.C. Cir. 2011) (Kavanaugh, J., concurring) ("HHS thus interprets the word 'entitled' differently within the same sentence of the statute. The only thing that unifies the Government's inconsistent definitions of this term is its apparent policy of paying out as little money as possible. I appreciate the desire for frugality, but not in derogation of law."); *see also Walter O. Boswell Mem'l Hosp. v. Heckler*, 749 F.2d 788, 799 (D.C. Cir. 1984) ("It would be arbitrary and capricious for [the Secretary] to bring varying interpretations of the statute to bear, depending upon whether the result helps or hurts Medicare's balance sheets....").

In rulemaking, commenters specifically requested that CMS include other payment codes that identified "entitled" individuals, but the Secretary nonetheless adopted a policy of including only codes that identify people receiving actual SSI cash payment. *Id.* For example, commenters requested that codes S06 (suspended payment because recipients' whereabouts are unknown based on "undeliverable checks, mail, reports of change or a change of address") and S07 ("checks returned for reasons that are unclear or for reasons other than address or a representative payee problem") be included. CMS refused the suggestion.

Because CMS's treatment of unpaid Part A days as "days entitled to benefits under part A" was upheld by the Supreme Court in *Becerra v. Empire Health Found., for Valley Hosp. Med. Ctr.*, 597 S.Ct. June 24, 2022 WL 227680 (2022), CMS must apply the same interpretation of the word "entitled" in the context of "entitled to supplemental security income benefits." By doing so, CMS will necessarily have to widen the number of SSI status codes it treats as being "entitled to SSI benefits" to encompass not just the three codes

CMS currently includes, but all codes that reflect *eligibility* for SSI benefits.²

In the **Improper Rulemaking group (Case No. 26-0520GC)**, the issue was described as follows:

Whether patient days associated with patients entitled to Medicare Part A for whom no Medicare Part A payment is made and who are eligible for Title XIX should be excluded from the Medicare fraction and included in the numerator of the Medicaid fraction of the Medicare Disproportionate Share Hospital (“DSH”) calculation?

The Provider challenges the inclusion of non-covered patient days in the Medicare fraction, *i.e.*, patient days not actually paid by the Medicare program, who are also eligible for Title XIX coverage. This category of patients includes exhausted benefit days, as well as Medicare secondary benefit days, in which payment for the specific patient days at issue are not actually paid by the Medicare program. The Provider contends that such days should be excluded from the DSH Medicare Fraction and included in the DSH Medicaid Fraction.³

Board Analysis and Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is \$10,000 or more (or \$50,000 for a group); and (3) 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:

² Group Issue Statement in 26-0519GC (Nov. 24, 2025).

³ Group Issue Statement in 26-0520GC (Nov. 24, 2025).

(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.

Further, this regulatory limitation is cross-referenced in the provider's right to a hearing in 42 C.F.R. § 405.1835(a) as follows:

(a) *Right to hearing on final contractor determination.*

A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -

(1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception:** If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).

(2) The amount in controversy (as determined in accordance with § 405.1839) must be \$10,000 or more.

(3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.⁴

In these two groups, the Board finds that it does not have jurisdiction over the Unduly Narrow and Improper Rulemaking issues based on the initiating provider, Boone, which filed from a RNPR.⁵ The RNPR was issued as a result of the Provider's SSI Realignment request and did not make

⁴ (Emphasis added).

⁵ In Case No. 26-0520GC, the MAC addressed this impediment in its Rule 15.2 letter, filed on Nov. 26, 2025. The MAC indicated "[t]here is no evidence that rulemaking related dual eligible days was revised in the RNPR . . . It seems unlikely that any future participant could appeal improper rulemaking related to dual eligible days."

adjustments related to the Unduly Narrow and Improper Rulemaking issues. 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[.]”⁶ The reopening for the initiating provider in these group cases was a result of the Provider’s request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. The audit adjustments associated with the RNPR referenced by Boone in both groups (Adj. #s 4, 5 and 6) clearly only revise the SSI percentage - to realign it from a federal fiscal year to the provider’s respective fiscal year. More specifically, the determinations were only reopened to include the realigned SSI percentage (as described in the Federal Register) and does not change either the Unduly Narrow or Improper Rulemaking issues under appeal in the two groups.⁷

Since the only matter specifically revised in the RNPR for Boone were the adjustments related to realigning the SSI percentages from federal fiscal year to the provider fiscal year, the Provider does not have a right to appeal the Unduly Narrow or Improper Rulemaking issues pursuant to 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1). In making this ruling, the Board notes that this application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.⁸

Conclusion

The Board finds that it lacks jurisdiction over Boone’s appeal of the two group issues in Case Nos. 26-0519GC and 26-0520GC because neither issue was specifically revised in the RNPR which is the basis for Boone’s appeal in both groups. Therefore, the Board hereby closes Case Nos. 26-0519GC and 26-0520GC and removes both cases from its docket.

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

⁶ 42 C.F.R. § 405.1889(b)(1).

⁷ 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)).

⁸ *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 Participating:

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

For the Board:

1/15/2026

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
Byron Lamprecht, WPS Government Health Administrators (J-5)



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

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

RE: **Determination re: Request for Reconsideration and Reinstatement**
WVU Medicine CY 2018 DSH SSI Dual Eligible Days CIRP Group
Case Number: 22-1216GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the subject group appeal in response to an October 13, 2025 request from Quality Reimbursement Services, Inc. (“QRS”). In its correspondence, QRS requests that the Board reconsider its August 13, 2025 dismissal and reinstate the group. The pertinent facts of the case and the Board’s determination are set forth below.

Pertinent Facts:

On **July 28, 2022**, QRS filed the “WVU Medicine CY 2018 DSH SSI Dual Eligible Days CIRP Group” in the Office of Hearings Case & Document Management System (“OH CDMS”). The group was formed without any providers, but on the same date, QRS transferred the SSI/Medicaid Dual Eligible Days issue for Wetzel County Hospital (Provider Number 51-0072) from its individual appeal, Case No. 22-0252, to the group.

On **July 29, 2022**, the Board issued a Case Acknowledgement & Critical Due Dates Notice, in which it set a deadline for the Medicare Contractor’s review of the group formation as well as a deadline for the Representative to file comments regarding the full formation of the group (which was due one year from the group’s filing date).

On **March 28, 2023**, and **May 25, 2023**, after resuming normal operations following the COVID-19 pandemic, the Board issued new Critical Due Dates notices which extended the Representative’s due date for full formation comments to **July 28, 2023**.

On **July 28, 2023**, QRS responded to the full formation comments and advised the Board that the group was not yet complete because it was still awaiting final determinations for two providers:

- United Hospital Center (Prov. No. 50-0006) and
- Camden Clark Memorial Hospital (Prov. No. 51-0058).

On **August 23, 2023, October 2, 2023 & October 23, 2023**, QRS effectuated transfers for three more providers (which had not been identified in the July 28, 2023 group full formation response):

- Reynolds Memorial Hospital (Prov. No. 51-0013) from Case 23-0488;
- City Hospital, Inc. (Prov. No. 51-0008) from Case 23-0915; and
- West Virginia University Hospitals, Inc. (Prov. No. 51-0001) from Case 23-1172.

On **July 9, 2025**, the Board issued a CIRP Group Status Request as the group had not been designated to be complete and the last transfers to the group had occurred in October 2023. The due date for the response was set for **August 8, 2025**.

On **August 13, 2025**, the Board dismissed the group case because the Representative failed to timely respond to the Group Status Request.

On **October 13, 2025**, QRS filed a request for reconsideration of the Board's dismissal and requested reinstatement of the group. In its correspondence, QRS admitted that, due to an administrative error, it did not submit its response to the Board's status request by the due date. However, QRS argued that the remedial action taken by the Board was punitive. QRS contends that the Board should have deemed the group to be complete and that it should be allowed to move forward with the current participants, as opposed to having dismissed the group in its entirety.¹

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.

In this case, QRS has filed a motion requesting that the Board reconsider and reinstate the WVU Medicine CY 2018 DSH SSI Dual Eligible Days CIRP Group under Case No. 22-1216GC.

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

¹ QRS requested that the Board issue a decision on its reconsideration/reinstatement request by December 12, 2025 so that it may file civil action contesting the dismissal if necessary.

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. . . .**

. . . .

47.3 Dismissals for Failure to Comply with Board Procedures

Upon written motion demonstrating good cause, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, **administrative oversight**, settlement negotiations or a change in representative **will not be considered good cause to reinstate**. . . If the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, then the motion for reinstatement must, *as a prerequisite*, include the required filing before the Board will consider the motion.²

Board Rule 47.1 makes clear that the Board will not reinstate a case or issue **if the provider was at fault**. Additionally, the Board refers the Representative to Board Rule 47.3, which is specific to dismissals due to failure to comply with Board procedures, which details what the Board **does not consider to be good cause for reinstatement**, specifically, *administrative oversight*.

After a review of the facts in this group, the Board finds that the Representative was at fault for failing to file its response to the Board's request for group status by the deadline due to a self-admitted administrative error. In addition, QRS' request for reinstatement is deficient in that it did not include the status update as is required by Board Rule 47.3 – in cases where reinstatement is requested when a deadline was missed. Additionally, although QRS contends there would be no prejudice to the Board or the Medicare Contractor in administering QRS' proposed remedy, the Board finds that QRS' motion for reinstatement is deficient in this regard as the motion does not include a statement, as required by Board Rule 44.2, confirming it had actually contacted the Medicare Contractor prior to filing the motion to determine whether the Medicare Contractor concurred.³

Further, the Board finds that QRS' assertion that the Board's dismissal is punitive does not bear weight. QRS was given the opportunity to respond to the July 9, 2025 letter and failed to do so. That notice specifically warned that “[f]ailure to submit a *timely* and *complete* response to this request (without a Board-approved extension) will result remedial action by the Board (*e.g.*, dismissal of the case).” Even after the Board dismissed the appeal, QRS still failed to address the issue for two months, and when it did respond, it failed to include what was required. The Board finds that, therefore, this is an instance where the Representative is entirely at fault, and Board Rule 47.1 makes clear that reinstatement will not be granted in such a case.

The Board also notes the Provider's request “that the Board issue a decision on our request by December 12, 2025, so that the Provider may timely file a civil action contesting the dismissal if

² (Italics and underline emphasis in original, and bold emphasis added except the titles had bold emphasis in original.)

³ Board Rules v 3.2 (Dec. 15, 2023) Rule 44.2: Duty to Confer.

necessary.”⁴ The regulations at 42 C.F.R. § 405.1877 speak to the Provider’s access to judicial review. They read, in pertinent part:

(a) Basis and scope.

(1) Notwithstanding the provisions of 5 U.S.C. 704 or any other provision of law, sections 205(h) and 1872 of the Act provide that a decision or other action by a review entity is subject to judicial review solely to the extent authorized by section 1878(f)(1) of the Act. This section, along with the EJR provisions of § 405.1842 of this subpart, implements section 1878(f)(1) of the Act.

(2) Section 1878(f)(1) of the Act provides that a provider has a right to obtain judicial review of a final decision of the Board, or of a timely reversal, affirmation, or modification by the Administrator of a final Board decision, by filing a civil action in accordance with the Federal Rules of Civil Procedure in a Federal district court with venue no later than 60 days after the date of a receipt by the provider of a final Board decision or a reversal, affirmation, or modification by the Administrator. The Secretary (and not the Administrator or CMS itself, or the contractor) is the only proper defendant in a civil action brought under section 1878(f)(1) of the Act.

(3) A Board decision is final and subject to judicial review under section 1878(f)(1) of the Act only if the decision—

(i) Is one of the Board decisions specified in § 405.1875(a)(2)(i) through (a)(2)(iii) of this subpart or, in a particular case, is deemed to be final by the Administrator under § 405.1875(a)(2)(iv) of this subpart; and

(ii) Is not reversed, affirmed, modified, or remanded by the Administrator under §§ 405.1875(e) and 405.1875(f) of this subpart within 60 days of the date of receipt by the provider of the Board’s decision. A provider is not required to seek Administrator review under § 405.1875(c) first in order to seek judicial review of a Board decision that is final and subject to judicial review under section 1878(f)(1) of the Act.

As mentioned above, the Board’s final decisions subject to judicial review are listed at 42 C.F.R. § 405.1875(a)(2) and include Board hearing decisions, a Board dismissal decision, and a Board EJR decision.⁵ Here, the Board’s dismissal decision was issued on August 13, 2025. Therefore, the deadline for the Provider to file a civil action in relation to that decision was 60 days from August 13, 2025, so the time for filing a civil action has lapsed, long before the December 12, 2025 date specified by QRS. The Provider’s *Reconsideration Request*, filed 60 days after the “final Board decision,” does not give the Provider an additional 60 days to file an appeal of the decision, which it seemingly failed to appeal in a timely manner.

⁴ Request for Reconsideration and Reinstatement of Dismissal of Medicaid Eligible Days & Section 1115 Waiver Days Issue at 4.

⁵ See 42 C.F.R. § 405.1875(a)(2)

Therefore, the Board finds it properly exercised its authority under 42 C.F.R. § 405.1868(b) to dismiss the case and declines to exercise its discretion to reinstate Case No. 22-1216GC. The Board finds that the Representative was at fault and failed to establish good cause under Board Rules 47.1 and 47.3 as it admitted fault for not timely responding to the Board's request for group status. In addition, the Representative failed to confer with the Medicare Contractor prior to filing the motion as required by Board Rules 47.1 and 44. Accordingly, this case remains closed and off the Board's docket. The time for filing a civil action of the Board's August 13, 2025 dismissal has also lapsed.

Board Members:

Kevin D. Smith, CPA

Ratina Kelly, CPA

Nicole E. Musgrave, Esq.

Shakeba Dubose, Esq.

FOR THE BOARD:

1/22/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA

Board Chair

Signed by: Kevin D. Smith -A

cc: Wilson C. Leong, Federal Specialized Services

Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)



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Via Electronic Delivery

Amy Stephens, AVP, Enterprise Reimbursement
West Virginia University Health System
1 Medical Center Drive
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RE: *Notice of Dismissal*

City Hospital (Prov. No. 51-0008), FYE 12/31/2016, PRRB Case No. 21-0448

Dear Mr. Summar:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 21-0448. 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”) SSI Provider Specific issue.

Background:

A. Procedural History for Case No. 21-0448

On **July 17, 2020**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end Dec. 31, 2016. The Provider is commonly owned by West Virginia University Health System (“WVU Medicine”).

On **January 7, 2021**, WVU Medicine filed the Provider’s individual appeal request which included eight (8) issues:

1. DSH SSI Percentage (Provider Specific)
2. DSH SSI Percentage (Systemic Errors)¹
3. DSH SSI Fraction Medicare Managed Care Part C Days²
4. DSH SSI Fraction Dual Eligible Days³
5. DSH Payment – Medicaid Eligible Days⁴
6. DSH Medicaid Fraction Medicare Managed Care Part C Days⁵
7. DSH Medicaid Fraction Dual Eligible Days⁶
8. Standardized Payment Amount.⁷

¹ On August 24, 2021, this issue was transferred to PRRB Case No. 21-1434GC.

² On August 24, 2021, this issue was transferred to PRRB Case No. 21-1544GC.

³ On August 24, 2021, this issue was transferred to PRRB Case No. 21-1546GC.

⁴ On October 21, 2025, this issue was withdrawn.

⁵ On August 24, 2021, this issue was transferred to PRRB Case No. 21-1544GC.

⁶ On August 24, 2021, this issue was transferred to PRRB Case No. 21-1546GC.

⁷ On August 24, 2021, this issue was transferred to PRRB Case No. 21-1435GC.

As the Provider is commonly owned/controlled by WVU Medicine, it is subject to the mandatory common issue related party (“CIRP”) group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on August 24, 2021, WVU Medicine transferred Issues 2, 3, 4, 6, 7 and 8 to WVU Medicine CIRP groups. As a result of the transfers, and after the recent withdrawal of Issue 5, there is one (1) remaining issue in this appeal: Issue 1 - DSH SSI Percentage (Provider Specific).

On **January 8, 2021**, 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.

On **September 8, 2021**, WVU Medicine timely filed the Provider’s preliminary position paper (*hereinafter* “PPP”).

On **November 4, 2021**, the MAC filed a jurisdictional challenge, requesting the dismissal of Issue 1. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider *failed* to file any response.

On **December 15, 2021**, the MAC timely filed its PPP.

On **May 19, 2025**, the Board scheduled Case No. 21-0448 for a hearing on January 30, 2026.

On **October 21, 2025**, WVU Medicine withdrew the Medicaid Eligible Days issue.

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

In its Individual Appeal Request, the Provider summarizes its DSH- SSI Provider Specific issue as follows:

The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations

...

The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider’s cost reporting period.⁸

⁸ Issue Statement at 1 (Jan. 7, 2021).

