DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Lisa Ellis
Toyon Associates, Inc.
1800 Sutter Street, Suite 600
Concord, CA 94520

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

Case Number: 22-0721GC	*BS&W Health FFY 2022 IPPS Section 401 Hospitals Rural Floor CIRP Group*
Case Number: 22-0722GC	*Providence St. Joseph FFY 2022 IPPS Section 401 Hospitals Rural Floor CIRP Group*
Case Number: 22-0724G	*Toyon Associates FFY 2022 IPPS Section 401 Hospitals Rural Floor Group*

Dear Ms. Ellis:

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

Issue:

The Board received requests to establish two Common Issue Related Party ("CIRP") groups and an optional group from Toyon Associates, Inc. on **February 9, 2022**. The participants in these groups are appealing from the Final Rule published in the Federal Register on August 13, 2021 with regard to the calculation of the rural floor for federal fiscal year ("FFY") 2022. Specifically, the Providers argue that, for FFY 2022, CMS unlawfully excluded reclassified rural hospitals from the data used to calculate the rural floor.[1] On **June 9, 2026**, the Providers filed a Consolidated Petition for Expedited Judicial Review over this issue.

Statutory and Regulatory Background:

1. Wage Index; Rural and Urban Classification

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[2]

[1] Consolidated Petition for Expedited Judicial Review at 6-7 (June 9, 2026).
[2] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).

known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs"). The base payment rate is comprised of a standardized amount[3] for all subsection (d) hospitals located in an "urban" or "rural" area.[4]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[5] adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).[6]

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives "an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts."[7]

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

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

based wage area to a nearby wage area for payment purposes if it met certain criteria"[8] and established the Medicare Geographic Review Board (MGCRB) to administer the reclassification process.[9,10]

Ten years after the MGCRB was established, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106-113).[11] This legislation instructed the Secretary that urban hospitals that applied to the MGCRB for redesignation as rural were to be treated as such. Hospitals that receive these redesignations are sometimes known as "Section 401" hospitals. Codified at 42 U.S.C. § 1395ww(d)(8)(E), the statute states that:

> (E)(i) For purposes of this subsection, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital described in clause (ii), the Secretary ***shall treat the hospital as being located in the rural area*** (as defined in paragraph (2)(D)) of the State in which the hospital is located.
> (ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban area (as defined in paragraph (2)(D)) and satisfies any of the following criteria:
> (I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).
> (II) The hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).
> (III) The hospital would qualify as a rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.
> (IV) The hospital meets such other criteria as the Secretary may specify.[12]

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

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

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

> extended to referral centers and sole community hospitals, if such hospitals are so designated.[13]

2. Rural Floor Adjustment

In 1997, Congress observed that the calculation of the wage index for all regions of a state can sometimes result in "some urban hospitals being paid less than the average rural hospital in their state."[14] To correct this problem, in the Balanced Budget Act of 1997, Congress provided that the wage index assigned to a hospital in an urban area must be at least as great as the wage index assigned to rural hospitals within the same state. The statute provides that:

> For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)) may not be less than the area wage index applicable under such section to hospitals located in rural areas in the State in which the hospital is located.[15]

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

3. Changes to the Wage Index Calculation

In the FFY 2019 IPPS proposed rule,[16] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information ("RFI") as part of the FFY 2020 IPPS proposed rule.[17] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[18] In the FFY 2020 IPPS Final Rule, the Secretary proposed several policies to address wage index disparities.[19] Relevant to the issue under appeal here are the Secretary's proposals to prevent allegedly inappropriate payment increases due to rural reclassifications made under the

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[13] H.R. Conf. Rep. No. 106-479, 512 (1999).
[14] H.R. Rep. No. 105-149, at 1305 (1997).
[15] 42 U.S.C. § 1395ww note (Floor on Area Wage Index).
[16] 83 Fed. Reg. 20164 (May 7, 2018).
[17] 84 Fed Reg 19158, 19393-94 (May 3, 2019).
[18] *Id.*
[19] *See generally* 84 Fed. Reg. 42044, 42336-42339 (Aug. 16, 2019).

provisions of 42 C.F.R. § 412.103.[20,21] The Secretary finalized without modification the proposals

> - to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103); and
> - for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . .(as implemented at § 412.103) from the calculation of 'the wage index for rural areas in the State in which the county is located' referred to in section [1395ww](d)(8)(C)(iii). . . .[22]

The Secretary contends that this policy "is necessary and appropriate to address the unanticipated effects of rural reclassification on the rural floor and resulting wage index disparities, including the effects of the manipulation of the rural floor by certain hospitals."[23] The Secretary concludes that "the inclusion of reclassified hospitals in the rural floor calculation has had the unforeseen effect of exacerbating the wage index disparities between low and high wage index hospitals."[24]

Under the 2020 IPPS Final Rule, the Secretary "would continue to calculate the rural floor based on the physical non-MSA area of the state, which is the same rural area to which a hospital is reclassified under section [1395ww](d)(8)(E). However, for purposes of calculating the rural floor wage index for a state, [the Secretary] would not include in the rural area the data of hospitals that have been reclassified as rural under section [1395ww](d)(8)(E)."[25] The Secretary pointed out that the "legislative intent of the rural floor was to correct the 'anomaly' of 'some

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[20] 42 C.F.R. § 412.103 states in relevant part that:

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

[21] *Id.* 84 Fed. Reg. at 42332.
[22] *Id.* at 42336.
[23] *Id.* at 42333.
[24] *Id.*
[25] *Id.* at 42334.

urban hospitals being paid less than the average rural hospital in their States.'"[26]

The Secretary found that "[u]nder the current rural floor wage index calculation, rather than raising the payment of some urban hospitals to the level of the average rural hospital in their State, urban hospitals may have their payments raised to the relatively high level of one or more geographically urban hospitals reclassified as rural."[27] The Secretary explained that "[w]hile urban hospitals in mostly rural states may benefit from an increase in the rural floor due to urban to rural reclassification . . . other states with high wage urban hospitals using [42 C.F.R.] § 412.103 reclassifications to raise the rural floor can mitigate those gains for mostly rural states, due to budget neutrality."[28] The Secretary believes that "excluding the data of hospitals that reclassify as rural under section [1395ww](d)(8)(E) from the rural floor wage index is necessary and appropriate to address these unanticipated effects of the rural reclassifications on the rural floor and the resulting wage index disparities."[29]

The Secretary contends that his reimbursement calculation "is permissible under [42 U.S.C. § 1395ww](d)(8)(E) (as implemented by [42 C.F.R.] § 412.103) and the rural floor statute [42 U.S.C. § 1395ww(d) note]" and notes that the statute "does not specify where the wage data of reclassified hospitals must be included."[30] Therefore, the Secretary believes that he has the "discretion to exclude the wage index data of such hospitals from the calculation of the rural floor. Furthermore, the rural floor statute does not specify how the rural floor wage index is to be calculated or what data are to be included in the calculation."[31] Consequently, the Secretary believes that the he has the "discretion under the rural floor statute to exclude the wage data of hospitals reclassified under section [1395ww](d)(8)(E) from the calculation of the rural floor."[32]

CMS has adopted the FY 2020 IPPS Final Rule's policy in its FY 2022 IPPS Final Rule, meaning for FFY 2022 it will calculate the rural floor in a state without reference to the wage index that applies for any hospitals in that state which were reclassified as rural pursuant to Section 401.[33]

Positions of the Parties:

1. Providers' Appeal Requests

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

> The Providers in this group appeal challenge the Secretary's calculation of the rural floor for federal fiscal year (FFY) 2022. The Secretary's

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

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

For the forging reasons, the Providers in this group appeal are seeking reversal of CMS's policy of divorcing the rural floor from the rural wage index.[34]

[34] *E.g.,* Case No. 22-0721GC, Statement of the Issue at 1-2 (Feb. 9, 2022).

2. Providers' Request for EJR

The Providers filed their Consolidated Petition for EJR to challenge CMS' new wage index rules as unlawful because they conflict with the Medicare statute.[35] They argue that the FY 2020 rulemaking (1) does not treat reclassified "Section 401" hospitals as being located in a rural area as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[36]

The Providers argue:

> CMS's election to exclude Section 401 hospitals from its rural floor calculations is contrary to the text of the statute that the secretary purports to interpret. Section 401 specifies that, for purposes of the IPPS statute, CMS "*shall* treat" a qualifying hospital "as being located in the rural area … of the State in which the hospital is located." 42 U.S.C. § 1395ww(d)(8)(E)(i) (emphasis added). And the rural floor statute specifies that the wage index for hospitals in a state "*may not* be less than the area wage index applicable under such section to hospitals located in rural areas in the State in which the hospital is located." Pub. L. No. 105–33, § 4410(a), 111 Stat. 251, 402 (Aug. 5, 1997) (emphasis added). Contrary to CMS's characterization of these provisions in its rulemaking, neither provision leaves it to CMS's discretion as to whether it will comply with their terms. Instead, these statutes are mandatory. *See, e.g., Lopez v. Davis*, 531 U.S. 230, 231 (2001) ("Congress used 'shall' to impose discretionless obligations").[37]

They note that CMS changed this approach in the FY 2023 IPPS Rule, but only on a prospective basis.[38]

The Providers insist they have met the criteria set forth in 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), namely that the Board has jurisdiction over the appeal but lacks the authority to grant the relief the Provider seeks.[39]

3. Medicare Contractor's Position

On **June 15, 2026**, the Medicare Contractor's designated representative, Federal Specialized Services, filed a response to the Consolidated Request for Expedited Judicial Review. It took no position on the Request for EJR but noted that Substantive Claim Challenges had previously been filed in all three cases.[40] The Substantive Claim Challenges are addressed below.

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[35] Consolidated Petition for Expedited Judicial Review at 6 (June 9, 2026).
[36] *Id.* at 1, 4-6.
[37] *Id.* at 6.
[38] *Id.* at 7 (citing 87 Fed. Reg. 48780, 49004 (Aug. 10, 2022)).
[39] *Id.* at 7-11.
[40] *See* Response to Provider's Request for Expedited Judicial Review at 1 (June 15, 2026).

Decision of the Board:

1. Jurisdiction and Request for EJR

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

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

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

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[41] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[42] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the NPR issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). All of the participants in these cases have fiscal years that began on or after January 1, 2016, so the claim-specific dissatisfaction requirement is not applicable to the Board's analysis regarding **jurisdiction**. The

[41] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[42] *Id.* at 70555.

Board must, however, prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

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

> (1) *General Requirement*. In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), **must include an appropriate claim for the specific item**, by either—
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> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
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> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
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> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
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> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
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> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **and describing** how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[43]

[43] (Bold and underline emphasis added.)

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

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider **must include in its cost report an appropriate claim for the specific item** (as prescribed in § 413.24(j) of this chapter). If the provider files an appeal to the Board seeking reimbursement for the specific item and any party to such appeal questions whether the provider's cost report included an appropriate claim for the specific item, the Board must address such question in accordance with the procedures set forth in this section.
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> (b) *Summary of Procedures*.
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> ***
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> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
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> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
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> ***
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> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
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> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*
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> (1) Board jurisdictional dismissal decision. **If the Board issues a jurisdictional dismissal decision** regarding the specific item under appeal (pursuant to § 405.1840(c)), **the Board's specific findings of fact and conclusions of law** (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost

> report included an appropriate claim for the specific item, **must not be included in such jurisdictional dismissal decision**.[44]

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

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

As previously noted, Substantive Claim Challenges were filed in 22-0721GC, 22-0722GC, and 22-0724G, and these are discussed below. The Providers encompassed in these three (3) challenges will be collectively referred to as "the Challenged Providers."

i. Case 22-0721GC

FSS filed a Substantive Claim Challenge on **December 3, 2024**. The challenge argues that none of the Providers in this group made an appropriate claim on their cost reports for the issue being appealed.[45] It claims that the Providers either claims $0 in protested amounts on their cost reports, or, if they did claim some amount, the accompanying summary of protested items did not establish a self-disallowed item for the Rural Floor IPPS issue.[46]

ii. Case 22-0722GC

FSS filed a Substantive Claim Challenge on **December 5, 2026**. The challenge argues that Grace Medical Center (Provider Number 45-0162: FYEs 12/31/2021 and 12/31/2022) did not make an appropriate claim on its cost reports for the issue being appealed. It claims that this Provider reported $0 in Part A protested amounts on the relevant cost reports and did not properly establish a self-disallowed item for the specific Rural Floor IPPS issue.[47]