The Group issue Statement in Case No. 21-1434GC 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.⁹

On September 8, 2021, the Board received the Provider's PPP in Case No. 21-0448. The following is the Provider's *complete* position on Issue 1 set forth therein:

Provider Specific

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

⁹ Group Issue Statements, Case Nos. 21-1434GC.

that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (April 30).¹⁰

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

Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).¹¹

The amount in controversy listed for both SSI Percentage Issues 1 and 2 in the Provider's individual appeal request is \$45,000.

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

The MAC argues that the Board lacks jurisdiction over the SSI Percentage (Provider Specific) issue, which has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of the SSI Percentage issue (No. 2) which was transferred to a CIRP group. 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.¹² For these reasons, the MAC requests dismissal of the SSI Percentage (Provider Specific) issue.

¹⁰ Although Provider referenced FYE as April 30, its FYE actually ended on December 31.

¹¹ Provider's PPP at 8-9 (Sept. 8, 2021).

¹² MAC's Jurisdictional Challenge at 2 (Nov. 4, 2021).

Provider’s Jurisdictional Response: Issue 1- SSI Percentage (Provider Specific)

The Board Rules require that Provider Responses to the MAC’s Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.¹³ The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: “Providers must file a response within thirty (30) days of the Medicare contractor’s jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider’s failure to respond will result in the Board making a jurisdictional determination with the information contained in the record.”

Board Analysis and Decision:

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

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

A. 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. 21-1434GC.

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 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

¹³ Board Rule 44.4.3, v. 2.0 (Aug. 2018).

¹⁴ Issue Statement at 1.

¹⁵ *Id.*

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. 21-1434GC 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. 21-0448 is duplicative of the DSH/SSI Percentage (*Systemic Errors*) issue in Case No. 21-1434GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6¹⁷, 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 the CIRP Group, Case No. 21-1434GC.

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. 21-1434GC but instead, refers to systemic *Baystate* data matching issue that is the subject of the issue in the group appeal. Moreover, although not specifically challenged by the MAC, 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:

¹⁶ *Id.*

¹⁷ Board Rules v. 2.0 (Aug. 2018).

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 (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.¹⁹

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>.²⁰

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.”²¹

¹⁹ (Italics and underline emphasis added.)

²⁰ Last accessed January 16, 2026.

²¹ 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. 21-1434GC are the same issue.²² Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider’s DSH percentage, “[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request” Moreover, without this written request, the MAC cannot issue a final determination with which the Provider can be dissatisfied for Board appeal purposes. There is nothing in the record to indicate the MAC has made a final determination regarding DSH SSI Percentage realignment. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

Based on the foregoing, the Board is dismissing the last remaining issue in this case: DSH SSI Percentage (Provider Specific) - Issue No. 1. As no issues remain, the Board hereby closes Case No. 21-0448 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:

X Nicole E. Musgrave

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

1/22/2026

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

²² Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a WVU Medicine CIRP group per 42 C.F.R. § 405.1837(b)(1).



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***
Middlesex Hospital (07-0020)
FYE: 09/30/2016
Case No.: 21-0721

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 21-0721. 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 payment.

Background

A. Procedural History for Case No. 21-0721

On **August 26, 2020**, the Provider, Middlesex Hospital (“Middlesex”) was issued a Notice of Program Reimbursement (“NPR”) for the fiscal year ending September 30, 2016.

On **February 9, 2021**, Middlesex timely filed an Individual Appeal Request appealing the following (8) issues:

1. DSH Payment SSI Percentage (“Provider Specific”)¹
2. DSH SSI Percentage²
3. DSH SSI Fraction Part C Days³
4. DSH SSI Fraction Dual Eligible Days⁴
5. DSH Medicaid Eligible Days
6. DSH Medicaid Fraction Part C Days⁵
7. DSH Medicaid Fraction Dual Eligible Days⁶
8. Standardized Payment Amount⁷

¹ On October 31, 2025, this issue was withdrawn.

² On September 21, 2021, this issue was transferred to Case No. 21-0235G.

³ On September 21, 2021, this issue was transferred to Case No. 21-0236G.

⁴ On September 21, 2021, this issue was transferred to Case No. 21-0237G.

⁵ On September 21, 2021, this issue was transferred to Case No. 21-0236G.

⁶ On September 21, 2021, this issue was transferred to Case No. 21-0239G.

⁷ On November 12, 2021, this issue was transferred to Case No. 21-1705G.

After the transfers, two issues remained in the appeal: Issue 1, DSH – SSI Percentage (“Provider Specific”), and Issue 5, DSH – Medicaid Eligible Days.⁸

On **February 11, 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 25.⁹

On **September 30, 2021**, the Provider timely filed its preliminary position paper. With respect to Issue 5, Medicaid eligible days, 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 explanation was included explaining why that listing was not included with the preliminary 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 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 of Medicaid eligible days. . . .”¹⁰ As a result, the Provider included, as an exhibit, the original “estimated impact” for this issue of \$122,713 based on an *estimated* 150 days.

On **November 11, 2021**, the Provider changed its designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. (“QRS”).

On **January 31, 2022**, the Medicare Contractor filed its preliminary position paper. Regarding Issue 5, DSH Medicaid eligible days, the Medicare Contractor’s preliminary position paper noted that it requested a Medicaid eligibility days listing from the Provider. The Provider had failed to include a Medicaid eligible days listing with its preliminary position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position.

On **October 19, 2022**, the Medicare Contractor filed a Jurisdictional Challenge¹¹ with the Board over Issues 1, DSH SSI Percentage (“Provider Specific”) and 5, DSH Medicaid eligible days,

⁸ Issue 1 was withdrawn on October 31, 2025.

⁹ (Emphasis added.)

¹⁰ Provider’s September 30, 2021 Preliminary Position Paper at 8.

¹¹ 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

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 a response within 30 days (the Provider did not file its response until December 10, 2025).

On **November 3, 2025**, the Provider filed its Final Position Paper. With respect to Issue 5, DSH Medicaid eligible days, the Provider's final position paper included Ex. P-1 with a redacted copy of its Medicaid eligible listing.

On **December 1, 2025**, the Medicare Contractor filed its Final Position Paper. Regarding Issue 5, DSH Medicaid eligible days, the Medicare Contractor noted a redacted version of the Medicaid eligible days listing was submitted with the Provider's Final Position Paper. However, the Provider has not submitted a complete and auditable listing for additional Medicaid eligible days.¹²

On **December 10, 2025**, the Provider filed an untimely response to the Medicare Contractor's Jurisdictional Challenge (over 3 years after the due date).

B. Description of Issue 3 in the Appeal Request

In their Individual Appeal Request, the Provider summarizes its DSH Medicaid eligible days issue as follows:

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 34,460 with [sic] 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.

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).

¹² Medicare Contractor's December 1, 2025 Final Position Paper at 6.

Audit Adjustment Number(s): 2,16, 18, S-D

Estimated Reimbursement Amount: \$122,000¹³

Regarding the Medicaid eligible days issue, the Provider argues in its preliminary position paper that pursuant to the *Jewish Hospital* case¹⁴ 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.¹⁵

Medicare Contractor’s Contentions

Issue 5 – DSH Payment – Medicaid Eligible Days

The Medicare Contractor contends 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. Additionally, the Provider has failed to meet the burden of furnishing the appropriate data pursuant to 42 C.F.R. § 413.24(c) and 42 C.F.R. § 412.106(b)(4)(iii). The Medicare Contractor asserts the Provider has not submitted a Medicaid eligible days listing. It requested the listing of additional eligible days in dispute from the Provider’s Representative on 10/21/21, 09/14/2022, and 09/28/2022; it received no response to the requests. The Medicare Contractor asserts the Provider has abandoned this issue and therefore requests the Board dismiss the issue.¹⁶

Provider’s Jurisdictional Response

The Board Rules require that Providers response 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 December 10, 2025, over 3 years after the due date of November 18, 2022. . 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. § 139500(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (20186), 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.

¹³ Provider’s February 9, 2021 Individual Appeal Request, Issue 5.

¹⁴ *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994).

¹⁵ Provider’s September 30, 2021 Preliminary Position Paper at 7.

¹⁶ Medicare Contractor’s October 19, 2022 Jurisdictional Challenge at 10,13-14.

¹⁷ Board Rule 44.4.3, v. 3.1 (Nov. 2021).

For the reasons set forth below, the Board hereby *dismisses* the Provider's remaining DSH Medicaid eligible days 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 preliminary position paper.

With regard to the filing of an individual appeal, Board Rule 7.3.2 (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) (October 2020) 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.**¹⁸

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:

¹⁸ (Bold emphasis added.)

Rule 25 Preliminary Position Papers¹⁹

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

¹⁹ (Underline emphasis added to these excerpts and all other emphasis in original.)

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

COMMENTARY: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on February 11, 2021, included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 5, Medicaid eligible days, 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.²⁰

²⁰ (Emphasis added.)

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

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

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

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

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

On September 30, 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.²¹ 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 \$122,713 based on an estimated 150 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:

²¹ Provider’s September 30, 2021 Preliminary Position Paper at 8.

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 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 complete list of additional Medicaid eligible days with its preliminary position paper or submit such list under separate cover to it. The Medicare Contractor maintains it requested the listing of additional eligible days in dispute from the Provider’s Representative on October 21, 2021, September 14, 2022, and September 28, 2022. It received no response to the requests. The Medicare Contractor asserts the Provider has yet to submit complete, unredacted listings to it.²² The Medicare Contractor maintains the Provider has 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 the regulations and Board Rules.²³

The Board finds that in the Provider’s November 3, 2025 final position paper, Exhibit P-1, the Provider included a redacted listing of 308 days identified as “Additional ME Days.” As it relates to the Medicaid eligible days under appeal, the Provider’s exhibit states “A listing of the additional Medicaid Eligible days being claimed is being submitted directly to the MAC. A redacted version of this same list is being included with this position paper.”²⁴ The Board finds the Medicare Contractor asserts to date, the Provider has not submitted the referenced listing; the Provider has not submitted a complete and auditable listing for additional Medicaid eligible days.²⁵ Additionally, the Board finds the listing included at Exhibit P-1 states “Listing pending

²² Provider’s October 19, 2022 Jurisdictional Challenge at 10.

²³ *Id.* at 13.

²⁴ Provider’s November 3, 2025 Final Position Paper at Ex. P-1.

²⁵ Medicare Contractor’s December 1, 2025 Final Position Paper at 6, 11.

finalization upon receipt of State eligibility data,” indicating that the list is incomplete and not suitable for audit, had an unredacted auditable version been submitted.²⁶

The Board finds the Provider’s filing does not explain why the listing of 308 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 9 years after the fiscal year at issue had closed*. NOTE—the roughly 308 days included in this belated listing is *double* 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)(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).

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”²⁷ and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the preliminary 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.²⁸

²⁶ Provider’s November 3, 2025 Final Position Paper at Ex. P-1.

²⁷ (Emphasis added.)

²⁸ See also *Evangelical Commtty 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

* * * * *

Based on the foregoing, the Board dismisses the (1) remaining issue in this case – (Issue 5, DSH Medicaid Eligible Days). As no issues remain, the Board hereby closes Case No. 21-0721 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-Burdette, Esq.
Shakeba DuBose, Esq.

For the Board:

1/28/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Danelle Decker, National Government Services, Inc.
Wilson Leong, Federal Specialized Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***

Navarro Regional Hospital, Prov. No. 45-0447, FYE 12/31/2018
Case No. 23-0335

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal request in Case No. 23-0335. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider’s Disproportionate Share Hospital (“DSH”) for Medicaid Eligible Days.

Background

A. Procedural History for Case No. 23-0335

On **June 27, 2022**, the Provider was issued a Notice of Program Reimbursement (“NPR”) for fiscal year end December 31, 2018. The Provider is commonly owned by Community Health Systems, Inc. (“CHS”).

On **December 1, 2022**, CHS filed the Provider’s individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. DSH Payment/SSI Percentage (Provider Specific)¹
2. DSH/SSI Unduly Narrow Definition of SSI Entitlement²
3. DSH Payment – Medicaid Eligible Days
4. DSH Payment – Medicare/SSI and Medicaid Fractions – Medicare Managed Care Part C Days³
5. DSH Payment – SSI/Medicare and Medicaid Fractions – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)⁴

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party (“CIRP”) group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **June 9, 2023**, the Provider transferred Issues 2, 4, and 5 to CHS CIRP groups.

¹ On January 23, 2026, this issue was withdrawn.

² On June 9, 2023, this issue was transferred to Case No. 21-1206GC.

³ On June 9, 2023, this issue was transferred to Case No. 20-2149GC.

⁴ On June 9, 2023, this issue was transferred to Case No. 21-0066GC.

As a result of the case transfers, there is one (1) remaining issue in this appeal: Issue 3 (the DSH – Medicaid Eligible Days).

On **December 2, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** state the material facts that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and provide arguments applying the material facts*** to the controlling authorities. This filing ***must include any exhibits the Provider will use to support its position*** and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.⁵

On **July 5, 2023**, the Provider timely filed its preliminary position paper. With respect to Issue 3, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent 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 \$33,372 based on an *estimated* 50 days.

On **September 13, 2023**, the Medicare Contractor timely filed a Jurisdictional Challenge⁶ with the Board over Issues 1⁷ and 3 requesting that the Board dismiss these issues. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **September 14, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. (“QRS”).

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, the Provider subsequently withdrew Issue 1 on January 23, 2026.

On **October 26, 2023**, the Medicare Contractor filed its preliminary position paper. With regard to Issue 3, the Medicare Contractor's position paper noted that the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position.

On **November 27, 2023**, over one month 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."⁸ The Listing was 4 pages with roughly 547 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 547 days) was being submitted at this late date or why it was not final (*i.e.*, why it was "pending finalization") at this late date, ***nearly 5 years after the fiscal year at issue had closed***. NOTE—the roughly 547 included in this belated listing is *significantly* larger than the original *estimated* impact of 50 days included with the appeal request.

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 Preliminary Position Paper.

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.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.

⁸ (Emphasis added.)

⁹ Board Rule 44.4.3, v. 3.1 (Nov. 2021).

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 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.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 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:

¹⁰ (Bold emphasis added.)

Rule 25 Preliminary Position Papers¹¹

COMMENTARY:

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

25.1 Content of Position Paper Narrative

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

25.1.1 Provider's Position Paper

The provider's preliminary position paper must:

- A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
- B. For *each* issue that has not been fully resolved, provide a *fully* developed narrative that:
 - States the material facts that support the provider's claim.
 - Identifies the controlling authority (*e.g.*, statutes, regulations, policy, or case law) supporting the provider's position.
 - Provides a conclusion applying the material facts to the controlling authorities.
- C. Comply with Rule 25.2 addressing Exhibits.

...

25.2 Position Paper Exhibits

¹¹ (Underline emphasis added to these excerpts and all other emphasis in original.)

25.2.1 General

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

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

25.2.2 Unavailable and Omitted Documents

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

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

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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 December 2, 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.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 carry[es] the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

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

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

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

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

On July 5, 2023, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent 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 continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of \$33,372 based

¹² (Emphasis added.)

¹³ Provider's Preliminary Position Paper at 10 (Jul. 5, 2023).

on an estimated 50 days). The Provider's complete briefing of this issue in its position paper is as follows:

Issue #3: Medicaid Eligible Days

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

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

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

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

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

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

With respect to section 1115 waiver days, the courts have firmly rejected CMS's interpretation of its regulations, holding instead that the plain language of the statute and the regulations require inclusion in the Medicaid Fraction of the days belonging to individuals who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool. *See Forrest General Hospital*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. 2018); *Bethesda Health Inc., v. Azar*, 389 F. Supp. 3d 32 (D.D.C. 2019), *aff'd*, 980 F.3d 121 (D.C. Cir. 2020). CMS has acquiesced in *Bethesda* and is now following the statute and the plain meaning of its own regulations (which regulations represent the official policy of CMS all along). *See CMS Manual Instructions System*, Change Request 12669, Transmittal No. 11912 (March 163 [sic], 2023) ("Transmittal 11912"), attached as Exhibit P-4.

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.

On November 27, 2023 (over a month after the deadline to respond 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." The Listing was 4 pages with roughly 547 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 547 days) was being submitted at this late date or why it was not final (*i.e.*, why it was "pending finalization") at this late date, ***nearly 5 years after the fiscal year at issue had closed***. NOTE—the roughly 547 included in this belated listing is *significantly* larger than the original estimate of 50 days included with the appeal request. Regardless, this filing was more than a month past the deadline for responding to the Jurisdictional Challenge *and, more importantly, was roughly 4 months past the deadline for including it with its preliminary position paper* since the position paper deadline was July 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 merely 2 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 27, 2023 filing as a “Supplement to Position Paper” and does not accept that filing because:

1. The alleged “Supplement” was filed *roughly 4 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 a month 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 547 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 nearly a year after this appeal was filed and nearly 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 December 2, 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* 547 days listed in the alleged “Supplement” is, without explanation, *significantly* larger than the original estimated 50 days included with the appeal request).¹⁴

¹⁴ 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.”

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”¹⁵ 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, 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.¹⁶

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 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,

¹⁵ (Emphasis added.)

¹⁶ See also *Evangelical Commtty 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.

including an account of...