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[44] (Bold and underline emphasis added.)
[45] Case No. 22-0721GC, Medicare Administrative Contractor's Substantive Claim Challenge at 1 (Dec. 3, 2024).
[46] *Id.* at 4-7.
[47] Case No. 22-0722GC, Medicare Administrative Contractor's Substantive Claim Challenge at 4-5 (Dec. 5, 2024).

iii. Case 22-0724G

FSS filed a Substantive Claim Challenge on **December 9, 2024**. The challenge argues that none of the Providers in this group made an appropriate claim on their cost reports for the issue being appealed.[48] It claims that while the Providers listed amounts for Part A protested items in their cost reports, the accompanying summary of protested items was either not provided or did not establish a self-disallowed item for the Rural Floor IPPS issue.[49]

iv. Non-Challenged Participants

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

v. Providers' Responses

The Providers filed timely, materially identical responses to all the Substantive Claim Challenges outlined above. The Providers do not dispute that they failed to include an appropriate cost report claim for the issue under appeal. Instead, they argue that the regulations requiring an appropriate cost report claim are unlawful and unenforceable. They cite *Bethesda Hosp. Ass'n v. Bowen*[51] and *Banner Heart Hospital v. Burwell*[52] in support of their position that these regulations are unlawful.[53]

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

The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[54] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one.

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[48] Case No. 22-0724G, Medicare Administrative Contractor's Substantive Claim Challenge at 1 (Dec. 9, 2024).
[49] *Id*. at 4-11.
[50] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."
[51] 485 U.S. 399 (1988).
[52] 201 F.Supp.3d 131 (D.D.C. 2016)
[53] *E.g.*, Case No. 22-0721GC, Response to MAC's Substantive Claim Challenge at 1-3 (Dec. 22, 2024).
[54] (Emphasis added.)

Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law as to whether an appropriate claim was included.

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

3. Analysis Regarding Appealed Issue

As set forth below, the Board finds that the Secretary's determination to "calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103)"[55] was made through notice and comment in the form of an uncodified regulation.[56]

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

> After consideration of the public comments we received, for the reasons discussed in this final rule and in the proposed rule, we are finalizing without modification our proposal to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103). Additionally, we are finalizing without modification our proposal, for purposes of applying the provisions of section 1886(d)(8)(C)(iii) of the Act, to remove the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103) from the calculation of "the wage index for rural areas in the State in which the county is located" referred to in section 1886(d)(8)(C)(iii) of the Act.[57]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as the "Uncodified Regulations on Rural Floor Calculation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation.[58]

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[55] 84 Fed. Reg. 42044 at 42336.
[56] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals."
[57] 84 Fed. Reg. at 42336.
[58] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

CMS has continued the application of the FY 2020 IPPS Final Rule's policy in the FY 2022[59] IPPS Final Rule. The continued application of this policy means that, for FFY 2022, CMS will calculate the rural floor in a state without reference to the wage index that applies for any hospitals in that state which were reclassified as rural pursuant to Section 401 for IPPS.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulations on Rural Floor Calculation published in the FFY 2020 IPPS Final Rule (and as continued for FY 2022) and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulations on Rural Floor Calculation which they allege (1) does not treat reclassified "Section 401" hospitals as being located in a rural area as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[60] As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in Cases 22-0721GC, 22-0722GC, and 22-0724G.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the Uncodified Regulations on Rural Floor Calculation Issue for the subject years in Cases 22-0721GC, 22-0722GC, and 22-0724G and that the Providers in the group appeals are entitled to a hearing before the Board;

2) The review process in 42 C.F.R. § 405.1873(a)-(b) has been triggered for the Challenged Providers and the Board specifically finds that the Challenged Providers failed to include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1);

3) The review process in 42 C.F.R. § 405.1873(a)-(b) has not been triggered for the remaining Non-Challenged Participants and, therefore, there are no findings regarding whether their cost reports included appropriate claims for the specific item at issue in these appeals;

4) Based upon the Providers' assertions regarding the rural wage index and rural floor calculations, there are no findings of fact for resolution by the Board;

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

[59] 86 Fed. Reg. 44774, 45175 (Aug. 12, 2021).
[60] *See* Consolidated Petition for Expedited Judicial Review at 1, 4-6.

6) It is without the authority to decide the legal question of whether the codified Regulations on Rural Floor Calculation published in the FFY 2020 IPPS Final Rule (and carried forward to FFY 2022) is valid.

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

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes Cases 22-0721GC, 22-0722GC, and 22-0724G 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:

7/2/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

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

RE: ***Board Determination: Failure to Timely Respond to Show Cause Order***
Case Number: 25-3697GC - Fairview Health CY 2020 Budget Neutrality CIRP Group
Case Number: 25-3680GC - Fairview Health CY 2021 Budget Neutrality CIRP Group

Dear Ms. Del Santro:

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

Pertinent Facts:

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

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

On **March 13, 2026**, after Fairview failed to file a timely response to the "Group's Comments Regarding Full Formation" in both groups, the Board issued a Show Cause Order and notice deeming the Case Nos. 25-3697GC and 25-3680GC to be fully formed. The Board's Order required the Representative to submit its comments within 15 days (*i.e.*, by *March 28, 2026*

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

which was extended to the next business day, ***March 30, 2026***), showing cause as to why the cases should not be dismissed.

On **April 2, 2026**, the Board dismissed the group appeals because Fairview had not responded to the Show Cause Order.

On **May 11, 2026**, on its own motion, the Board reinstated the two group appeals because it had noted that due to a technical issue, the original March 13, 2026 Show Cause Order was not properly transmitted to the Parties. The Representative was given an additional 15 days to respond to the newly issued Show Cause Order.