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

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

Board Rule 7.2.1 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) ...*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:

¹⁷ 42 C.F.R. § 405.1835(b).

¹⁸ (Bold and italic emphasis added).

¹⁹ 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, 2000.²⁰ Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 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

²⁰ 65 FR 47054, 47087 (Aug. 1, 2000).

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

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

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

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

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 foregoing, the Board has dismissed the remaining issue in this case – (Issue 3). As no issues remain, the Board hereby closes Case No. 23-0335 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:

1/28/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

²⁵ *Id.*



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

Imran Khan, Administrator
Axiom Hospice, LLC
12815 Northline Road
Southgate, MI 48195 - 1104

Re: “Axiom Hospice FFY 2024 Appeal for Quality Reporting Program Noncompliance Decision Group”, PRRB Case No. 26-1342G

Dear Mr. Khan:

The Provider Reimbursement Review Board (“Board”) is in receipt of the above-referenced *group* appeal request. The pertinent facts of the case and the Board’s determination are set forth below.

Pertinent Facts:

On **January 26, 2026**, Axiom Hospice, LLC (“Axiom”/Prov. No. 23-1717) filed a group appeal with the Board. Upon review of the document uploaded as the issue statement, the appeal appears to have been filed on behalf of a *single* Provider that received a “Notice of Quality Reporting Program Noncompliance Decision Upheld” (“Noncompliance Determination”) on November 12, 2025.¹

The Board notes that, although the appeal included an issue statement with “supporting documents”, the appeal did not include:

- a copy of the Provider’s final determination (*i.e.*, the November 12, 2025 Noncompliance Determination) (see 42 C.F.R. § 405.1835(b)(3)); and
- a representation letter (see Board Rule 5.4)

Finally, the Board notes that the appeal, which appears to be for a single Provider (Axiom) was filed using the group appeal format. Board Rule 12.2 discusses the general requirements for a group and explains that the group appeal format is used when there are at least two providers appealing “. . . a single question of fact or interpretation of law, regulation, or CMS Rulings that is common to each provider in the group.”²

¹ The issue statement also referenced November 17, 2025 as the date of the Noncompliance Determination.

² Board Rules Version 3.2 (Dec. 15, 2023)

Decision of the Board:

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

42 C.F.R. § 405.1835(b) specifies that, if a Provider’s appeal request does not meet the requirements of paragraph (b)(3) of the same section, the Board may dismiss the appeal with prejudice, or take any other remedial action it considers appropriate. Paragraph (b)(3) states in part that the following must be included in the Provider’s request:

A copy of the determination, including any other documentary evidence the provider considers necessary to satisfy the hearing request requirements

Including the actual determination with the appeal request is critical for a myriad of reasons, including determining whether the Provider meets the claim filing requirements specified in 42 C.F.R. § 405.1835.

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

In this case the Board finds that the Provider failed to submit the required copy of the final determination under appeal as well as a letter of representation.³ Therefore, the Board finds that the Provider did not meet the regulatory requirements for filing an appeal (***individual or group***) before the Board. Accordingly, the Board finds dismissal is appropriate under § 405.1835(b) and Board Rules and hereby dismisses Case No. 26-1342G. Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 105.1877.

Based on the final determination date referenced in Axiom’s issue statement, the Provider may still be within its appeal period. Therefore, if the Provider elects, it may refile an individual appeal. Please see 42 CFR 405.1835 and Board Rule 6, which both discuss individual appeal rights, and requirements. Additionally, since the Provider is appealing a Quality Reporting determination, it may be helpful to refer to the Frequently Asked Questions (“FAQs”) for

³ The Office of Hearings Case & Document Management System (“OH CDMS”) also requires **separate uploads** for the Letter of Representation (see Board Rule 5.4), the final determination, the issue statement, audit adjustment pages and calculation support. In the case of a QRP appeal, there are no audit adjustments so an upload stating “there are no adjustments associated with this determination” may be uploaded.

Quality Reporting Appeals located at <https://www.cms.gov/files/document/faqs-quality-reporting-appeals.pdf>.

Board Members:

Kevin D. Smith, CPA

Ratina Kelly, CPA

Nicole E. Musgrave, Esq.

Shakeba DuBose, Esq.

For the Board:

1/29/2026

X Ratina Kelly

Ratina Kelly, CPA

Board Member

Signed by: PIV

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Pamela VanArsdale, National Government Services, Inc. (J-6)



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RE: ***Expedited Judicial Review Determination***

25-1276GC *Northwell Health CY 2010 Post-Allina II DSH Part C Days CIRP Group*
25-1297GC *Northwell Health CY 2011 Post-Allina II DSH Part C Days CIRP Group*

Dear Ms. Webster:

The Provider Reimbursement Review Board (“Board”) has reviewed the Providers’ Petitions for Expedited Judicial Review (“EJR”) filed on **January 5, 2026** in the above-referenced appeals. The Board’s decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Board received requests to establish Common Issue Related Party (“CIRP”) groups for these two (2) cases on **January 3 and 6, 2025**. The Providers 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 (“FYE”) in calendar years 2010 and 2011.

The issue in these appeals is “the proper treatment in the Medicare disproportionate share hospital (“DSH”) calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute (“part C days”) in the aftermath of the *Allina II* litigation. The Providers contend that part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction (for patients eligible for Medicaid).”² The Providers are seeking to challenge the CMS policy adopted in the June 2023 Final Rule to be applied *retroactively* for periods prior to October 1, 2013.³

¹ 88 Fed. Reg. 37772 (June 9, 2023).

² *E.g.*, Case No. 25-1276GC, Statement of Group Issue at 1 (Jan. 3, 2025).

³ *Id.* at 2-3.

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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 subchapter¹¹

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

⁴ See 42 U.S.C. § 1395ww(d)(1)-(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. § 412.106(c)(1).

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).

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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 Secretary¹⁵ 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

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).

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

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

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

... We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days

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).

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*associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*²⁴

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

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

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

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

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* (“*Allina I*”),²⁹ vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005

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).

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IPPS rule.³⁰ In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.³¹ However, the Secretary has not acquiesced to that decision.

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

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.³⁹ On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as “CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in *Allina II*”:

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

³⁰ *Id.* at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

³¹ *Id.* at 2011.

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

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

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

³⁵ 139 S.Ct. 1804 (2019).

³⁶ *Id.* at 1817.

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

³⁸ 139 S.Ct. at 1814.

³⁹ 85 Fed. Reg. 47723 (Aug. 6, 2020).

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

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.⁴¹ The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

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

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

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

⁴⁰ CMS Ruling 1739-R at 1-2.

⁴¹ 88 Fed. Reg. 37772 (June 9, 2023).

⁴² 88 Fed. Reg. at 37788 (emphasis in original).

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

2. “We do not agree that it is arbitrary or capricious to treat hospitals’ Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II*. It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital’s appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary’s interpretation set forth in this final action.**”⁴⁴
3. “Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions contained in the NPRs or revised NPRs.* Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights.* Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised NPRs will provide hospitals with a vehicle to appeal the new final action* even if the Medicare fraction or DSH payment does not change numerically.”⁴⁵
4. “*When the Secretary’s treatment of Part C days in this final action is reflected in NPRs and revised NPRs, providers, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], will be able to challenge the agency’s interpretation by appealing those NPRs and revised NPRs.* While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings.”⁴⁶

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

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are “entitled to [Part A] benefits” within the context of 42 U.S.C. § 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.⁴⁷ It ruled,

⁴³ 88 Fed. Reg. at 37774-75 (emphasis added).

⁴⁴ *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).

⁴⁵ *Id.* at 37788 (emphasis added).

⁴⁶ *Id.* (emphasis added).

⁴⁷ *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).

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however, that the June 9, 2023 Final Rule is both impermissibly retroactive⁴⁸ 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

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

⁴⁸ *Id.* at *12-19.

⁴⁹ *Id.* at *19-22.

⁵⁰ *Id.* at *23.

⁵¹ *E.g.*, Case No. 25-1276GC, Appeal Request, Statement of Jurisdiction at 1 (citations omitted).

⁵² *E.g.*, Case No. 25-1276GC, Statement of Group Issue at 1.

⁵³ *Id.*

⁵⁴ *Id.* (citing to 139 S. Ct. at 1816).

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vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.⁵⁵

Based on the above, the Providers maintain that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule “is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, exceeds the agency’s statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence.”⁵⁶

B. Providers’ Petitions for EJR

The Providers have requested EJR over the “post-*Allina* retroactive Part C policy issue” because they believe they have met the requirements for a hearing before the Board, but the Board lacks the authority to decide the substantive and procedural validity of CMS’ final rule published in the Federal Register on June 9, 2023.⁵⁷ They seek a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.⁵⁸ “The Providers contend that the new, post-*Allina* retroactive part C days rule, applied in the [NPRs] appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency’s statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence.”⁵⁹ Since the Board is bound by this regulation,⁶⁰ it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

On **January 12, 2026**, the Medicare Contractor’s representative, Federal Specialized Services, filed timely responses to the Requests for EJR in both cases. Each response simply noted “that the MAC will not file a jurisdictional challenge and will not file a substantive claim challenge.”⁶¹

Decision of the Board:

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

⁵⁵ *Id.*

⁵⁶ *Id.* (citing 4 U.S.C. § 706(2)).

⁵⁷ *E.g.*, Case No. 25-1276GC, Provider’s Petition for Expedited Judicial Review at 13 (Jan. 5, 2026).

⁵⁸ *Id.* at 16-17.

⁵⁹ *Id.* at 1-2.

⁶⁰ 42 C.F.R. § 405.1867.

⁶¹ *E.g.*, Case No. 25-1276GC, Response to Provider’s Request for Expedited Judicial Review at 1 (Jan. 12, 2026).

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A. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a “final determination” related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination;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, \$50,000 or more for a group of providers.⁶³

For these two (2) CIRP group 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 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 Cases 25-1276GC and 25-1297GC have all filed timely appeals from their original and 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 for each CIRP group appeal exceeds \$50,000 as required by 42 C.F.R. § 405.1837(a)(3). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

B. Board’s Decision Regarding the EJRs 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 Case Nos. 25-1276GC and 25-1297GC, 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;

⁶² 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).

⁶³ 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

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- 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 Cases 25-1276GC and 25-1297GC, the Board hereby closes these two (2) 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:

1/29/2026

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)
Scott Berends, Federal Specialized Services



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RE: ***Expedited Judicial Review Determination***

25-1365GC *Northwell Health CY 2012 Post-Allina II DSH Part C Days CIRP Group*
25-1463GC *Northwell Health CY 2013 Post-Allina II DSH Part C Days CIRP Group*

Dear Ms. Webster:

The Provider Reimbursement Review Board (“Board”) has reviewed the Providers’ Petitions for Expedited Judicial Review (“EJR”) filed on **January 7, 2026** in the above-referenced appeals. The Board’s decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Board received requests to establish Common Issue Related Party (“CIRP”) groups for these two (2) cases on **January 10 and 17, 2025**. The Providers 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 (“FYE”) in calendar years 2012 and 2013.

The issue in these appeals is “the proper treatment in the Medicare disproportionate share hospital (“DSH”) calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute (“part C days”) in the aftermath of the *Allina II* litigation. The Providers contend that part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction for patients eligible for Medicaid.”² The Providers are seeking to challenge the CMS policy adopted in the June 2023 Final Rule to be applied *retroactively* for periods prior to October 1, 2013.³

¹ 88 Fed. Reg. 37772 (June 9, 2023).

² *E.g.*, Case No. 25-1365GC, Statement of Group Issue at 1 (Jan. 10, 2025).

³ *Id.* at 2-3.

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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 subchapter¹¹

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

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. § 412.106(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).

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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 Secretary¹⁵ 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

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).

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

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

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

... We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days

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).

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*associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*²⁴

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

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

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

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

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* (“*Allina I*”),²⁹ vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005

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).

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IPPS rule.³⁰ In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.³¹ However, the Secretary has not acquiesced to that decision.

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

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.³⁹ On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as “CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in *Allina II*”:

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

³⁰ *Id.* at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

³¹ *Id.* at 2011.

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

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

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

³⁵ 139 S.Ct. 1804 (2019).

³⁶ *Id.* at 1817.

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

³⁸ 139 S.Ct. at 1814.

³⁹ 85 Fed. Reg. 47723 (Aug. 6, 2020).

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

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.⁴¹ The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

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

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

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

⁴⁰ CMS Ruling 1739-R at 1-2.

⁴¹ 88 Fed. Reg. 37772 (June 9, 2023).

⁴² 88 Fed. Reg. at 37788 (emphasis in original).

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

2. “We do not agree that it is arbitrary or capricious to treat hospitals’ Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II*. It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital’s appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary’s interpretation set forth in this final action.**”⁴⁴
3. “Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions contained in the NPRs or revised NPRs*. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised NPRs will provide hospitals with a vehicle to appeal the new final action* even if the Medicare fraction or DSH payment does not change numerically.”⁴⁵
4. “*When the Secretary’s treatment of Part C days in this final action is reflected in NPRs and revised NPRs, providers, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], will be able to challenge the agency’s interpretation by appealing those NPRs and revised NPRs*. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings.”⁴⁶

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

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are “entitled to [Part A] benefits” within the context of 42 U.S.C. § 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.⁴⁷ It ruled,

⁴³ 88 Fed. Reg. at 37774-75 (emphasis added).

⁴⁴ *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).

⁴⁵ *Id.* at 37788 (emphasis added).

⁴⁶ *Id.* (emphasis added).

⁴⁷ *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).

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however, that the June 9, 2023 Final Rule is both impermissibly retroactive⁴⁸ 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

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

⁴⁸ *Id.* at *12-19.

⁴⁹ *Id.* at *19-22.

⁵⁰ *Id.* at *23.

⁵¹ *E.g.*, Case No. 25-1365GC, Appeal Request, Statement of Jurisdiction at 1 (citations omitted).

⁵² *E.g.*, Case No. 25-1365GC, Statement of Group Issue at 1.

⁵³ *Id.*

⁵⁴ *Id.* (citing to 139 S. Ct. at 1816).

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vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.⁵⁵

Based on the above, the Providers maintain that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule “is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, exceeds the agency’s statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence.”⁵⁶

B. Providers’ Petitions for EJR

The Providers have requested EJR over the “post-*Allina* retroactive Part C policy issue” because they believe they have met the requirements for a hearing before the Board, but the Board lacks the authority to decide the substantive and procedural validity of CMS’ final rule published in the Federal Register on June 9, 2023.⁵⁷ They seek a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.⁵⁸ “The Providers contend that the new, post-*Allina* retroactive part C days rule, applied in the [NPRs] appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency’s statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence.”⁵⁹ Since the Board is bound by this regulation,⁶⁰ it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

On **January 13, 2026**, the Medicare Contractor’s representative, Federal Specialized Services, filed timely responses to the Requests for EJR in both cases. Each response simply noted “that the MAC will not file a substantive claim challenge in this case. The MAC notes no jurisdictional impediments.”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.

⁵⁵ *Id.*

⁵⁶ *Id.* (citing 4 U.S.C. § 706(2)).

⁵⁷ *E.g.*, Case No. 25-1365GC, Provider’s Petition for Expedited Judicial Review at 13 (Jan. 7, 2026).

⁵⁸ *Id.* at 16-17.

⁵⁹ *Id.* at 1-2.

⁶⁰ 42 C.F.R. § 405.1867.

⁶¹ *E.g.*, Case No. 25-1365GC, Response to Provider’s Request for Expedited Judicial Review at 1 (Jan. 13, 2026).

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A. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a “final determination” related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination;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, \$50,000 or more for a group of providers.⁶³

For these two (2) CIRP group 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 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 Cases 25-1365GC and 25-1463GC have all filed timely appeals from their original and 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 for each CIRP group appeal exceeds \$50,000 as required by 42 C.F.R. § 405.1837(a)(3). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

B. Board’s Decision Regarding the EJR Requests

The Board finds that:

- 1) 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 Case Nos. 25-1365GC and 25-1463GC, 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;

⁶² 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).

⁶³ 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

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- 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 Cases 25-1365GC and 25-1463GC, the Board hereby closes these two (2) 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:

1/29/2026

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)
Scott Berends, Federal Specialized Services



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RE: ***EJR Determination***

Case No. 25-1782GC: *OSF Healthcare FFY 2025 Understated IPPS Standardized Amount CIRP Group*

Case No. 26-0941GC: *LifePoint Health FFY 2026 Understated IPPS Standardized Amount CIRP Group*

Dear Mr. Jenkins:

The Provider Reimbursement Review Board (“Board”) has reviewed the appeal requests and Requests for Expedited Judicial Review (“EJR”) filed by the Providers in the above-referenced Common Issue Related Party (“CIRP”) group cases. In these cases, the Providers challenge the FFY 2025 and FFY 2026 inpatient prospective payment system (“IPPS”) standardized amount and payment rates as calculated and published in the FFY 2025 and FFY 2026 Final Rules. As the basis of their challenges, the Providers allege that the respective rates are understated due to an embedded “Transfer/Discharge Error” that has unlawfully been in place since the establishment of the inaugural amounts for federal fiscal year (“FFY”) 1984. As such, the Providers have requested Expedited Judicial Review (“EJR”) to challenge the FFY 2025 and 2026 IPPS rates, and the decision of the Board Majority ***GRANTING*** the Request is set forth below.