Fairview was obligated to respond by the new deadline, but to date, has not. The Board's Order explicitly stated that "[f]ailure of the Group Representative to file a separate response in each case by this deadline will result in the Board taking remedial action and the cases will be dismissed."[2]

Board Determination:

Board Rule 4.4.2 states the following:

> *All filings* other than an appeal request or request to add issues (*e.g.*, position papers and other responsive documents) ***must*** *be received by the Board no later than the date specified on the Board's notice* or, if silent, the date specified in these Rules. ***If a party fails to file by the established due date***, ***the Board may take action as described in 42 C.F.R. § 405.1868***. For example, Rule 23.4 addresses the timely filing of preliminary position papers and specifies that the Board will dismiss the appeal if the representative for the provider(s) fails to file their preliminary position paper or PJSO by the established due date.[3]

Further, Board Rule 41.2 permits the Board to dismiss a case if it has a reasonable basis to believe that the issues have been fully settled or abandoned, or the group fails to comply with Board filing deadlines.[4]

After a review of the facts in this case, the Board finds dismissal of the groups to be appropriate based on Fairview's failure to respond to the Group's Comments Regarding Full Formation **and its failure to respond** to the Board's Show Cause Order. Fairview has failed to meet its responsibilities per Board Rule 5.2, which require the representative to meet Board deadlines and respond timely to correspondence or requests from the Board. The Rule specifically notes that, "[f]ailure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines." In addition, Fairview failed to comply with Board 19.2, which requires that "at the one-year mark . . . , they must notify the Board if the

[2] Board Determination and Show Cause Order at 2 (May 11, 2026).
[3] (Bold and italics emphasis added.)
[4] Board Rule 41.2 Own Motion – The Board may dismiss a case or an issue on its own motion:
- if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
- upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868) . . .

group is complete and, if not, which providers have not yet received a final determination for the specified fiscal year and intend to join the group."

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

For the Board:

7/6/2026

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Baylor Scott & White Medical Center McKinney, Prov. No. 67-0082, FYE 06/30/2019
Case No. 23-0986

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0986. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific).

Background

A. *Procedural History for Case No. 23-0986*

On **September 9, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2019.

On **February 20, 2023**, the Board received the Provider's individual appeal request. The Individual Appeal Request contained seven (7) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage – Unduly Narrow Definition of SSI Entitlement[1]
3. DSH Payment – Medicaid Eligible Days[2]
4. DSH/SSI Percentage – Medicaid Part C[3]
5. DSH/SSI Percentage – Dual Eligible Days[4]
6. Standardized Payment Amount[5]
7. Medicaid Fraction Dual Eligible Days[6]

After the issue withdrawal, there is one (1) remaining issue in this appeal: Issue 1 (the DSH – SSI Percentage Provider Specific).

[1] On October 2, 2023, this issue was transferred to 23-1404GC.
[2] On June 17, 2026, this issue was withdrawn.
[3] On October 2, 2023, this issue was transferred to PRRB Case No. 23-1405GC.
[4] On October 2, 2023, this issue was transferred to PRRB Case No. 23-1407GC.
[5] On September 11, 2023, this issue was withdrawn.
[6] On October 2, 2023, this issue was transferred to PRRB Case No. 23-1406GC.

On **February 22, 2023**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[7]

The Provider is commonly owned/controlled by Baylor Scott & White Health (herein after "BS&W Health") and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **October 2, 2023**, the Provider transferred Issues 2, 4, 5 and 7 to BS&W CIRP groups.

On **October 10, 2023**, the Provider filed its preliminary position paper.

On **January 26, 2024**, the Medicare Contractor filed its preliminary position paper.

On **February 10, 2026**, the Board issued a Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

> Provider's Final Position Paper – *For each remaining issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 27 for more specific content requirements.[8]

On **April 7, 2026**, the Provider timely filed its final position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.

[7] (Emphasis added).
[8] (Emphasis added).

> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[9]

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

On **April 28, 2026**, the Medicare Contractor filed a jurisdictional challenge[10] with the Board over Issue 1 requesting that the Board dismiss the issue.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-0552GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.

---

[9] Provider's Final Position Paper at 8-9 (Apr. 7, 2026).

[10] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment. [11]

The group issue statement in Case No. 23-1404GC, BS&W Health CY 2019 DSH SSI Unduly narrow Definition of SSI Entitlement CIRP Group, to which the Provider transferred Issue 2 reads:

> **Statement of the Issue:**
>
> The Provider protests 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 does not include days in the numerator of the SSI fraction when individuals 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 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

[11] Issue Statement at 1 (Feb. 20, 2023).

> 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. [12]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $46,017.

MAC's Jurisdictional Challenge

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

The Medicare Contractor notes that according to the Provider's appeal request, Issue 1 has three components: 1) SSI data accuracy; 2) realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. [13]

[12] Group Appeal Issue Statement in 23-1404GC.
[13] Medicare Contractor's Jurisdictional Challenge at 5 (Apr. 28, 2026).

The Medicare Contractor contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2 which was transferred to Group Case No. 23-1404GC, BS&W Health CY 2019 DSH SSI Percentage CIRP Group. This means that the Provider is appealing an issue from a single final determination in more than one appeal, which is prohibited by Board Rule 4.6.1.[14]

The Medicare Contractor also argues that the SSI realignment issue was not briefed in the preliminary position paper, is therefore abandoned, and should be withdrawn.[15]

Finally, the MAC argues "the Provider did not file a **complete** preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3."[16] The MAC posits that the Provider "failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its Preliminary Position Paper."[17]

Provider's Jurisdictional Responses

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

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

Board Rule 44.3 specifies the time for filing a response: "Unless the Board imposes a different deadline, an opposing party may file a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party. Refer to Rule 30.3.1 regarding specific time limitations to respond to a motion to postpone a hearing and Rule 42.4 regarding specific time limitations to respond to an EJR request."

The Medicare Contractor filed its Jurisdictional Challenge on April 28, 2026, after the final position paper deadlines. The Provider, to date, has not filed a Jurisdictional Challenge Response.

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.

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[14] *Id.* at 6.
[15] *Id*. at 6-7.
[16] *Id*. at 7-8.
[17] *Id*. at 9.

As set forth below, the Board hereby ***dismisses*** the Provider's remaining issue – DSH Payment/SSI Percentage (Provider Specific):

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider disagrees with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Unduly Narrow Definition of SSI Entitlement issue that was appealed in PRRB Case No. 23-1404GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[18] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[19] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[20]

The Provider's DSH SSI Unduly Narrow Definition of SSI Entitlement issue in group Case No. 23-1404GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH SSI Percentage Unduly Narrow Definition of SSI Entitlement in Case No. 23-1404GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6.1,[21] the Board should dismiss this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[22] Accordingly, Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 23-1404GC.

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[18] Issue Statement at 1.
[19] *Id.*
[20] *Id.*
[21] PRRB Rules v. 3.2 (Dec. 2023).
[22] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

To this end, the Board also reviewed the Provider's Preliminary and Final Position Papers to see if they further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 23-1404GC but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary and Final Position Papers failed to comply with the Board Rules 25 and 27 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 the any alleged "errors" in its Preliminary or Final Position Papers and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[23]

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."

[23] (Emphasis added).

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 18-0552GC.

Accordingly, the Board finds that the issue in the instant appeal and the group issue from Group Case 23-1404GC are the same issue.[24] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6.1, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

Additionally, in its Preliminary and Final Position Paper, the Provider states, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra [sic] (Appellants' reply brief included as Exhibit P-3)." The Board finds that this incorporation by reference does not comply with the regulatory and Board rule requirements to *fully* develop the Provider's position in the position papers. Particularly, 42 C.F.R. § 405.1853 provides in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[25]

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

2. *Second Aspect of Issue 1*

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

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

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[24] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a CHS CIRP group per 42 C.F.R. § 405.1837(b)(1).
[25] (Emphasis added).

3. *Third Aspect of Issue 1*

The third aspect of the DSH Payment/SSI Percentage (Provider Specific) issue – the provider's argument regarding the treatment of "entitled to SSI" vs. "entitled to Medicare" in the SSI Percentage – is dismissed by the Board.

The Board notes that this issue is being pursued by the Provider in CIRP Group Case No. 23-1404GC, based upon the same final determination, the NPR dated September 9, 2022. Board Rule 4.6.1 clearly states "[a] provider may not appeal and pursue the same issue from a single final determination in more than one appeal (individual or group)." [26] As the provider is pursing this issue as part of the Unduly Narrow CIRP group, it is being dismissed from the individual appeal.

* * * * *

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 23-1404GC and because the purported realignment portion of the issue is premature in absence of a properly submitted written realignment request subject to a final determination from which the Provider can appeal. As no issues remain pending, the Board hereby closes Case No. 23-0986 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:

7/6/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[26] Board Rule 4.6.1 (v. 3.1, Nov. 2021)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Case No. 21-1516 - Baylor Scott & White Medical Center Carrollton (Prov. No. 45-0730), FYE 09/30/2016

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 21-1516. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Payment - Medicaid Eligible Days issue.

Background:

A. ***Procedural History for Case No. 21-1516***

On **February 17, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2016.

On **July 16, 2021**, the parent organization, Baylor Scott & White Health (hereinafter "BS&W") filed the Provider's individual appeal request which included eight (8) issues:

1. SSI Percentage (Provider Specific)[1]
2. SSI Percentage[2]
3. SSI Fraction Medicare Managed Care Part C Days[3]
4. SSI Fraction Dual Eligible Days[4]
5. Medicaid Eligible Days
6. Medicaid Fraction Medicare Managed Care Part C Days[5]
7. Medicaid Fraction Dual Eligible Days[6]
8. Standardized Payment Amount[7]

[1] On March 2, 2026, this issue was withdrawn.
[2] On February 11, 2022, this issue was transferred to Case No. 19-2456GC.
[3] On February 11, 2022, this issue was transferred to Case No. 19-2457GC.
[4] On February 11, 2022, this issue was transferred to Case No. 19-2458GC.
[5] On February 11, 2022, this issue was transferred to Case No. 19-2457GC.
[6] On February 11, 2022, this issue was transferred to Case No. 19-2460GC.
[7] On February 11, 2022, this issue was transferred to Case No. 19-2462GC.

On **July 30, 2021**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter*, "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[8]

On **February 7, 2022**, BS&W requested a change of representation to Quality Reimbursement Services, Inc. ("QRS"), which the Board granted on February 11, 2022 (after BS&W filed an updated representation letter).

On **March 10, 2022**, QRS timely filed the Provider's PPP.[9]

On **June 14, 2022**, the Medicare Contractor ("MAC") filed its PPP.

On **February 26, 2026**, the Board issued a Notice of Hearing scheduling the case for a **July 17, 2026** hearing**.**

On **April 17, 2026**, the Provider filed its final PP.

On **May 7, 2026**, the MAC filed a Jurisdictional Challenge over the Medicaid Eligible Days issue.

On **March 13, 2026**, the MAC filed its final PP.

On **July 1, 2026**, QRS filed a request for postponement of the hearing and a late responsive jurisdictional brief.

B. ***Description of Issue 5 in the Individual Appeal Request***

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations. The Provider describes Issue 5 as:

[8] (Emphasis added.)
[9] On March 15, 2022, QRS refiled the PPP with a corrected Representation letter.

Statement of Issue

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

Statement of the Legal Basis

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

The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[10]

Audit Adjustment Number(s): 4, 5, 20, 21, S-D

Estimated Reimbursement Amount: $28,000

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[11] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[12]

In its final PP, the Provider then, for the first time in this appeal, states it is seeking reimbursement for Section 1115 Waiver days as a part of the Medicaid eligible day issue. Specifically, the Provider states:

> [M]edicaid eligible days (including section 1115 waiver days (where applicable), which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days where applicable).[13]

[10] Issue Statement at 3 (Jul 16, 2021).
[11] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[12] Provider's PPP at 7 (March 10, 2022).
[13] Provider's final PP at 9-10.

MAC's Contentions: Issue 5 – DSH Medicaid Eligible Days

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

Section 1115 Waiver Days

Finally, the MAC argues that the Provider is attempting to untimely and improperly add the Section 1115 Waiver days issue as a sub-issue via its final PP filed on April 17, 2026, which was well beyond the 240-day deadline to add an issue. Therefore, the MAC contends that the Section 1115 Waiver days, which is a separate issue from the Medicaid eligible days issue, should be dismissed on the grounds that it was untimely and improperly added to the case.

Provider's Jurisdictional Response: Issue 5- Medicaid Eligible Days

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."[14] On July 1, 2026, the Provider filed a response to the Jurisdictional Challenge. However, the Jurisdictional Brief was filed beyond the June 6, 2026 deadline and, therefore, will not be considered.

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 sole remaining issue.

A. Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider's issue statement for Issue 5 is stated, *supra*. The Provider did not include a list of the specific additional Medicaid eligible days that are in dispute in this case in the initial appeal nor did it include it with its PPP.

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

No Access to Data

[14] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

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

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

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[15]

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

Board Rule 25 (Aug. 2018) requires the Provider to file its complete, *fully* developed PPP with all available documentation and gives the following instruction on the content of PPs:

Rule 25 - Preliminary Position Papers[16]

> **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.