BACKGROUND:

A. Group Issue –Alleged Improper Inclusion of Transfers in Calculating 1984 IPPS Standardized Amount

1. Initial Appeal and Issue Statement

The Board received a request on **January 29, 2025**, filed by the Providers’ designated representative, Hospital Reimbursement Group, (“Providers’ Representative”), to establish a CIRP group appealing from the FFY 2025 IPPS Final Rule published in the Federal Register on **August 28, 2024** (Case 25-1782GC). The Board received a separate request on **December 30, 2025**, to establish a group appealing from the FFY 2026 IPPS Final Rule published in the Federal Register on **August 4, 2025** (Case 26-0941GC).

The Providers' Statement of Issue Under Appeal in Case 25-1782GC states:

The common issue before the PRRB is whether the hospitals have been underpaid for the periods covered by the 2025 federal fiscal year because the inpatient hospital prospective payment system (PPS) standardized amounts are understated for the 2025 federal year due to the Secretary's failure to properly distinguish between patient transfers and discharges in establishing the PPS 1983 base year amounts.¹

The Statement of Issue Under Appeal in Case 26-0941GC is identical except it refers to FFY 2026 instead of FFY 2025. In each case, the Providers are appealing from the Federal Registers which established the standardized rate effective for their respective FFYs.

Both Case 25-1782GC and Case 26-0941GC were fully formed on **December 30, 2025**. As such, the Providers' Preliminary Position Papers are not due until **August 27, 2026** and therefore have not been briefed, and the Medicare Contractor has not had an opportunity, outside of responding the pending Requests for Expedited Judicial Review ("EJR"), to present its position or respond to the Providers' allegations.

2. Requests for EJR

The Providers filed a Request for EJR in each case on **December 30, 2025**, which is the same date the cases were deemed complete and fully formed. The Requests for EJR briefly expand upon their issue statement, explaining:

The issue in this Group Appeal is whether the Inpatient Prospective Payment System ("IPPS") standardized amount and payment rates for federal fiscal year ("FFY") [2025 and 2026]² are unlawfully understated because the Secretary calculated them without correcting for a known embedded error that has been causing substantial underpayments to Medicare providers since the inception of IPPS. Specifically, the Providers contend that the Secretary improperly determined the inaugural IPPS standardized amounts by including *transfer* cases when determining "the allowable operating *costs per discharge* of inpatient hospital services for [each] hospital for the most recent cost reporting period for which data are available." 42 U.S.C. § 1395ww(d)(2)(A) (emphasis added). This error (the "Transfer/Discharge Error") caused an understatement of the original IPPS standardized amounts

¹ E.g., Case 25-1782GC, Statement of Issue Under Appeal (Jan. 29, 2025).

² The Requests for EJR are materially identical except the request filed in Case 26-0941GC references FFY 2026.

and payments rates and caused underpayments in every subsequent FFY, including FFY [2025 and 2026].

Correction of this “predicate fact” Transfer/Discharge Error to ensure that the Providers’ FFY [2025 and 2026] IPPS payments are correct is permitted under *Kaiser Foundation Hospital v. Sebelius*, 708 F.3d 226 (D.C. Cir. 2013), *Saint Francis Medical Center v. Azar*, 894 F.3d 290 (D.C. Cir. 2018), and other authorities.

Specifically challenged here are the unlawful IPPS underpayments resulting from the understatement of the standardized amount and payment rates published in the FFY [2025 and 2026] IPPS Final Rule[s] [...].³

The Providers argue that 42 U.S.C. § 1395ww(d)(2)(A) mandates the Secretary determine the allowable operating *costs per discharge* of inpatient hospital services but that when implementing IPPS the Secretary in fact calculated the average *costs per discharge or transfer* because the Secretary did not remove or adjust for transfers that were included in the 1981 base year data.⁴ The Providers contend that:

[b]ecause transfers cost less on average than discharges, the Secretary’s treatment of transfers as discharges for the purpose of rate-setting in FFY 1984 caused an understatement of his average ‘costs per discharge’ calculation and the resulting FFY 1984 standardized amounts, which led to IPPS underpayments from FFY 1984 to this day, because the standardized amounts in each FFY are based on the standardized amounts from the prior FFY with certain percentage adjustments.⁵

The Providers also claim that this calculation error was implicitly recognized when the Secretary implemented the PPS for capital costs in FFY 1992, where he “acknowledged that counting transfers as discharges was improper and would cause an understatement of the standardized amounts.”⁶ There, the Secretary applied a correction factor of 0.9% in the Capital PPS rates to remove the effect of transfers, but has never applied a similar correction for IPPS.⁷

The Providers aver that they are entitled to EJR of their appeals as the Board has jurisdiction to conduct a hearing on the specific matters at issue, but lacks the authority to decide the specific

³ Request for Expedited Judicial Review, 1-2 (Dec. 30, 2025) (original emphasis); *see* footnote 2 *supra*, citations omitted, *but see* 89 Fed. Reg. 68986 (Aug. 28, 2024) and 90 Fed. Reg. 36536 (Aug. 4, 2025).

⁴ Request for Expedited Judicial Review at 2 (citing 48 Fed. Reg. 39751, 39763-39764 (Sept. 1, 1983)).

⁵ Request for Expedited Judicial Review at 3 (citing 42 U.S.C. § 1395ww(d)(3)(A)–(C) and *Cape Cod Hosp. v. Sebelius*, 630 F.3d 203, 205 (D.C. Cir. 2011)).

⁶ *Id.* (citing 56 Fed. Reg. 43,358, 43,383, 43,386–97 (Aug. 30, 1991)).

⁷ *Id.*

legal questions relevant to the matters at issue.⁸ To demonstrate that they meet the criteria for granting EJR, first, the Providers argue that these groups' challenges to the FFY 2025 IPPS standardized amount and payment rates published in the FFY 2025 Final Rule stem from an appealable final determination,⁹ and that the appeals were timely filed.¹⁰

Second, the Providers contend that the \$50,000 amount in controversy ("AIC") requirement has been met in each case, whereby each estimate "was calculated by multiplying each Provider's expected total applicable IPPS reimbursement for FFY 2025 by 0.9%, which is the correction factor the Secretary used to correct for the inclusion of transfer data in the Capital PPS Final Rule."¹¹ In evaluating the AIC, the Providers acknowledge that the 1981 MedPAR data would be the best data for evaluating any AIC, however, despite their requests, CMS has not provided that data. Thus, instead, they rely on an analysis of alternative data that resulted in an estimated correction factor of 0.65%, which also exceeds the AIC threshold of \$50,000.¹²

Third, relying on a D.C. District Court opinion in *St. Mary's Regional Medical Center v. Becerra*,¹³ the Providers assert that 42 U.S.C. § 1395ww(d)(7) does not preclude the Board's jurisdiction over these appeals. Notwithstanding the Board's jurisdiction, Providers argue that EJR is appropriate since the Board "lacks the authority to decide the legal question presented or to grant the relief requested[.]" since the Board must comply with all Provisions of Title XVIII of the Social Security Act and regulations issued thereunder.¹⁴ Particularly, the Providers contend that:

[b]ecause the Board lacks authority to invalidate the standardized amount or payment rates in question or to grant the relief the Providers are seeking, EJR must be granted because "[t]he Board lacks the authority to decide [the] specific legal question relevant to the specific matter at issue." 42 C.F.R. § 405.1842(f)(1)(ii).¹⁵

Finally, the Providers address whether EJR is appropriate at this time. The Providers claim their EJR Request is complete as required by 42 C.F.R. § 405.1842(e)(2). This regulatory provision establishes that a Request for EJR is complete if the Board receives a request from a provider that includes sufficient information and documentation for the Board to determine whether to grant or deny EJR. In making their determination, the Board has to determine whether (1) it has jurisdiction, and (2) it has the authority to decide the specific legal question presented based on whether it is a challenge to the constitutionality of a provision of a statute, or a challenge to the substantive or

⁸ *Id.* at 4 (citing 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1)).

⁹ *Id.* at 5 (citing *Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986); *District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993); CCH Medicare & Medicaid Guide ¶ 41,025; PRRB Rules 7.1.1, 7.1.2.3, 42.3).

¹⁰ *Id.* at 6.

¹¹ *Id.* at 5.

¹² *Id.* at 5-6.

¹³ Memorandum Opinion, No. 1:23-cv-1594-RCL, 2024 WL 5186641 (D.D.C. Dec. 20, 2024).

¹⁴ *Id.* at 7 (citing 42 C.F.R. § 405.1867).

¹⁵ *Id.*

procedural validity of a regulation or CMS Ruling. The Providers state that they have met the requirements for a complete EJR Request by providing the requisite information on which the Board can make its determination for granting or denying the Request.¹⁶

Additionally, the Providers acknowledge that Board Rule 42.3 requires that a Request for EJR confirm the group is fully formed and that there are no factual disputes. However, the Providers argue “that these requirements are not prerequisites for EJR under the statute or regulation governing EJR” but nevertheless they are satisfied because the group is fully formed and there are no factual issues in need of resolution or further development for a determination on the EJR Request.¹⁷

Referring back to the underlying dismissals subject of the D.C. District Court’s opinion in *St. Mary’s*, the Providers point to the Board’s prior suggestion that record was in need further development as to questions of jurisdiction, actual damages or actual injury, and material fact disputes—all prior to determining whether EJR was appropriate.¹⁸

Importantly, in this case, the Providers insist that the record does not need further development before EJR is granted, particularly as it relates to meeting the jurisdictional amount in controversy threshold. In support of their position that they have met the AIC, the Providers submitted an analysis which explains how they have quantified their AIC estimate based on a proposed adjustment factor.¹⁹ The report assumes the correction factor for IPPS should be 0.9% (the same as the Capital PPS correction factor adopted for FFY 1992) “[i]f transfer practices were approximately the same in the base period for the initial implementation of IPPS as in FFY 1989.”²⁰ Alternatively, the report explains that, using alternative data to evaluate the actual transfers for FFY 1981, the average costs per discharge for FFY 1984 was understated by 0.65%.²¹

The report also assumes that the FFY 1981 MedPAR data file would contain transfer status data and would allow the calculation of an accurate transfer correction factor to be applied to FFY 1984 (which would carry forward to all subsequent FFYs).²² However, since that MedPAR data is not available, the report explains that alternative data was used: (a) the 1981 National Hospital Discharge Survey (“NHDS”) to calculate the transfer rate and (b) several years of MedPAR files to calculate the average payment percentage on transfer cases.²³ NHDS data contains both Medicare and non-Medicare stay data, including length of stay and transfer status and is available

¹⁶ *Id.* at 8.

¹⁷ *Id.* (citing 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842).

¹⁸ *See generally* PRRB Case 19-1723GC *et al.*

¹⁹ Request for EJR, Exhibit 5, referring to the report of Constantijn Panis, Ph.D. (the “Panis Report”). The author’s professional summary indicates that he is “an expert in healthcare, demographic issues, statistics, and forecasting.” *Id.* at 38. The Panis Report analyzes available alternative hospital data (in the absence of the 1981 MedPAR file) and calculates an estimated correction factor. For sake of clarity, the Board reviewed the Panis Report solely to assess whether the AIC meets the jurisdictional threshold.

²⁰ *Id.* at ¶ 9.

²¹ *Id.* at ¶ 10.

²² *Id.* at ¶ 43.

²³ *Id.* at ¶ 44.

at <https://www.cdc.gov/nchs/nhds>.²⁴ The report removed non-Medicare stays to create its data sample.²⁵ The report also evaluated MedPAR data from 1997 through 2017 to estimate the average payment percentage of transfer cases in 1981, assuming there is nothing that would have caused a difference in the average ratio of length of stay to deviate from 1997 to 1981.²⁶ Using this data, the report explains that the correction factor could range from 0.62 to 0.71%, or could simply be deemed the same as used for FFY 1992 when adjusting the Capital PPS (0.9%).²⁷

Ultimately, the Providers do not believe any findings related to this report are necessary for the Board to grant EJR because it was simply submitted to demonstrate that the jurisdictional AIC has been satisfied.²⁸ Moreover, the Providers contend that the calculation of any precise damages would only be necessary after a court invalidates the FFY 2025 standardized amount and payment rates and remands to the Secretary for further proceedings.²⁹

B. Board Jurisdiction

1. St. Mary's Regional Medical Center v. Becerra

The Board Majority has historically found that the Board lacks substantive jurisdiction over the issue presented in these appeals relying on a statutory review preclusion provision. Accordingly, on appeal of such findings, the D.C. District Court's decision in *St. Mary's Regional Medical Center v. Becerra*,³⁰ concerned the same substantive issue presented in the instant group appeals – namely whether the Secretary miscalculated the standardized amount in FY 1984 by including transfer cases in the denominator – and the Court decided whether section 1395ww(d)(7)(A) bars review of this issue.

Here, relative to a challenge relating back to FY 1984, it is important to note that while there are time limits on when a provider can challenge their payment determinations, providers are generally permitted to challenge “predicate facts.” Specifically, courts have permitted providers to modify “predicate facts in closed years provided the change will only impact the total reimbursement determination in open years.”³¹ Predicate fact challenges are permitted “no matter how long ago the facts were established, so long as the providers raise their challenge in a timely administrative appeal and seek damages only for underpayment during an open cost year.”³²

²⁴ *Id.* and n.9.

²⁵ *Id.* at ¶ 44.

²⁶ *Id.* at ¶ 47.

²⁷ *Id.* at ¶ 56.

²⁸ Request for EJR at 9.

²⁹ *Id.* (citing *Tri-County Hospice, Inc. v. Sebelius*, 788 F. Supp. 2d 1274, 1276 (E.D. Okla. 2010) (stating that requiring factual findings as to damages would “render[] nugatory the word ‘expedited’ in EJR”).

³⁰ 2024 WL 5186641 (D.D.C. 2024).

³¹ *Id.* (citing *Kaiser Found. Hosps. v. Sebelius*, 708 F.3d 226, 232-233 (D.C. Cir. 2013)).

³² *Id.* (citing *St. Francis Med. Ctr. v. Azar*, 894 F.3d 290, 294 (D.D.C. 2018)).

Accordingly, in *St. Mary's*, a group of providers challenged their FY 2019 IPPS payments, alleging that when calculating “allowable operating costs per discharge” in calculating the IPPS, “the Secretary erroneously counted inter-hospital transfers as ‘discharges,’ . . . [which] depressed the inaugural standardized amounts and, . . . has perpetuated chronic underpayment up to the present day.”³³ In April 2023, the Board dismissed the underlying providers’ appeals in *St. Mary's* for lack of subject matter jurisdiction, finding the standardized amounts at issue were inextricably intertwined with the budget neutrality adjustments which were precluded from administrative review.³⁴ With regard to whether the providers had standing to bring their case before the Board, the court in *St. Mary's* addressed the Board’s findings ***and rejected them all***.

Where the Board opined that the original standardized amount calculations were actually inflated, rather than deflated, the Court found that this did not obviate “the independent, judicially cognizable injury which the plaintiffs now allege—to wit, that the Secretary's supposedly unlawful categorization of transfers as discharges exerted downward pressure on their compensation.”³⁵ The Court went on to hold that the injury alleged by *St. Mary's* was not erased by “some unrelated benefit of equal or greater value” claimed to be conferred by the Secretary.³⁶ Moreover, the summation of the gravity of the alleged errors would be relevant to the issue of damages during the litigation phase, if reached, but irrelevant to the ponderance of jurisdiction.³⁷

The Court also rejected the Board’s acceptance of the notion that other adjustments to the standardized amount “between 1985 and 1997 may have broken the chain between the inaugural calculations and the allegedly depressed 2019 standardized amounts.”³⁸ The Court seemed skeptical,³⁹ and while it did not outright reject this argument, it was not sufficiently explored to defeat the Provider’s jurisdictional claim of standing.

The Court then looked to whether the statutory preclusion provisions actually precluded review of the 1984 standardized amounts. Contrary to the Board’s finding, the Court held that the statutes did not explicitly preclude review,⁴⁰ and also found that the calculation of the 1984 standardized amounts is not “inexplicably intertwined” with the budget neutrality adjustments, especially in light of the Administrative Procedure Act’s strong presumption of judicial review.⁴¹

³³ *St. Mary's*, at *4.

³⁴ PRRB Case 19-1723GC *et al.*

³⁵ *St. Mary's* at *7.

³⁶ *Id.*

³⁷ *St. Mary's* at *7.

³⁸ *Id.*

³⁹ *Id.* (“[T]he Secretary himself reiterated that the current standardized amount is the result of adjusting and updating the original standardized amounts, necessarily—if implicitly—disclaiming the possibility that subsequent statutory or regulatory changes have washed away any trace of the inaugural calculations.”) (citing 83 Fed. Reg. 41144, 41713 (Aug. 17, 2018)).

⁴⁰ *Id.* at *11-12.

⁴¹ *Id.* at *13-17.

Ultimately, the Court remanded the case for further proceedings.⁴² The Secretary then filed a motion for clarification or partial reconsideration of the Court’s decision. On September 26, 2025, the Court issued a Memorandum & Order granting the Secretary’s motion to confirm that the Court’s holdings are limited to the Board’s subject matter jurisdiction over the dispute relative to reviewing the matter absent the purported statutory review preclusion, and denying the motion for partial reconsideration.⁴³ The cases have been remanded to the Board and are currently pending on the Board’s docket.⁴⁴

2. *Jurisdictional and Substantive Claim Challenges*

Board Rule 44.6 (2023) governs the timing of Jurisdictional and Substantive Claim Challenges in cases where a Request for EJR is filed less than sixty (60) days from the filing of a Final Schedule of Providers (or Board Rule 20 Certification filed in lieu of a Final SOP (“Schedule of Providers”) which certifies that the group is complete and fully populated in the Board’s case management system, OH CDMS).⁴⁵ In such instances, Board Rule 44.6 requires any party questioning the Board’s jurisdiction or whether an appropriate cost report claim was made to file the challenge, or a certification that a challenge is forthcoming, within five (5) business days of the date the EJR Request was filed. If the Medicare Administrative Contractor files a certification that a challenge is forthcoming, it must file its challenge no later than twenty (20) days following the filing of the EJR Request.

Board Rule 44.6 also explicitly states:

If the Medicare contractor files the certification, then the failure of the Medicare contractor to file any challenges within the 20-day deadline will be grounds for the Board to take remedial action pursuant to 42 C.F.R. § 405.1868(c)(1), unless the Medicare contractor establishes good cause.

On **December 30, 2025**, the Providers certified that their respective groups in these cases were fully formed. On the same day, the Requests for EJR were filed.

On **January 5, 2026**, the Medicare Administrative Contractor’s designated representative, Federal Specialized Services (“FSS”) filed timely certifications in both cases which simply stated:

Federal Specialized Services (“FSS”), as representative for the Medicare Administrative Contractor (“MAC”), responds to the Providers’ request for

⁴² *Id.* at *19.

⁴³ *St. Mary’s Reg’l Med. Ctr. v. Kennedy*, No. 1:23-cv-01594-RCL (Sept. 26, 2025).

⁴⁴ *See e.g.*, EJR Ex. 9 at 2, Status Report 12/19/2025 in *Nea Baptist* (where all 14 status reports state, “Given the Decision in *St. Mary’s*, the Secretary anticipates filing a motion for voluntary remand in this case by January 30, 2026.”)

⁴⁵ The Providers never certified that these two cases were fully populated in OH CDMS as required by Board Rule 20, but the Board will presume the date the Providers’ Representative acknowledged that the cases were fully formed was an indication that they were, in fact, fully populated.

Expedited Judicial Review (EJR) and notes that a jurisdictional challenge will be filed.

As such, any jurisdictional and/or substantive claim challenges were due by January 20, 2026. Unfortunately, between January 20 - 21, 2026, OH CDMS experienced a system outage. Because no challenges were received in the instant matters, the assigned Board Advisor reached out to FSS on January 22, 2026 to inquire whether there was an attempt to file any challenges. FSS replied:

With respect to 25-1782GC and 26-0941GC, both cases are standardized amount cases and in light of the *St. Mary's* decision, we are not filing a jurisdictional challenge.

The Board ***admonishes*** FSS for certifying that it would, in fact, be filing jurisdictional challenges in both cases and failing to do so. The Board emphasizes that the *St. Mary's* decision was published in December 2024, and that the Court's Order clarifying that decision was issued in September 2025. Following its certification that it would, in fact, be filing jurisdictional challenges in these cases, FSS failed to timely alert the Board of its decision not to do so until the Board Advisor affirmatively inquired—two days after the deadline for filing such jurisdictional challenges. Thus, the Board intends to take remedial actions it considers appropriate pursuant to 42 C.F.R. § 405.1868(c)(1)(ii) by issuing a written notice to CMS describing the contractor's actions and requesting that CMS take appropriate action, such as review of the contractor's compliance with the contractual requirements for 42 C.F.R. §§ 421.120, 421.122, and 421.124.

3. *Board Findings on Jurisdiction and Appropriate Cost Report Claims*

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

a. Preliminary and Subject Matter Jurisdiction

Pursuant to 42 C.F.R. § 405.1840(a)(2)(i), the Board must make a preliminary jurisdictional determination “(that is, whether the request for hearing was timely, and whether the amount in controversy requirement has been met), if any, over the matters at issue in the appeal before [] determining its authority to decide a legal question relevant to a matter at issue” (i.e., expedited judicial review).

As previously noted, all of the participants in these group cases appealed from the FFY 2025 and 2026 IPPS Final Rules.⁴⁶ The Board Majority has determined that: (1) the appeals were timely filed, and (2) the participants' documentation in the group appeal shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal.⁴⁷ In finding that the groups meet the \$50,000 amount in controversy, the Board Majority recognizes that amounts in controversy are calculated by applying an *estimated* correction factor of 0.65%.⁴⁸ Accordingly, the Board Majority finds that the amounts claimed were made in good faith and are sufficient to meet the *jurisdictional threshold* required for the Providers to be entitled to a hearing on the issue presented.⁴⁹

As to any concerns about the accuracy of these estimates (specifically with regard to the data used and the assumptions made in the calculations), or expert qualification, or any questions of whether the Providers would ultimately be able to prove actual damages, the Board Majority acknowledges that such concerns involve *underlying factual matters* that would be addressed during a case on the merits and damages, *if reached*. But the foregoing are not to be used as blocks to a jurisdictional finding for purposes of determining a right to a hearing or the appropriateness of EJR for a legal challenge outside of the Board's authority.

Next, we recognize that in prior Board decisions, the Board found that the Transfer/Discharge Error was *inextricably* tied with the FFY 1985 budget neutrality adjustment ("BNA") to the standardized amounts *for purposes of future FFYs* under the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), and both 1395ww(d)(2)(F) and 1395ww(d)(3)(C) which reference 1395ww(e)(1)(B), as demonstrated by the fact that the FFY 1985 budget-neutrality adjusted rates were used as the basis for the determination of rates for FFY 1986 and later years. Further, the Board found that 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations⁵⁰) prohibit administrative and judicial review of those BNAs. Based on those findings, the Board concluded that it did not have substantive jurisdiction over the issue in those group cases and denied the providers' requests for EJR, and further, dismissed the cases.⁵¹

As previously mentioned, based on the ruling in *St. Mary's*, Board review of the matter in this appeal is ***not precluded by statute or regulation***, and thus, the Board has subject matter jurisdiction

⁴⁶ 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.

⁴⁷ See 42 C.F.R. § 405.1837.

⁴⁸ Request for EJR, Exhibit 5.

⁴⁹ See *Infinity Care of Tulsa v. Sebelius*, 2011 WL 778111, *3 (N.D. OK 2011). Compare *Beacon Healthcare Svcs., Inc. v. Leavitt*, 629 F.3d 981, 984 (9th Cir. 2010) (distinguishing the amount in controversy, which is typically determined from the face of the pleadings, with the remedy sought).

⁵⁰ See, e.g., 42 C.F.R. §§ 405.1804, 405.1840(b)(2).

⁵¹ See, e.g., PRRB Case Nos. 19-1723GC, 19-1735GC, 19-1763, 19-0233GC, 19-1628GC and 19-0710GC, the precursor to *St. Mary's*.

over such appeals.⁵² However, *St. Mary's* holding is “‘confin[ed]’ to reviewing the ‘validity of th[at] ground[]’”⁵³ and does not make a dispositive determination regarding the appropriateness of EJR for the instant matter or the like.

Based on the foregoing, the Board Majority acknowledges that it has jurisdiction over the Providers’ above-captioned appeals.

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

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

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

(b) *Summary of Procedures.*

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

(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*

⁵² See *St. Mary's* at 17.

⁵³ See Providers’ Exhibit 8, Memorandum and Order on Motion for Clarification, p. 5 (quoting *SEC v. Chenery Corp.*, 318 U.S. 80, 88 (1943)).

*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.**⁵⁴*

The substantive claim 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 arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to **only** require the Board to review a provider's "compliance"⁵⁵ 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.⁵⁶

As discussed above, FSS failed to file any jurisdictional or substantive claim challenges to Providers' Request for Expedited Judicial Review. Pursuant to § 405.1873(a) and in compliance

⁵⁴ (Bold italics emphasis added.)

⁵⁵ 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."

⁵⁶ See 42 C.F.R. § 405.1873(a).

with the Board’s Rules, since no party to the appeal has questioned whether an appropriate claim was made,⁵⁷ 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.

BOARD DECISION:

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers “inpatient hospital services.” Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the IPPS.⁵⁸ Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.⁵⁹

In order to implement IPPS, “the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services.”⁶⁰ The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and “requires that certain base period cost data be developed and modified in several specified ways (*i.e.*, inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation.”⁶¹ Section 1395ww(d)(2)(A) requires that the Secretary determine a “base period” operating cost per discharge using the most recent cost reporting period for which data are available:

(A) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

Consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the “base period” operating cost per discharge.⁶² The Secretary then *updated* the per discharge amount by an inflationary factor.⁶³

⁵⁷ 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.”

⁵⁸ See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

⁵⁹ *Id.*

⁶⁰ 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).

⁶¹ *Id.*

⁶² 48 Fed. Reg. 39752, at 39763 (Sept. 1, 1983).

⁶³ *Id.* at 39763-64.

The Providers dispute how the Secretary determined “discharges” and allege that the Secretary improperly treated transfers as discharges for purposes of this calculation. In doing so, they point to the 1984 IPPS Final Rule and the discussion therein, arguing CMS acknowledged the distinction between transfers and discharges but incorrectly claimed the effect was insignificant:

With respect to the data used in computing prospective payment rates, we recognize that transfers were previously considered as discharges. Under the interim final rule, the transfer of a patient between two hospitals, each of which is subject to the prospective payment system, will not be considered a discharge for the transferring hospital. This type of a transfer would have been a discharge under the reasonable cost reimbursement system. However, no data were presented to indicate the actual effect, if any that this difference between the definitions of discharge under the old and new payment system might have on the DRG rates.

With respect to the Federal rates, we would expect any discrepancy between the “old” and “new” definitions of discharge to have no significant effect on the rates. This is because patients transferred to another hospital constitute only a small fraction of the total number of discharges. It should also be noted that certain transfers under the prospective payment system will still be considered discharges, namely, transfers between a hospital subject to prospective payment and an excluded hospital. This would reduce even further the already small discrepancy between the definition of discharges under the old system and the definition under the new system.

In discussing the transfer policy with respect to the difference in the definition of “discharge”, a distinction must be made between the computation of the Federal rates, and the payments made to a particular hospital under the prospective payment system. While we would expect, as stated above, that there would be little effect of the difference in definitions on the rates, individual providers could receive a significant amount of unjustified payments, if they had a large number of transfers and we paid for each transfer at the full prospective payment rate as if it were a discharge.

Finally, we wish to reiterate that the transfer policy contained in the interim final rule was intended as an interim policy. As we stated in the preamble to the interim final rule (48 FR 39759), our ultimate goal, which we expect to implement within the next few years, is to pay a single rate to one hospital for a given course of treatment to a

given patient. Therefore, we believe that hospital managers should begin to anticipate our final transfer policy and to incorporate this eventual change into their financial and management planning.⁶⁴

B. Board Majority's Decision Regarding the EJR Request

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), the Board must grant a request for EJR if it has jurisdiction over the appealed issue and lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling. Having already found that it has jurisdiction over these appeals, the Board must determine whether it has the authority to decide the legal question relevant to the matter at issue.

1. Factual Disputes and Board Record Development

At the outset of this of our analysis, the Board Majority acknowledges that Board Rule 42.3 requires a Request for EJR to demonstrate that there are “no factual issues in dispute.” Here, it is important to note that the duty to establish whether there are factual disputes first lies with the parties to the appeal. Although Board Rule 42.3 requires a demonstration that there are “no factual issues in dispute,” such is not to be interpreted as any and all facts must be resolved to pursue expedited review of a **legal question** outside of the Board’s authority, which is distinguished from a question of fact. Moreover, from a purely legal perspective, a Request for EJR is akin to a motion for summary judgment in trial court where to prevail, the moving party must show there are no genuine disputes of **material fact**.⁶⁵ The Board Majority recognizes that “material” is not used as an adjective that modifies the noun “fact” to specify the significance of the facts to be discerned versus trivial ones.⁶⁶ However, in its prior dismissals of the issue presented herein, even the Board

⁶⁴ 49 Fed. Reg. 234, 245-246 (Jan. 3, 1984).

⁶⁵ See e.g. Federal Rule of Civil Procedure 56.

⁶⁶ Even if the reference to “no factual issues in dispute” in Board Rule 42.3 is taken at face value, a historical review of 42 C.F.R. § 405.1842 reveals that prior to 2008, versions of regulation specified that:

If there are factual or legal issues in dispute on an issue **within the authority of the Board to decide**, the Board will not make an expedited review determination on the particular issue but will proceed with a hearing. The Board has the authority to decide when two or more issues are sufficiently related to preclude separation for purposes of an expedited review determination on one or more of them and a hearing on the other or others.

See 48 Fed. Reg. 22920, 22922-22925 (May 23, 1983). However, by May 23, 2008, 405.1842 had been overhauled and all references to the words “factual” or “fact” were removed from the regulation in an effort to clarify that EJRs were specific to legal questions over which the Board had no authority to resolve. See 73 Fed. Reg. 30190, 30214-30215:

acknowledged that “no factual issues in dispute” in Board Rule 42.3 is with reference to “material” facts, not merely any facts that have no dispositive impact on the matter.⁶⁷

Additionally, in accordance with 42 C.F.R. § 405.1865, *et. seq.*, the Board Majority recognizes the importance of developing a sufficient record for review by the CMS Administrator or the district courts.⁶⁸ However, here too, the initial responsibility to develop the record lies with the parties in either the pursuit or defense of the appeal. For instance, 42 C.F.R. § 1865(a)(2) states, “For proceedings before the Board, ***the administrative record consists of all evidence, documents and any other tangible materials submitted by the parties to the appeal and by any nonparty*** (as described in §§ 405.1853(e)(4) and 405.1857(c)(3) of this subpart), along with all Board correspondence, rulings, subpoenas, orders, and decisions.” Although the trier-of-fact in matters before it, the Board must remain impartial and balanced in developing the record (that is, finding out what the facts are) based on the documentary and testimonial evidence presented by the parties, and even some pertinent public factual information of which it may take notice. That is to say, “[t]he administrative [tribunal] must not go so far in developing the record so as to take on the aspects of a litigant with a decided point of view.”⁶⁹ Furthermore, with respect to EJR, the record is limited to the documentary evidence produced by the parties in support of or opposition to the legal question or challenge posed by the appellant.⁷⁰

2. *Providers’ legal challenge and whether EJR is appropriate.*

Under section 1878(f)(1) of the Act, a provider in certain situations may immediately seek judicial review of an action of the intermediary involving a question of the statute or regulations whenever the Board determines that it is without authority to decide the issue. If the Board determines that it has jurisdiction over the issue, but it lacks the authority to decide the issue, the provider may obtain expedited judicial review (EJR). The intent of this provision is to eliminate undue delays resulting from a requirement that providers pursue time-consuming and unproductive administrative reviews before they could obtain judicial review of a Board determination. We proposed several changes to § 405.1842 to clarify any confusion surrounding the procedures and the types of cases to which EJR applies.

⁶⁷ See PRRB Case 19-1723GC at 10-11 (“Similarly, the Board notes that consideration of expedited judicial review is not appropriate if there are **material** facts in dispute. Accordingly, the Board’s RFI was designed to further develop the record regarding both the highly complex nature of the Providers’ dispute as it relates to whether the Board has jurisdiction to hear the Providers’ dispute and whether EJR is appropriate (including whether there are **material** factual disputes.”); see *id* at 3 (where the Board discusses a prior denial of EJR and requested additional information “to allow the Board to determine whether... (3) there are **material** factual disputes.”); see *id* at 30, Fn. 63 (where the Board pondered that additional input from the parties could lead to a determination “that **material** factual disputes exist”).

⁶⁸ See also 42 C.F.R. § 405.1875 and § 405.1877.

⁶⁹ Richard Murphy & Charles H. Koch, Jr., *Administrative Law And Practice* § 5:25 (3d ed. 2021).

⁷⁰ See e.g., 42 C.F.R. § 405.1842(d)(2) and (e)(2)(ii).

Courts have unequivocally held that the Board lacks the power to adjudicate direct challenges to IPPS rules.⁷¹ Moreover, pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program.