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

25.1 Content of Position Paper Narrative

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

25.1.1 The Provider's Position Paper

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

25.2 Position Paper Exhibits

25.2.1 General

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

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. §

> 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

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

The July 30, 2021 Acknowledgement and Critical Due Dates notice issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

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

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[17]

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

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

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

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

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
- upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868);

[17] (Emphasis added.)

- if the Board is unable to contact the provider or representative at the last known address; or
- upon failure to appear for a scheduled hearing.

On March 10, 2022, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the unredacted listing was being sent to the MAC under separate cover.[18]

The Provider's complete briefing of this issue in its PPP is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> 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.

[18] Provider's PPP at 8 (March 10, 2022).

In its May 7, 2026 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid Eligible days issue because the Provider was in violation of Board Rules 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its PPP. Moreover, the MAC contends that the Provider neglected to include all supporting documentation (***i.e.***, furnish an **unredacted, auditable list** of additional Medicaid eligible days), or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with and 42 C.F.R. § 405.1853 and Board Rule 25.2.2.[19] Thus, the MAC asserted that the Provider essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the Board Rules.[20]

In addition, the MAC contends that the Provider attempted to untimely, and improperly, add the Section 1115 waiver days issue by including it in its final PP submission.

The Board concurs with the MAC - that the Provider is required to identify *the material facts* (*i.e*., the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board also finds that the Provider failed to fully develop the merits of the Medicaid eligible days issue because it did not include a listing with the PPP.

It was not until the final PP filing that the Provider filed a redacted exhibit with a 23-page listing of 3,203 days. The listing titled "1115 Waiver and Additional ME Days Consolidated," was incomplete and included a caveat that said the "Listing was pending finalization upon receipt of State eligibility data." QRS failed to explain why the listing of 3,203 days was so much larger than the original estimate of 50 days included in the appeal request or why it was being filed at such a late date. Finally, the listing clearly had not been verified with the State (as denoted by the header "Listing pending finalization upon receipt of State eligibility data") and, as such, fails to meet the minimum threshold burden of proof under 42 C.F.R. § 412.106(b)(4)(iv). Thus, the Board finds that the Provider has abandoned the issue.

B. Section 1115 Waiver Days

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

The appeal was filed with the Board in July of 2021 and the regulations required the following:

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[19] Emphasis added.

[20] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[21]

Board Rule 7.2.1 (Aug. 2018) elaborated on this regulatory requirement, instructing providers:

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>   - the adjustment, including the adjustment number,
>   - the controlling authority,
>   - why the adjustment is incorrect,
>   - how the payment should be determined differently,
>   - the reimbursement effect, and
>   - the basis for jurisdiction before the [Board].

Board Rule 8 (Aug. 2018) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[22]

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.[23]

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

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[21] 42 C.F.R. § 405.1835(b).
[22] (Bold and italic emphasis added).
[23] *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 properly or timely added the Section 1115 Waiver days issue to the case.

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid Eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.[24] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying Section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a Section 1115 Waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

[24] 65 FR 47054, 47087 (Aug. 1, 2000).

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

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

Regardless, even if the Provider had included in its appeal request (***which it did not***), the Provider failed to properly develop the issue in its PPP filing. In fact, the Provider's PPP does not even mention Section 1115 Waiver days. It was not until the final PP that the Provider first discussed the Waiver days and even then, it does not identify the specific 1115 Waiver days program(s) at issue). In addition, the final PP does not discuss whether or not the Section 1115 Waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the final PP is perfunctory in that it only makes cursory conclusions.[25] Again, the Provider failed to so develop its PP, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Aug. 2018).

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

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[26] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[27] The Court found that "[t]his description

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[25] For example, BS&W 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, BS&W fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is BS&W asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? BS&W 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 PP references "uncompensated care pool."

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

[27] *Id*. at *11.

does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[28] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[29] Here, the Board makes the same finding based on similar *overly generalized language.*

* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible days (Issue No. 5) including Section 1115 Waiver days. As no issues remain, the Board hereby closes Case No. 21-1516 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:

7/10/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[28] *Id.*
[29] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Case No. 21-1517 - Baylor All Saints Medical Center (Prov. No. 45-0137), FYE 09/30/2016

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 21-1517. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Payment - Medicaid Eligible Days issue.

Background:

A. ***Procedural History for Case No. 21-1517***

On **January 25, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2016.

On **July 16, 2021**, the parent organization, Baylor Scott & White Health (hereinafter "BS&W") filed the Provider's individual appeal request which included eight (8) issues:

1. SSI Percentage (Provider Specific)[1]
2. SSI Percentage[2]
3. SSI Fraction Medicare Managed Care Part C Days[3]
4. SSI Fraction Dual Eligible Days[4]
5. Medicaid Eligible Days
6. Medicaid Fraction Medicare Managed Care Part C Days[5]
7. Medicaid Fraction Dual Eligible Days[6]
8. Standardized Payment Amount[7]

[1] On March 2, 2026, this issue was withdrawn.
[2] On February 11, 2022, this issue was transferred to Case No. 19-2456GC.
[3] On February 11, 2022, this issue was transferred to Case No. 19-2457GC.
[4] On February 11, 2022, this issue was transferred to Case No. 19-2458GC.
[5] On February 11, 2022, this issue was transferred to Case No. 19-2457GC.
[6] On February 11, 2022, this issue was transferred to Case No. 19-2460GC.
[7] On February 11, 2022, this issue was transferred to Case No. 19-2462GC.

On **July 30, 2021**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter*, "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[8]

On **February 7, 2022**, BS&W requested a change of representation to Quality Reimbursement Services, Inc. ("QRS"), which the Board granted on February 11, 2022 (after BS&W filed an updated representation letter).

On **March 10, 2022**, QRS timely filed the Provider's PPP.

On **June 14, 2022**, the Medicare Contractor ("MAC") filed its PPP.

On **February 26, 2026**, the Board issued a Notice of Hearing scheduling the case for a **July 17, 2026** hearing**.**

On **April 17, 2026**, the Provider filed its final PP.

On **May 13, 2026**, the MAC filed a Jurisdictional Challenge over the Medicaid Eligible Days issue.

On **March 13, 2026**, the MAC also filed its final PP.

On **June 30, 2026**, QRS filed a request for postponement of the hearing and a late responsive jurisdictional brief.

B. ***Description of Issue 5 in the Individual Appeal Request***

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations. The Provider describes Issue 5 as:

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.