In this case, the Providers challenge “the unlawful IPPS underpayments resulting from the understatement of the standardized amount and payment rates published in the FFY 2025 IPPS Final Rule, 89 Fed. Reg. 68,986 (Aug. 28, 2024)”⁷² and “the unlawful IPPS underpayments resulting from the understatement of the standardized amount and payment rates published in the FFY 2026 IPPS Final Rule, 90 Fed. Reg. 36,536 (Aug. 4, 2025).”⁷³ As set forth above, to support its challenge of the validity of the FY 2025 and FY 2026 IPPS rates based on a perpetually embedded Transfer/Discharge Error, Providers argue the Secretary acknowledged the inclusion of transfers.

In these cases, it is undisputed that 42 U.S.C. § 1395ww(d)(2)(A) required the Secretary to “determine the allowable operating *costs per discharge* of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.”⁷⁴ Providers’ “claim that the Secretary lumped discharges and transfers together is uncontroverted. 49 Fed. Reg. 234, 245–46 (Jan. 3, 1984).”⁷⁵ The record is clear that the Secretary used 1981 data to make this determination, and acknowledged that certain transfers, namely transfers between hospitals subject to IPPS, counted as discharges in 1981 would no longer be considered discharges starting in 1984 under the new IPPS. However, the Secretary believed that these certain types of transfers would not significantly impact the calculation of the 1984 standardized amounts and did not adjust for them.⁷⁶ Whether 42 U.S.C. § 1395ww(d)(2)(A) require the removal of these transfers from the calculation of the 1984 standardized amount is *a purely legal question*. Even if the Board had the authority to find that they should have been removed, the Board lacks the authority to order the removal or to order the invalidation and recalculation of IPPS rates based on such a finding.⁷⁷ Therefore, the Board Majority finds that EJR is appropriate.

The Board Majority acknowledges that if the Providers prevail in this legal challenge at the district court level, they must then prove the impact of any alleged errors in setting the inaugural IPPS standardized amounts on present day rates with the presentation of evidence. Moreover, in *St. Mary’s*, the Court signaled that EJR is appropriate as to the legal question presented and that the Board’s lack of authority to resolve the matter:

If the plaintiffs cannot establish *ultra vires* jurisdiction, the appropriate next step is to remand the case to the agency,

⁷¹ See *St. Mary’s Regional Medical Center v. Becerra*, 2024 WL 5186641, *5 (D.D.C. Dec. 20, 2024) (citing *Bayshore Cmty. Hosp. v. Azar*, 325 F. Supp. 3d 18, 21 (D.D.C. 2018)); *Cape Cod Hosp.*, 630 F.3d 203, 205 (D.C. Cir. 2011).

⁷² EJR Request, Case No. 25-1782GC (OSF Healthcare FFY2025), at 2.

⁷³ EJR Request, Case No. 26-0941GC (LifePoint Health FFY2026), at 2.

⁷⁴ Emphasis added.

⁷⁵ *St. Mary’s* at 7.

⁷⁶ 49 Fed. Reg. 234, 245-246 (Jan. 3, 1984).

⁷⁷ 42 C.F.R. § 405.1867.

which will likely result in certification for expedited judicial review. *See Bayshore Cmty. Hosp*, 325 F. Supp. 3d at 21 (citing 42 C.F.R. § 405.1867). Remanding for this purpose may seem like a pointless formality, but as another court in this District has concluded, the statutory scheme appears to condition the district court’s jurisdiction on the plaintiffs’ receipt of expedited judicial review certification. *[citations omitted]*.

Additionally, if and when the case returns to federal court, the parties’ briefs will be focused on the merits of the dispute, rather than the jurisdictional questions addressed herein.

As for the second element [of the *ultra vires* review], the Court has already clarified that the PRRB has subject matter jurisdiction to entertain the plaintiffs’ challenge and certify it for judicial review, affording an “alternative procedure for review of the [plaintiffs’] statutory claim” [citation omitted].⁷⁸

Based on the foregoing, the Board Majority finds that:

- 1) It has jurisdiction over the challenges to the calculation of the standardized amounts used in federal rates for the IPPS during FFY 1984 as it allegedly impacts the Providers’ FFY 2025 and 2026 IPPS rates 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 challenges⁷⁹ have been filed pursuant to 42 C.F.R. § 405.1873(a) to trigger Board review under § 405.1873(b) or reporting under § 405.1873(d)(2);
- 3) Based upon the Providers’ uncontested assertions regarding the calculation of the standardized amounts used in federal rates for the IPPS during FFY 1984 and its alleged impact on the Providers’ FFY 2025 and 2026 IPPS rates, there are no findings of fact for resolution by the Board;

⁷⁸ *St. Mary’s* at 17-18.

⁷⁹ 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.”

- 4) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867);
and
- 5) It lacks the authority to decide the legal question of whether the Providers' FFY 2025 and 2026 IPPS rates are understated because transfers were erroneously included in the calculation of the standardized amounts used in federal rates for the IPPS during FFY 1984.

Accordingly, the Board concludes that the question of whether the Providers' FFY 2025 and 2026 IPPS rates are understated falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and in accordance with 42 C.F.R. §405.1842(f)(1), and hereby grants the Providers' requests for EJRs 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 Cases 25-1782GC and 26-0941GC, the Board hereby closes them and removes them from its docket.

Board Members Participating:

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

For the Board:

1/29/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Pamela VanArsdale, National Government Services, Inc. (J-6)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Scott Berends, FSS

Dissent, Kevin D. Smith, CPA

I find myself having to dissent with the Board Majority regarding the Provider’s Request for Expedited Judicial Review (“EJR”). Historically, the Board denied EJR in these types of cases as it determined it lacked substantive jurisdiction, however the District Court for the District of Columbia rejected that argument in *St. Mary’s Regional Medical Center v. Becerra*.⁸⁰ CMS did not appeal that decision. CMS did, however, seek clarification of the scope of the Court’s ruling on summary judgement. In the Memorandum & Order resulting from that Motion for Clarification, the D.C. District Court made clear that its decision addressed only the single determination of the Board that it did not have jurisdiction for the reasons it had cited in its EJR denial. The Court stated:

The Court appreciates that aspects of the Court’s extensive analysis on standing could be read as portending a ruling on the justiciability of the plaintiffs’ claims on the merits. But to the extent they do so, that discussion should be understood only as dicta. The plaintiffs present thin justifications for why it could and should be construed otherwise. For example, they contend that ‘[t]he Court had an obligation to satisfy itself that Plaintiffs were entitled to be in federal court.’ But that obligation . . . was limited to determining Article III standing only to the extent necessary for resolving the jurisdictional question before it. The plaintiffs also contend that a broader reading of the ruling would promote judicial economy. But a litigant’s perspective on efficiency cannot justify sidestepping the exhaustion procedures set out by Congress. ‘Though Congress implemented the EJR provision to avoid unnecessary delays, those necessary to and inherent in the legal process are often unavoidable.’ *Cape Cod Hosp.*, 565 F. Supp. 2d at 141. ‘The proper procedures’ still ‘must be followed.’ *Id.*⁸¹

Additionally, in its original decision, the D.C. District Court addressed “issue exhaustion,” stating:

Issue exhaustion in the administrative context is ‘an analogy to the rule that appellate courts will not consider arguments not raised

⁸⁰ No. 1:23-cv-1594-RCL, 2024 WL 5186641 (D.D.C. Dec. 20, 2024).

⁸¹ No. 1:23-cv-1594-RCL, Memorandum and Order, 6 (Sep. 26, 2025).

before trial courts. . . .the plaintiffs had no genuine opportunity ‘to develop the issue[] in an adversarial administrative proceeding’ before they arrived in this court.⁸²

In that same December 20, 2024 decision, the D.C. District Court further stated:

As the case proceeds from here to a determination on the merits, the agency should be given an opportunity to examine the administrative record and determine whether it is adequately developed. . . . the Court will order the parties to submit periodic status reports updating the Court on the parties’ progress toward finalizing the administrative record (if any supplementation is necessary). . . .⁸³

It is clear that the Court expects the agency, and by extension of remand, the Board, to ensure that the record is “adequately developed,” expecting “periodic status reports” (both “periodic” and the plural term “reports” implies a potential length of time). In the *St. Mary’s* case, five group cases before the Board were requesting EJR. In all five cases, both parties had filed a preliminary position paper, the Board had issued a Request for Information (“RFI”) on certain issues, and the parties had responded. Yet, the Court still was aware of the possibility that the record may not have been fully developed and might require supplementation. In the two cases before us now, the cases were filed on January 29, 2025 and December 30, 2025, respectively. Both were certified to be fully formed, with all common issue related party participants added to the groups, on December 30, 2025, less than one month ago. Neither record contains any preliminary position papers or other briefing documents. As it stands, the only documents in the records that may address the merits of the issue are the original appeal requests (which include a quite brief issue statement) and the EJR Requests. The records in these cases are substantially less developed than the *St. Mary’s* cases, which have been remanded back to the Board for analysis of the record.

The Code of Federal Regulations at 42 C.F.R. § 405.1842(f) addresses the Board’s decision on EJR. Section 405.1842(f)(2) states:

(2) The Board’s decision must deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if any of the following conditions are satisfied:

⁸² No. 1:23-cv-1594-RCL, 2024 WL 5186641 (D.D.C. Dec. 20, 2024).

⁸³ *Id.*

(i) The Board determines that it does not have jurisdiction to conduct a hearing on the specific matter at issue in accordance with § 405.1840 of this subpart.

(ii) The Board determines it has the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is neither a challenge to the constitutionality of a provision of a statute, nor a challenge to the substantive or procedural validity of a regulation or CMS Ruling.

(iii) The Board does not have sufficient information to determine whether the criteria specified in paragraph (f)(1)(i) or (f)(1)(ii) of this section are met.⁸⁴

Similarly, in the Board's own Rules, Rule 42.3 addresses the Content of the EJR Request, and states:

A provider or a group of providers must file a written request for EJR with a *fully developed narrative* that:

- Identifies the issue for which EJR is requested;
- Demonstrates that there are no factual issues in dispute;
- Demonstrates that the Board has jurisdiction;
- Identifies the controlling law, regulation, Federal Register notice, or CMS ruling that is being challenged; and
- Explains why the Board does not have authority to decide the legal question posed by the appeal.⁸⁵

Again, in the instant cases, I find it hard to ensure that the EJR narrative is “fully developed,” as required by Board Rule 42.3, because there are no other briefs in the records to ensure that there is a complete narrative with respect to the issue. Further, there is nothing at all from the Agency's perspective at all in the records for these cases. This leads me to the opinion that the Board does not yet “have sufficient information to determine whether the criteria specified” in the regulation are met. I would consider requiring complete briefs/position papers before granting, or denying, EJR. I feel that the current state of the record in these two cases is not complete, nor is it fully

⁸⁴ 42 C.F.R. § 405.1842(f)(2). The Board notes that the references to (f)(1)(i) and (f)(1)(ii) reflect the same criteria which are reiterated in (f)(2)(i) and (f)(2)(ii).

⁸⁵ Board Rules v. 3.2 (Dec. 15, 2023).

developed. I have concerns that I would be abdicating my duty to ensure the record is complete and fully developed if I voted to grant EJR at this stage, in these particular cases.

I also have doubts that the facts are as clear as the Providers attempt to suggest, which also reflects upon the requirement in Board Rule 42.3 to “[d]emonstrate[] that there are no factual issues in dispute.” Indeed, in its discussion of the Providers’ *ultra vires* argument in the *St. Mary’s* case, the D.C. District noted that:

the plaintiffs do not contend that § 1395ww explicitly defines ‘discharge’ at all, let alone so as to unambiguously exclude transfers. . . . Thus, the Court cannot say that the Secretary’s decision to include transfers in his count of discharges runs ‘contrary to a specific prohibition in the statute.’ This is not to prejudge the plaintiffs’ likelihood of success on the merits; it is merely to say that the plain language of the statute does not compel their victory so obviously as to sustain a claim for *ultra vires* jurisdiction.⁸⁶

In these cases, the Providers’ single sentence issue statement is as follows:

The common issue before the PRRB is whether the hospitals have been underpaid for the periods covered by the 2025 federal fiscal year because the inpatient hospital prospective payment system (PPS) standardized amounts are understated for the 2025 federal year due to the Secretary’s failure to properly distinguish between patient transfers and discharges in establishing the PPS 1983 base year amounts.⁸⁷

In their EJR request, the Providers have expanded the issue statement somewhat, now arguing that:

The standardized amount and payment rates for federal fiscal year (“FFY”) 2025 are unlawfully understated because the Secretary calculated them without correcting for a known embedded error that has been causing substantial underpayments to Medicare providers since the inception of IPPS. Specifically, the Providers contend that the Secretary improperly determined the inaugural IPPS standardized amounts by including *transfer* cases when

⁸⁶ No. 1:23-cv-1594-RCL, 2024 WL 5186641 (D.D.C. Dec. 20, 2024) (Citations omitted).

⁸⁷ *E.g.*, Case No. 25-1782GC, Statement of Issue Under Appeal at 1 (Jan. 29, 2025). In the case of Case No. 26-0941GC, the statement is identical but references federal fiscal year 2026 instead of 2025.

determining “the allowable operating *costs per discharge* of inpatient hospital services for [each] hospital for the most recent cost reporting period for which data are available.” (42 U.S.C. § 1395ww(d)(2)(A) (emphasis added))

As discussed above, the D.C. Circuit Court noted that the Providers in *St. Mary’s* stopped short of stating that “§ 1395ww explicitly defines ‘discharge’ at all, let alone so as to unambiguously exclude transfers.” In the instant cases, the Providers contend that there is a differentiation somehow required between “transfers” and “discharges.” But, the regulation only refers to “allowable operating costs per discharge.” No suggestion that “transfers” must be excluded is made in the statute. In the Final 1984 IPPS Rule⁸⁸ published on January 3, 1984, the Secretary stated:

With respect to the data used in computing prospective payment rates, we recognize that transfers were previously considered as discharges. Under the interim final rule, the transfer of a patient between two hospitals, each of which is subject to the prospective payment system, will not be considered a discharge for the transferring hospital. This type of transfer would have been a discharge under the reasonable cost reimbursement system. However, no data were presented [in the comments to the Rule] to indicate the actual effect, if any, that this difference between the definitions of discharge under the old and new payment system might have on the DRG rates.⁸⁹

The 1984 Interim Final Notice With Comment Period was issued as 48 Fed. Reg. 39746 on September 1, 1983. The Final Rule was then issued as 49 Fed. Reg. 234 on January 3, 1984. Both refer to 42 C.F.R. 405.470, as follows. In the Interim Final Notice, the purpose of § 405.470 is given as:

Sections 405.470 through 405.477 of this subpart implement section 1886(d) of the Act by establishing a *prospective payment system for inpatient hospital services furnished to beneficiaries in cost reporting periods beginning on or after October 1, 1983.*⁹⁰

The Final Rule revises § 405.470(c) as follows:

⁸⁸ 49 Fed. Reg. 234 (Jan. 3, 1984).

⁸⁹ *Id.* at 245-46.

⁹⁰ 48 C.F.R. 39746, 39817 (Sept. 1, 1983) (italics emphasis added).

(c) Discharges and transfers.

(c)(1) Discharges. A hospital inpatient is discharged when –

(c)(1)(i) The patient is formally released from the hospital (release of the patient to another hospital as described in paragraph (c)(2) of this section, or a leave of absence from the hospital, will not be recognized as a discharge for the purpose of determining payment under the prospective payment system);

(c)(1)(ii) The patient dies in the hospital; or

(c)(1)(iii) The patient is transferred to a hospital or unit that is excluded from the prospective payment system under § 405.471.

(c)(2) Transfers. Except as provided in paragraph (c)(1)(iii) of this section, a discharge of a hospital inpatient is not counted *for purposes of the prospective payment system* when the patient is transferred –

(c)(2)(i) From one inpatient area or unit of the hospital to another area or unit of the hospital;

(c)(2)(ii) From the care of a hospital *paid under this section* to the care of another such hospital;

(c)(2)(iii) From the care of a hospital *paid under this section* to the care of another hospital –

(c)(2)(iii)(A) Excluded from the prospective payment system only because of its participation in an approved statewide cost control program or demonstration; or

(c)(2)(iii)(B) That would be paid under this section except that its first cost reporting period under the prospective payment system has not yet begun; or

(c)(2)(iv) From the care of a hospital paid under this section to the care of another hospital or hospital unit not officially determined to be excluded from the prospective payment system under § 405.471.⁹¹

⁹¹ 49 Fed. Reg. 314 (emphasis added).

These sections, which were new in 1983/1984 (as they implemented section 1886(d) of the Act), address how discharges/transfers will be handled for purposes of payment under the IPPS system, “for hospital services furnished to beneficiaries in cost reporting periods beginning **on or after October 1, 1983.**”⁹² The regulation states that “a discharge of a hospital inpatient is not counted *for purposes of the prospective payment system* when the patient is transferred....”⁹³ The regulation goes on to identify “from the care of a hospital paid under this section to the care of another such hospital.”⁹⁴ The Providers would like to apply these definitions to the data from the **1981** cost reports used in the development of the standardized rates, but those services were furnished before October 1, 1983, and further, at that time, no hospital was “paid under this [inpatient prospective payment system] section.” In this case, the Provider would like to apply retroactive definitions that were published in 1983/1984 to data from 1981. Any prior definitions of transfers as being different than discharges, prior to the implementation of IPPS in 1983/1984, have not been substantiated in the records before the Board.