[8] (Emphasis added.)

Statement of the Legal Basis

> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[9]
>
> Audit Adjustment Number(s): 5, 8, 9, 35, S-D
>
> Estimated Reimbursement Amount: $47,000

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[10] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[11]

In its final PP, the Provider then, for the first time in this appeal, states it is seeking reimbursement for Section 1115 Waiver days as a part of the Medicaid eligible day issue. Specifically, the Provider states:

> [M]edicaid eligible days (including section 1115 waiver days (where applicable), which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days where applicable).[12]

MAC's Contentions: Issue 5 – DSH Medicaid Eligible Days

In its jurisdictional challenge, The MAC contends the Provider failed to file a complete PPP and final PP including all supporting exhibits to document the merits of its argument and failed to properly

[9] Issue Statement at 3 (Jul 16, 2021).
[10] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[11] Provider's PPP at 7 (March 10, 2022).
[12] Provider's final PP at 9-10.

develop its argument within its position papers in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rules 25 and 27. The Provider failed to timely submit an auditable listing of additional Medicaid eligible days nor did it explain why it could not produce those documents.

Section 1115 Waiver Days

Finally, the MAC argues that the Provider is attempting to untimely and improperly add the Section 1115 Waiver days issue as a sub-issue via its final PP filed on April 17, 2026, which was well beyond the 240-day deadline to add an issue. Therefore, the MAC contends that the Section 1115 Waiver days, which is a separate issue from the Medicaid eligible days issue, should be dismissed on the grounds that it was untimely and improperly added to the case.

Provider's Jurisdictional Response: Issue 5- Medicaid Eligible Days

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."[13] On June 30, 2026, the Provider filed a response to the Jurisdictional Challenge. However, the Jurisdictional Brief was filed beyond the June 12, 2026 deadline and therefore, will not be considered.

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 sole remaining issue.

A. Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider's issue statement for Issue 5 is stated, *supra*. The Provider did not include a list of the specific additional Medicaid eligible days that are in dispute in this case in the initial appeal, nor with the PPP. It wasn't until the final PP submission that the Provider included an incomplete listing as an exhibit.

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

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

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

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

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[14]

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

Board Rule 25 (Aug. 2018) requires the Provider to file its complete, *fully* developed PPP with all available documentation and gives the following instruction on the content of PPs:

Rule 25 - Preliminary Position Papers[15]

> **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.

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

25.1 Content of Position Paper Narrative

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

25.1.1 The Provider's Position Paper

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

25.2 Position Paper Exhibits

25.2.1 General

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

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. §

> 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

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

The July 30, 2021 Acknowledgement and Critical Due Dates notice issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

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

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[16]

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

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

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

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

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
- upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868);

[16] (Emphasis added.)

- if the Board is unable to contact the provider or representative at the last known address; or
- upon failure to appear for a scheduled hearing.

On March 10, 2022, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the unredacted listing was being sent to the MAC under separate cover.[17]

The Provider's complete briefing of this issue in its PPP is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> 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.

[17] Provider's PPP at 8 (March 10, 2022).

In its May 13, 2026 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid Eligible days issue because the Provider was in violation of Board Rules 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its PPP. Moreover, the MAC contends that the Provider neglected to include all supporting documentation (***i.e.***, furnish an **unredacted, auditable list** of additional Medicaid eligible days), or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with and 42 C.F.R. § 405.1853 and Board Rule 25.2.2.[18] Thus, the MAC asserted that the Provider essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the Board Rules.[19]

In addition, the MAC contends that the Provider attempted to untimely, and improperly, add the Section 1115 waiver days issue by including it in its final PP submission.

The Board concurs with the MAC - that the Provider is required to identify *the material facts* (*i.e*., the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board also finds that the Provider failed to fully develop the merits of the Medicaid eligible days issue because, it did not include a listing with the PPP.

It was not until the final PP filing that the Provider filed a redacted exhibit with a 36-page listing of 5,237 days. The listing titled "1115 Waiver and Additional ME Days Consolidated" was incomplete and included a caveat that said the "Listing was pending finalization upon receipt of State eligibility data." QRS failed to explain why the listing of 5,237 days was so much larger than the original estimate of 150 days included in the appeal request, nor did it explain why it was being submitted at such a late date. Finally, the listing clearly had not been verified with the State (as denoted by the header "Listing pending finalization upon receipt of State eligibility data") and, as such, fails to meet the minimum threshold burden of proof under 42 C.F.R. § 412.106(b)(4)(iv). Thus, the Board finds that the Provider has abandoned the issue.

B. Section 1115 Waiver Days

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

The appeal was filed with the Board in July of 2021 and the regulations required the following:

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[18] Emphasis added.

[19] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[20]

Board Rule 7.2.1 (Aug. 2018) elaborated on this regulatory requirement, instructing providers:

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>   - the adjustment, including the adjustment number,
>   - the controlling authority,
>   - why the adjustment is incorrect,
>   - how the payment should be determined differently,
>   - the reimbursement effect, and
>   - the basis for jurisdiction before the [Board].

Board Rule 8 (Aug. 2018) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[21]

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.[22]

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

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[20] 42 C.F.R. § 405.1835(b).
[21] (Bold and italic emphasis added).
[22] *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 properly or timely added the Section 1115 Waiver days issue to the case.

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid Eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.[23] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying Section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a Section 1115 Waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

[23] 65 FR 47054, 47087 (Aug. 1, 2000).

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

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

Regardless, even if the Provider had included in its appeal request (***which it did not***), the Provider failed to properly develop the issue in its PPP filing. In fact, the Provider's PPP does not even mention Section 1115 Waiver days. It was not until the final PP that the Provider first discussed the Waiver days and even then, it does not identify the specific 1115 Waiver days program(s) at issue). In addition, the final PP does not discuss whether or not the Section 1115 Waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the final PP is perfunctory in that it only makes cursory conclusions.[24] Again, the Provider failed to so develop its PP, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Aug. 2018).

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

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[25] 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 . . ."[26] The Court found that "[t]his description

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[24] For example, BS&W 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, BS&W fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is BS&W asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? BS&W 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 PP references "uncompensated care pool."