The Providers’ EJRs also quote the *Saint Francis Med. Ctr. v. Azar* (“*Saint Francis*”),⁹⁵ case, saying “[t]o this day. . . Medicare payments for inpatient services depend in part on *factual determinations* . . . embedded in 1983 calculation, including the calculation of ‘allowable operating costs per discharge.’”⁹⁶ The argument that these are factual determinations would suggest that the Board should ensure that no facts are in dispute (such as the data or definitions used in the calculation). Again, the record is not fully developed. The Providers make assumptions that the level of transfer data they are seeking was available and/or reported in the 1981 records,⁹⁷ even though the definition of excludable transfers was from 1983 and applied to services furnished on or after October 1, 1983. The Providers further contend in the EJR Request that “the Secretary knew - . . . that the inaugural FFY 1984 standardized amounts had been improperly calculated without excluding or applying any adjustment for the impact of transfers.”⁹⁸ This is an over-reach. The Secretary knew that no adjustments had been made to reflect the exclusion of transfers (as defined in 1983) from the 1981 data, but the statute required a calculation of allowable cost per discharge, from a time when transfers were considered to be discharges prior to 1983. That is not the same thing.

The Providers’ EJRs identify three potential “understatement” amounts, suggesting the use of the Capital PPS correction factor from 1991 (10 years after the IPPS data) of 0.9%. It

⁹² 48 Fed. Reg. 39817 (emphasis added).

⁹³ 49 Fed. Reg. 314 (emphasis added).

⁹⁴ *Id.*

⁹⁵ 894 F.3d 290, 291 (D.C. Cir. 2011).

⁹⁶ *Saint Francis Medical Center v. Azar*, 894 F.3d 290, 291 (D.C. Cir. 2018) (italics emphasis added).

⁹⁷ *E.g.*, Case No. 25-1782GC, Request for Expedited Judicial Review, Exhibit 5, ¶ 43 (Dec. 30, 2025).

⁹⁸ *Id.*, at 4.

uses that factor to develop its amount in controversy, according to the EJR Request.⁹⁹ Later, the Providers cite Exhibit 5 of the EJR Requests (the “Panis Report”) “which analyzes available alternative National Hospital Discharge Survey (“NHDS”) data [for 1981] and calculates an estimated correction factor of 0.65%.”¹⁰⁰ Finally, the Panis Report also evaluated MedPAR data from 1997 through 2017, resulting in a “transfer correction factor” that “ranges from 0.62% to 0.71%.”¹⁰¹ The Panis Report also shows a Table of “Inpatient Stay Destinations” in the 1981 NHDS alternative data it used to calculate the 0.65% correction factor.¹⁰² The Report indicates that “[t]ransfers to another short-term facility, which I have interpreted to mean another hospital as an inpatient, account for 2.0% of all inpatient stays.”¹⁰³ However, this reasoning is flawed, as there are short-term facilities, such as Rehab Hospitals, Psych Hospitals, and Cancer Hospitals which are exempt from IPPS. Even in the 1984 IPPS Final Rule, transfers to these hospitals were still deemed discharges, not excluded as transfers (see 42 C.F.R. 405.470(c)(1)(iii) (1984), *supra*). Thus, this data is not sufficient for the purpose it is being used for. Per the table included in Exhibit 5, no information is provided to identify the discharges to non-IPPS hospitals, which should remain discharges, as distinct from the discharges to IPPS hospitals, which would be considered as transfers, after October 1, 1983. The viability of the data to be able to imply the Providers’ desired retroactive definitions is definitely questionable.

In prior dismissals of this issue, where the Board found it did not have substantive jurisdiction, it also brought attention to the numerous adjustments made since the inception of IPPS that may or may not have affected the calculation of the standardized amount through the requirement of budget neutrality. When evaluating the impact of any alleged mistreatment of transfers in the base period data, it is important to note that the initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit’s 2011 decision in *Saint Francis*, the standardized amount is not adjusted each year simply for inflation.¹⁰⁴ Significantly, some of these annual adjustments were required to be *budget neutral*. In particular, 42 U.S.C. § 1395ww(c)(1)(B) provides the budget neutrality adjustment for “the applicable percentage increases” to the standardized amounts for 1984 and 1985 and states, in pertinent part:

⁹⁹ *Id.* at 5.

¹⁰⁰ *Id.* at 6.

¹⁰¹ *Id.* Exhibit 5 at ¶ 56.

¹⁰² *Id.* at ¶ 50.

¹⁰³ *Id.* at ¶ 51.

¹⁰⁴ 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

(e) **Proportional adjustments in applicable percentage increases**

(II)

(B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—

(II) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),

are not greater or less than—

(ii) the DRG percentage (as defined in subsection (d)(1)(C)) of the payment amounts which would have been payable for such services for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).¹⁰⁵

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 rate year and 1985 rate year respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

(II) *Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c) through (h) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of the **payment amounts that would have been payable** for the inpatient

¹⁰⁵ (Bold emphasis in original and italics and underline emphasis added.) The budget neutrality adjustment at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).

operating costs for those same hospitals for fiscal year 1984
**under the Social Security Act as in effect on April 19,
1983.**

(2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.¹⁰⁶

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

(v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of the reduced standardized amounts determined under paragraph (c) of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is **not greater or less** than 50 percent of the **payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983.**

(2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.¹⁰⁷

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than or less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e.*, reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average payment per case, is prescribed by law to be *no more **and** no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget neutrality for 1984 and 1985 are **external** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.¹⁰⁸ Since these points are ***fixed***, it also means that it is capped (*i.e.*,

¹⁰⁶ (Italics emphasis in original and bold and underline emphasis added.)

¹⁰⁷ (Italics emphasis in original and bold and underline emphasis added.)

¹⁰⁸ 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board's pie concept: Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation

cannot be increased subsequently outside of the budget neutrality adjustment). Additionally, the Board included in those decisions an Appendix (included here as Appendix A) which iterated the numerous adjustments made outside of the budget neutrality adjustments of 1984 and 1985. The records in these cases do not address how these may or may not affect the final outcome of the standardized amount as it is developed for FFY 2025/2026, should the Providers' argument prevail.

While I recognize that this issue may eventually require EJR, as the Providers in these cases are attempting to challenge the regulation, for all of the reasons I have expanded upon above, I find that the instant cases, at this time, are not ripe for EJR, as the record is not fully developed, and there are facts presumed that I find to be in question. I would therefore deny EJR and require the parties to fully brief the issue before I determined if EJR was appropriate.

1/29/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA

Board Chair

Signed by: Kevin D. Smith -A

for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.

Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

APPENDIX A

The following are examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments and the “applicable percentage increases” for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i):

- a. “Restandardization of base year costs per case used in [the] calculation of Federal rates” for both the labor and non-labor portions to reflect the survey-based wage index as discussed in the FY 1986 IPP Final Rule. 50 Fed. Reg. 35646, 35692 (Sept. 3, 1985).
- b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.¹⁰⁹ An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.¹¹⁰

¹⁰⁹ The Secretary confirmed that, beginning in 1991, these adjustments are to be made in a budget neutral manner: Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

59 Fed. Reg. 45330, 45348 (Sept. 1, 1994).

¹¹⁰ 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

Comment: A commenter was concerned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.

Response: This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs, inclusion of transfer cases tends to *increase* the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.

Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

Id. at 35655-56.

- c. Budget neutrality adjustments made to the standardized amount designated for urban hospitals and the one designated for rural hospitals when certain urban hospitals were deemed to be urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).¹¹¹
- d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)¹¹² and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).¹¹³
- e. Budget neutrality provision at 42 U.S.C. § 1395ww(d)(3)(A)(vi) that allows Secretary to adjust standardized amount to eliminate the effect of “changes in coding or classification of discharges that do not reflect real changes in case mix.”
- f. The discretion of the Secretary in 42 U.S.C. § 1395ww(d)(3)(I)(i) to “provide by regulation for such other exceptions and adjustments to such payments amounts under this subsection as the Secretary deems appropriate.”

¹¹¹ See also 56 Fed. Reg. 43358, 43373 (Aug. 30, 1991) (stating “Consistent with the prospective payment system for operating costs, the September 1, 1987 capital final rule provided for separate standardized amounts for hospitals located in urban and rural areas. Subsequently, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) provided for a higher update factor for hospitals located in large urban areas than in other urban areas and thereby established three standardized amounts under the prospective payment system for operating costs. Large urban areas are defined as those metropolitan statistical areas (MSAs) with a population of more than 1 million (or New England County metropolitan statistical areas (NECMAs) with a population of more than 970,000). Beginning with discharges on or after April 1, 1988 and continuing to F Y 1995, the Congress has also established higher update factors for rural hospitals than for urban hospitals. The differential updates have had the effect of substantially reducing the differential between the rural and other urban standardized amounts. Section 4002(c) of Public Law 101-508 provides for the elimination of the separate standardized amounts for rural and other urban hospitals in FY 1995 by equating the rural standardized amount to the other urban standardized amount. The separate standardized amount for large urban hospitals would continue. Currently, the large urban standardized amount under the prospective payment system for operating costs is 1.6 percent higher than the standardized amount for hospitals located in other urban areas.”).

¹¹² See 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A); *supra* note 18.

¹¹³ Omnibus Reconciliation Act of 1990, Pub. L. 101-508, § 4002(c), 104 Stat. 1388, 1388-33 – 1388-35 (1990).

- g. The subsequent amendments that Congress made in 1994¹¹⁴ and 1997¹¹⁵ to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. The Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS.¹¹⁶

To illustrate the complex nature of these issues, Board points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,¹¹⁷ the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).¹¹⁸ The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that developed since they were published. *We believe that it is necessary, each year, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries.* Further, we think this review must include assessment of whether the previous

¹¹⁴ Social Security Act Amendments of 1994, § 109, Pub. L. 103-432, 108 Stat. 4398, 4408 (1994) placed the then-existing language of 42 U.S.C. § 1395ww(d)(5)(I) into clause (i) and added the following clause (ii): "(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater than or lesser than those that would have otherwise been made in such fiscal year."

¹¹⁵ Balanced Budget Act of 1997, Pub. L. 105-33, § 4407, 111 Stat. 251, 401 (1997), further revised 42 U.S.C. § 1395ww(d)(5)(I) and added § 1395ww(d)(5)(J).

¹¹⁶ See 60 Fed. Reg. 45778, 45854 (Sept. 1, 1995) ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional payments for transfer cases of \$159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.")

¹¹⁷ 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).

¹¹⁸ U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.

In addition to this general consideration, *the FY 1985 adjusted average standardized amounts (**Federal rates**) were required by law to be adjusted to achieve budget neutrality*; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more **nor** less than* we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years.*

*Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were **higher** than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the **overstatement** of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts. To this end, we have identified several factors, **discussed in section II.A.3.c.**, below, that contributed to the overstatement of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and have combined them into **a proposed composite correction factor** for FY 1986 that equals -7.5 percent.*

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. **We have combined these values into a composite policy target adjustment factor, as discussed in section III.3.e., below.** For FY 1986, this factor equals -1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are “. . . necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality.” *Establishing FY 1986 prospective payment rates based on FY 1985 rates **that have been demonstrated to be overstated**, clearly would not comport*

with the statutory requirement that the rates represent payment for efficiently delivered care.

Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes is +.31 percent, it is clear that there is a potential justification of a – 4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:

	Percent
Forecasted market basket increase..	+4.27
Part B costs and FICA taxes.....	+.31
Composite correction factor.....	–7.5
Composite policy target adjustment factor.....	–1.5

However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.¹¹⁹

(3) Additional causes for the overstatement of FY 1985 Federal rates. In addition to the factors above, which we believe we must correct, **other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts.**

When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for

¹¹⁹ 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

1985. After application of the revised market basket, discussed previously, use of these actuarial estimates would reduce the standardized amounts by an additional 1.2 percent.

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates. The hospital specific rates were set using later (1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by \$2.2 billion, of which Medicare realized about \$900 million in inpatient recoveries. **Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount.** We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals' total inpatient costs are operating costs, and if only 40 percent of the \$900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.

We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we**

have decided at this time not to correct the standardized amounts for these factors.

We received no comments on this issue.

(4) **Composite Correction Factor.** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:

	<i>Percent</i>
Case mix.....	-6.3
Market basket.....	-1.2
Composite correction factor.....	-7.5 ¹²⁰

Congress did immediately act on the Secretary’s September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 (“EEA-85”) to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates (*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).¹²¹ Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

- Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
- Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
- Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
- Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.¹²²

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.¹²³

¹²⁰ *Id.* at 35703-04 (bold and underline emphasis added).

¹²¹ Pub. L. 99-107, § 5(a), 99 Stat. 479, 479 (1985). In July 1984, Congress had *already* reduced the 1 percent update factor planned for FFY 1986 to ¼ of a percentage point. Deficit Reduction Act of 1984, Pub. L. 98-369, § 2310(a), 98 Stat. 494, 1075 (1984). As part of the Emergency Extension Act of 1985, Congress further reduced the update factor for FFY 1986, presumably in response to the Secretary’s recommendation.

¹²² 51 Fed. Reg. 16772, 16772 (May 6, 1986).

¹²³ *See id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).

The examples highlight concerns about how certain future actions and decisions by the Secretary and Congress build upon prior decisions. Here, the Secretary's recommendation to Congress regard the FFY 1986 update factor were based on its analysis of the FFY 1984 and 1985 standardized amounts that had already been adjusted for budget neutrality. To the extent the 1984 standardized amounts had been *further* adjusted (*as **now** proposed by the Providers*), it could have potentially impacted the Secretary's recommendation to Congress for the FFY 1986 update factor as well as Congress' subsequent revisions to the updated factor. Accordingly, this highlights how revisiting and otherwise adjusting the FY 1984 standardized amounts can have ripple effects with the update factor and other adjustments that were made for subsequent years *based on analysis of the prior year(s) and other information.*



Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Expedited Judicial Review Determination***
Southwest Consulting Medicare Part C Days Groups
Case Number: 26-0210GC *et al.* (9 Cases – See **Appendix A**)

Dear Mr. Newell:

The Provider Reimbursement Review Board (“Board”) has reviewed the Providers’ Petitions for Expedited Judicial Review (“EJR”) filed on **January 6, 2026** in the above-referenced group appeals. The Board’s decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Board received requests to establish optional and Common Issue Related Party (“CIRP”) groups for these nine (9) groups between **December, 2024** and **October, 2025**. All nine (9) groups contain providers appealing from revised Notices of Program Reimbursement (“RNPRs”) which implement the final rule published in the June 9, 2023 Federal Register (“June 2023 Final Rule”)¹ as it pertains to the Providers’ Fiscal Year Ends (“FYE”) within calendar years (“CY”) from 2006 to 2013.

The issue in this appeal is “the proper treatment in the Medicare disproportionate share hospital (“DSH”) calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute (“part C days”) in the aftermath of the *Allina II* litigation. The Providers contends (*sic*) 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. 26-0210GC, Statement of Group Issue at 1 (Oct. 23, 2025).

³ *Id.* at 2-3.

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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 subchapter¹¹

⁴ See 42 U.S.C. § 1395ww(d)(1)-(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. § 412.106(c)(1).

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.)

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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 Secretary¹⁵ 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

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.

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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

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:

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).

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. . . 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.

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).

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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

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.

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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”:

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).

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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).

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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. § 1395w(d)(5)(F)(vi), even when they elect to receive Part C benefits.⁴⁷ It ruled, however, that the June 9, 2023 Final Rule is both impermissible retroactive⁴⁸ 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

Providers’ Position:

A. Providers’ Appeal Requests

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

The “Statement of Group Issue” included with the appeal requests state that the issue concerns “the proper treatment in the Medicare [DSH] calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute (“part C days”) in the aftermath of the *Allina II* litigation.”⁵² The Provider contends 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.

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. 26-0210GC, Appeal Request, Statement of Jurisdiction at 1 (citations omitted).

⁵² *E.g.*, Case No. 26-0210GC, Statement of Group Issue at 1.

⁵³ *Id.*

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2. In *Allina I*, the D.C. Circuit vacated that policy change.
3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary’s continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking. The Supreme Court’s decision “did not address the D.C. Circuit’s alternate ruling that the readopted standard was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the standard could not ‘take effect’ under the terms of the statute until after proper notice-and-comment rulemaking.”⁵⁴
4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.

Based on the above, the Providers maintain that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule “is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, exceeds the agency’s statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence.”⁵⁵

B. Providers’ Petitions for EJR

The Providers have requested EJR over the “post-*Allina* retroactive Part C policy issue” because they believe they have met the requirements for a hearing before the Board, but the Board lacks the authority to decide the substantive and procedural validity of CMS’ final rule published in the Federal Register on June 9, 2023.⁵⁶ They seek a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.⁵⁷ “The Providers contend that the new, post-*Allina* retroactive part C days rule, applied in the [RNPRs] appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency’s statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence.”⁵⁸ Since the Board is bound by this regulation,⁵⁹ it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

On **January 13, 2026**, the Medicare Contractor’s representative, Federal Specialized Services, filed timely responses to the Requests for EJR in all nine (9) cases. They simply advised that, in

⁵⁴ *Id.* (citing to 139 S. Ct. at 1816).

⁵⁵ *Id.* (citing 4 U.S.C. § 706(2)).

⁵⁶ *E.g.*, Case No. 26-0210GC, Providers’ Petition for Expedited Judicial Review at 13 (Jan. 6, 2026).

⁵⁷ *Id.* at 16-17.

⁵⁸ *Id.* at 1-2.

⁵⁹ 42 C.F.R. § 405.1867.

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each case, “the MAC will not file a substantive claim challenge in this case. The MAC notes no jurisdictional impediments.”⁶⁰

Decision of the Board:

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

A. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a “final determination” related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination;⁶¹
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, \$50,000 or more.⁶²

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

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

⁶⁰ *E.g.*, Case No. 26-0210GC, Response to Provider’s Request for Expedited Judicial Review at 1 (Jan. 13, 2026).

⁶¹ 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).

⁶² 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

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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 nine (9) Cases listed in **Appendix A** and that the Providers in each group appeal are entitled to a hearing before the Board;
- 2) Based upon the Providers’ assertions regarding the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867);
and
- 4) It is without the authority to decide the legal question of whether the Part C Days policy issue, as adopted on a retroactive basis in the June 9, 2023 Final Rule, is substantively or procedurally valid.

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

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes all nine (9) cases 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:

1/29/2026

X Kevin D. Smith, CPA

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

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Enclosures: Schedules of Providers

cc: Danelle Decker, National Government Services, Inc. (J-K)
Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-L)
Scott Berends, Federal Specialized Services

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26-0210GC	<i>Crozer-Keystone Health CY 2012 DSH Medicare Part C Days CIRP Group</i>
25-1056GC	<i>Tufts Medicine CY 2006 Medicare Part C CIRP Group</i>
25-1057GC	<i>Tufts Medicine CY 2008 Medicare Part C CIRP Group</i>
25-1058GC	<i>Tufts Medicine CY 2009 Medicare Part C CIRP Group</i>
25-2882GC	<i>SUNY CY 2010 DSH Medicare Part C CIRP Group</i>
26-0224GC	<i>Crozer-Keystone Health CY 2013 DSH Medicare Part C Days CIRP Group</i>
25-1005G	<i>Southwest Consulting CY 2007 Medicare Part C Group</i>
25-1006G	<i>Southwest Consulting CY 2008 Medicare Part C Group</i>
25-1203G	<i>Southwest Consulting CY 2006 Medicare Part C Group</i>



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: **Request for Reconsideration of Dismissal and Reinstatement**
24-0006GC *Quorum Health CY 2019 DSH SSI Unduly Narrow Definition of SSI*
Entitlement CIRP

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the Request for Reconsideration of Dismissal and Reinstatement filed on **October 20, 2025** in the above captioned Common Issue Related Party (“CIRP”) group appeal. The decision to **deny** the request for reconsideration and reinstatement of the appeal is set forth below.

Background:

On **October 3, 2023**, Quality Reimbursement Services, Inc. (“QRS”) filed a request to form a CIRP group appeal on behalf of Quorum Health for FY 2019. The issue in the CIRP group appeal is the Disproportionate Share Hospital (“DSH”)/Supplemental Security Income (“SSI”) Unduly Narrow Definition of SSI Entitlement. In their Appeal Request, the Providers summarized their DSH/SSI Unduly Narrow Definition of SSI Entitlement issue as follows:

The Provider(s) protest(s) CMS’s policy of excluding unpaid SSI days from the numerator of the Medicare fraction. Despite CMS’s seemingly contrary policy of treating unpaid Part A days as entitled to benefits under Part A, CMS requires that a beneficiary be paid SSI benefits (or “covered” by SSI) during the period of his or her hospital stay in order for such days to be considered “entitled to supplemental security income benefits” and included in the numerator of the SSI fraction.

CMS does not include days in the numerator of the SSI fraction when individual were eligible for SSI but did not receive a SSI payment during their hospitalization for such reasons as failure of the beneficiary to have a valid address, representative payee problems, Medicaid paying for more than 50 percent of the cost of care in a medical facility, or the period of hospitalization is during

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the first month of eligibility before a cash payment is made. None of these reasons affect the patient's indigency.

CMS's policy of applying different interpretations to the same term, "entitled," used in the same sentence of the statute is the epitome of arbitrary and capricious agency action and must be reversed. See *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 20 n.1 (D.C. Cir. 2011) (Kavanaugh, J., concurring) ("HHS thus interprets the word 'entitled' differently within the same sentence of the statute. The only thing that unifies the Government's inconsistent definitions of this term is its apparent policy of paying out as little money as possible. I appreciate the desire for frugality, but not in derogation of law."); see also *Walter O. Boswell Mem'l Hosp. v. Heckler*, 749 F.2d 788, 799 (D.C. Cir. 1984) ("It would be arbitrary and capricious for [the Secretary] to bring varying interpretations of the statute to bear, depending upon whether the result helps or hurts Medicare's balance sheets. . . .").

In rulemaking, commenters specifically requested that CMS include other payment codes that identified "entitled" individuals, but the Secretary nonetheless adopted a policy of including only codes that identify people receiving actual SSI cash payment. *Id.* For example, commenters requested that codes S06 (suspended payment because recipients' whereabouts are unknown based on "undeliverable checks, mail, reports of change or a change of address") and S07 ("checks returned for reasons that are unclear or for reasons other than address or a representative payee problem") be included. CMS refused the suggestion.

Because CMS's treatment of unpaid Part A days as "days entitled to benefits under part A" was upheld by the Supreme Court in *Becerra v. Empire Health Found., for Valley Hosp. Med. Ctr.*, 597 S.Ct. June 24, 2022 WL 227680 (2022), CMS must apply the same interpretation of the word "entitled" in the context of "entitled to supplemental security income benefits." By doing so, CMS will necessarily have to widen the number of SSI status codes it treats as being "entitled to SSI benefits" to encompass not just the three codes CMS currently includes, but all codes that reflect *eligibility* for SSI benefits.¹

On **November 27, 2024**, the Group timely filed its preliminary position paper.

¹ Appeal Request, Statement of the Issue at 1 (Oct. 3, 2023).

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On **December 13, 2024**, the Medicare Contractor filed a Substantive Claim Challenge² requesting that the Board find that there is not an appropriate cost report claim for these participants per 42 C.F.R. § 413.24(j) and that these items are not reimbursable under 42 C.F.R. § 405.1873(f)(1)(ii).³ Significantly, under Board Rule 44.5.1, the Provider had 30 days to respond to the Substantive Claim Challenge. On **January 11, 2025**, the Group Representative requested additional time to respond. On **January 15, 2025**, the Board denied this request. The Group Representative *failed* to file any response.

On **December 17, 2024**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of the appeal because: (1) the Group’s preliminary position paper relies on a presumption that the SSI ratios supplied by CMS are understated without any evidence or documentation; (2) the Providers failed to file a complete position paper in violation of Board Rules 25.3; and (3) the Provider has effectively abandoned its appeal by filing a perfunctory preliminary position paper.⁴ Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. On **January 11, 2025**, the Group Representative requested additional time to respond. On **January 15, 2025**, the Board denied this request. The Group Representative *failed* to file any response.

On **August 20, 2025**, the Board issued a Notice of Dismissal, finding “that the Providers’ Preliminary Position Paper in this matter failed to set forth the relevant facts and arguments regarding the merits of their Medicare payment claims.”⁵ The Board specified that “despite having access to their own records, MEDPAR data, and records from the Social Security Administration, the Board finds that the Providers have failed to identify or document any specific SSI patient days they believe should be included in their respective Medicare fractions or explain how the exclusion of such days affects reimbursement.”⁶ The Board concluded:

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 Providers 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 grants the Motion to Dismiss the appeal.⁷

The Board also went on to find that “the Providers also failed to include in their cost reports appropriate claims for the specific item under appeal as prescribed in 42 C.F.R. § 413.24(j).”⁸

² As explained at Board Rule 44.5, “The Board adoption of the term ‘Substantive Claim Challenge’ simply refers to any question raised by a party concerning whether *the cost report at issue* included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items.”

³ Medicare Administrative Contractor Substantive Claim Challenge at 4-13 (Dec. 13, 2024).

⁴ Medicare Administrative Contractor’s Motion to Dismiss at 3-4 (Dec. 17, 2024).

⁵ Notice of Dismissal at 7 (Aug. 20, 2025).

⁶ *Id.*

⁷ *Id.*

⁸ *Id.* at 8.

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Request for Reconsideration and Reinstatement:

The Providers filed a Request for Reconsideration and Reinstatement⁹ on **October 20, 2025**. The Providers note that CMS calculates their Medicare Fractions by comparing SSA data with CMS Medicare inpatient data in determining a patient’s “entitlement” to SSI benefits.¹⁰ They argue:

In accordance with the court’s decision in *Pomona Valley Hosp. Med. Ctr. v. Azar*, CMS has the burden “... ‘to produce countervailing evidence or a reason, not based on the insufficiency of the [plaintiff’s] showing’ that explains why the SSI numerator is accurate.”¹¹

They claim that their own records, MEDPAR data, and records from the SSA were insufficient to identify any SSI days that should have been included in their Medicare Fractions.¹² They also believe their Preliminary Position Paper *did* identify the codes which they feel should have been **included** in their Medicare Fractions (though the Board claimed they did not identify any codes which should be **excluded**):

Specifically, the Providers stated “...that certain additional SSI codes illustrate continued SSI eligibility even when the individual’s SSI payments are suspended or placed in a stop payment status and that these individuals continue to be ‘entitled to’ SSI benefits. Program Operations Manual SI § 0231.201. Exhibit P-4. Thus, the Providers respectfully submit that these additional SSI codes should be included in the data matching process used to determine the SSI ratio for the Medicare DSH calculation.” Providers’ Preliminary Position Paper at 9-10. Exhibit P-4 of the Providers’ Preliminary Position Paper shows some of the codes to which the Providers were referring, listing the “stop payment status” SSI payment codes as S08, E01, N01, and S09. The Providers further contended “...that CMS include all SSI codes, whether payment was or was not made during the month of hospitalization, in the computation of the numerator of the DSH Medicare Fraction.” Providers’ Preliminary Position Paper at 11-12.¹³

The Providers conclude by explaining that the issue of which codes should be included in the DSH calculation is currently being litigated and request the Board reinstate this case “and refrain

⁹ Request for Reconsideration of Dismissal and Reinstatement of Quorum Health CY 2019 DSH SSI Unduly Narrow Definition of SSI Entitlement CIRP Group, Case No. 24- 0006GC (Board Dismissal Decision dated August 20, 2025) (Oct. 20, 2025).

¹⁰ *Id.* at 1.

¹¹ *Id.* (citation omitted).

¹² *Id.* at 1-2.

¹³ *Id.* at 2.

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from issuing any final decision thereof pending the outcome of the pending court challenges to CMS's so-called 'three-code policy.'"¹⁴

Decision of the Board:

The Board has reviewed the Request for Reconsideration and Reinstatement and hereby *denies* the relief requested therein.

First, the Providers' reliance on *Pomona Valley Hosp. Med. Ctr. v. Azar* is misplaced. They posit that this case stands for the proposition that "CMS has the burden to explain . . . 'why the SSI numerator is accurate.'"¹⁵ To be clear, the Providers hold the burden of production of evidence and the burden proof in establishing, by a preponderance of the evidence, that they are entitled to relief on the merits of the matter at issue.¹⁶ This includes affirmatively establishing their legal arguments, as well as the facts and damages supporting the group issue in their appeal. The Plaintiffs in *Pomona Valley* **did** produce evidence of their attempts to recalculate their SSI numerators and identify patient days that CMS may have missed in matching SSA data with Medicare files. They also produced evidence to show that certain "aide codes" did not overlap with the SSA codes, suggesting the "aide codes do not definitively indicate that a patient is SSI-eligible for purposes of determining the SSI fraction."¹⁷ The court in *Pomona Valley* held that, **after** this presentation of evidence, the burden of proof shifted to CMS to produce ***countervailing*** evidence, meaning evidence that must offset or counter something already produced.¹⁸

Indeed, on appeal, the D.C. Circuit Court found that the hospital in *Pomona Valley* had made a *prima facie* showing that the CMS data matching process missed a number of Medicare patient days attributable to patients who qualified for SSI benefits.¹⁹ The D.C. Circuit Court found that, "[g]iven the strength of the hospital's showing, and the absence of any countervailing evidence, the Board's conclusion that Pomona had failed to prove an undercount was unreasonable."²⁰ In the instant case, however, the Board dismissed the appeal because the Preliminary Position Paper did not contain ***any*** listing or identify ***any*** specific days which Providers believe represent a patient who was "entitled" to SSI but nevertheless excluded from their Medicare Fractions.

Second, the Provider's argument in its Request for Reconsideration and Reinstatement that their own records, MEDPAR data, and records from the SSA were insufficient to identify any SSI days that should have been included in their Medicare Fractions is specifically contradicted by their own assertion in their Preliminary Position Paper. Indeed, the Providers ***explicitly*** stated that "based on records that the Providers have obtained from the Social Security Administration,

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ 42 C.F.R. § 405.1871(a)(3).

¹⁷ *Pomona Valley Hosp. Med. Ctr. v. Azar*, 2020 WL 5816486 at *11 (D.D.C. 2020).

¹⁸ *Id.* at *11-12.

¹⁹ *Pomona Valley Hosp. Med. Ctr. v. Becerra*, 82 F.4th 1252, 1259 (D.C. Cir. 2023).

²⁰ *Id.* at 1260.

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the Providers have determined that patient days entitled to SSI were excluded from the numerator of the DSH Medicare Fraction.”²¹

The lack of evidence and general nature of the arguments presented is glaringly obvious when looking at the amount in controversy calculations for each of the eleven Providers in this case. Each Provider’s calculation is prepared in an identical fashion, merely alleging a blanket 0.25% increase in its SSI percentage, multiplied by its DRG payments, and then multiplied by the exact same 82.50% “multiplier.”²² No explanation is given as to why the 0.25% increase figure was chosen, and it is clear that the Providers have not made any good faith endeavor to determine if CMS’ data matching “flaws” are present when evaluating the datasets for these Providers’ eligible days for the fiscal years at issue. Indeed, depending on the level of a provider’s total DSH percentage, the multiplier may either be 65% (if the Provider’s DSH percentage exceeds the 15% threshold, but is less than 20.2%) *or* 82.5% (if the Provider’s DSH percentage exceeds 20.2%). The calculations provided by the Providers in this appeal do not include the total DSH percentage of each hospital, making it impossible to verify whether the 82.5% is the proper multiplier.

Again, if “based on records that the Providers have obtained from the Social Security Administration, the Providers have determined that patient days entitled to SSI were excluded from the numerator of the DSH Medicare Fraction[,]”²³ the Board would expect a calculation that reflects the errors which were discovered. Instead, the Providers presented absolutely no explanation as to the number of days at issue (*i.e.*, the number of days discovered by evaluating their own records), on how their amounts in controversy were calculated, why the 82.50% “multiplier” was used for all eleven Providers, or why or how eleven different providers had an identical proportion of missing days (0.25%). Indeed, the records in these cases contain zero evidence related to any days that may have been improperly omitted from their Medicare Fractions (in fact, only an increase percentage, not a single “number” of days is shown in the calculations), despite the Providers’ affirmative representation that evaluation of their own records and data from other sources have verified missing days.

Conclusion:

The Providers argue that *Pomona Valley* placed the burden on CMS to prove the Providers’ SSI fractions are accurate. That case only shifted the burden after the Providers there had produced real evidence of discrepancies, and CMS failed to rebut the evidence at all. The Board dismissed the instant cases because there was *no evidence at all* to establish their claims.

Based on the foregoing, the Board *denies* the request to reconsider its dismissal of Case 24-0006GC and *denies* the request to reinstate the case. The Providers did not make any arguments in their Request for Reconsideration and Reinstatement related to its substantive claim findings, so the Board is not addressing those findings in this decision.

²¹ Providers’ Preliminary Position Paper at 9 (Nov. 27, 2024).

²² *E.g.*, Evanston Regional Hospital (Prov. No. 53-0032), Estimated Impact of Increase in SSI percentage due to the Provider Unduly Narrow Definition of SSI Entitlement at 1 (Feb. 9, 2024).

²³ Provider’s Preliminary Position Paper at 9.

Decision re: Request for Reconsideration of Dismissal and Reinstatement

Case No. 24-0006GC

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Board Members Participating:

Kevin D. Smith, CPA

Ratina Kelly, CPA

Nicole E. Musgrave, Esq.

Shakeba DuBose, Esq.

FOR THE BOARD:

1/30/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA

Board Chair

Signed by: Kevin D. Smith -A

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