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

[26] *Id*. at *11.

does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[27] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[28] Here, the Board makes the same finding based on similar *overly generalized language.*

* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible days (Issue No. 5) including Section 1115 Waiver days. As no issues remain, the Board hereby closes Case No. 21-1517 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:

7/10/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[27] *Id.*
[28] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Randall Gienko, Senior Consultant
Strategic Reimbursement Group
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RE: ***Board Determination on Representative's Response to Show Cause Order – Late Group Full Formation Comments***

Case Number: 25-4690GC - Adventist Health CY 2021 IME Labor & Delivery Bed Count CIRP Group

Case Number: 25-4705GC - Sinai Health CY 2022 SSI Calculation Error CIRP Group

Case Number: 25-4706GC - Sinai Health CY 2022 Unmatched Medicaid Days CIRP Group

Case Number: 25-4707GC - Sinai Health CY 2022 Understatement of PPS Standardized Amount CIRP Group

Case Number: 25-4708GC - Sinai Health CY 2022 IMPROPER CARRY-FORWARD OF 1985 BNA CIRP Group

Case Number: 25-4709GC - Sinai Health CY 2022 Area Wage Index Lowest Quartile CIRP Group

Case Number: 25-4714GC - Sinai Health CY 2022 Indirect Medical Education (IME) Labor & Delivery Bed Count CIRP Group

Dear Mr. Gienko:

The Provider Reimbursement Review Board ("Board") has reviewed the subject common issue related party ("CIRP") group appeals for which Show Cause Orders were issued. On June 15, 2026, Strategic Reimbursement Group LLC ("Strategic") responded to the Show Cause Order for the Adventist Health CIRP, Case No. 25-4690GC and on July 7, 2026, Strategic responded to the Show Cause Order for the Sinai CIRP groups. A summary of the pertinent facts and the Board's determination are set forth below.

Pertinent Facts – Case 25-4690GC:

On **June 12, 2026**, the Board issued a Show Cause Order for the Adventist Health CY 2021 IME Labor & Delivery Bed Count CIRP Group because Strategic failed to submit the required Full

Formation Comments by the June 10, 2026 deadline. The Show Cause Order deemed the group complete with the three current participants and requested that the representative submit its comments explaining why the Board should not dismiss the case for failure to timely and appropriately respond by the deadline.

On **June 15, 2026**, Strategic responded to the Board's Show Cause Order and explained that the missed deadline was not an intent to abandon, rather it was due to an administrative oversight that occurred because the Representative had been tracking/managing the Full Formation Comments deadlines in six other group cases that fell on the same date.[1] Strategic requested that the Board rescind its determination deeming the group complete and identified six additional related providers that are still awaiting final determinations that need to be added to the group.

Strategic argues that dismissal of the group would be an extreme sanction since the delay in responding was "de minimis" in that the full formation due date had just expired one day before the Board issued its Order. Strategic explained that the omission was unintentional due to the concurrent filing burdens and pointed out that the delay did not prejudice the MAC.[2]

Pertinent Facts – Case Nos. 25-4705GC – 25-4709GC & 25-4714GC:

On **June 22, 2026**, the Board issued a Show Cause Order for subject Sinai Health CIRP group cases because Strategic failed to ***timely*** submit Full Formation Comments in each by the June 11, 2026 deadline.[3] The Show Cause Order deemed the groups to be complete with the two current participants in each and requested comments explaining why the Board should not dismiss the cases for failure to timely and appropriately respond by the deadline.

On **July 7, 2026**, Strategic responded to the Board's Show Cause Order and explained that the deadline in each case was unintentionally missed by one day because the representative was awaiting receipt of the Notice of Program Reimbursement ("NPR") letter for Mount Sinai Hospital (Provider Number 14-0018) so it could be added to the groups as the final participant. Apparently due to significant personnel turnover at the hospital, the NPR letter was delayed. As soon as the NPR for Mount Sinai Hospital was received on June 12, 2026, Strategic added the provider to the groups and designated the groups to be fully formed.[4]

In its response Strategic argued that, although the Board has discretion to dismiss an appeal for failure to comply with a filing deadline, normally dismissal is reserved "for egregious, r**epeated,** or highly prejudicial delays." Here, Strategic claims the delay was "de minimis" and did not prejudice the MAC or the Board's proceedings (and in fact was cured prior to the issuance of the Board's Show Cause Order).[5]

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[1] Response to June 11, 2026 Show Cause Order at 1 (June 15, 2026). Although not specifically identified in Strategic's response, based on a search of the Board's database, the other six groups appear to be Case Nos. 25-4705GC through 25-4709GC and Case 25-4714GC. It should be noted that the Full Formation Comments in these groups were also filed a day after the applicable deadline. In addition, two of the six groups were designated complete but do not meet the $50K threshold required for a group.
[2] *Id.* at 2.
[3] On June 12, 2026, (one day after the due date), Strategic designated the groups to be fully formed and filed a Rule 20 Certification in each.
[4] Provider's Response to Board Show Cause Order and Rule 18 Request for Information at 1 (July 7, 2026).
[5] *Id.*

In addition, Strategic responded to the Board's Rule 18 Request for Information with regard to Case Nos. 25-4705GC and 25-4706GC, neither of which meet the $50K threshold required for jurisdiction. Strategic agreed with the Board's proposal (*should the Board allow the cases to proceed*) to expand two earlier CY 2021 CIRP groups under Case Nos. 26-0299GC and 26-0300GC, to include CY 2022 so the respective deficient groups could be consolidated into them. In support of the expansion/consolidation, Strategic certified that there are no factual or regulatory differences between the two CYs for the SSI Calculation Error and Unmatched Medicaid Days issues.[6]

Board Determination:

Board Rule 4.4.2 states the following:

> **All filings** other than an appeal request or request to add issues (*e.g.*, position papers and other responsive documents) **must be received by the Board no later than the date specified on the Board's notice o**r, if silent, the date specified in these Rules. **If a party fails to file by the established due date, the Board may take action as described in 42 C.F.R. § 405.1868.** For example, Rule 23.4 addresses the timely filing of preliminary position papers and specifies that the Board will dismiss the appeal if the representative for the provider(s) fails to file their preliminary position paper or PJSO by the established due date.[7]

Further, Board Rule 41.2 permits the Board to dismiss a case if it has a reasonable basis to believe that the issues have been fully settled or abandoned, or the group fails to comply with Board filing deadlines.[8]

After a review of the facts in these cases, the Board finds that this is not the first instance where Strategic has failed to meet the Board's deadline regarding Full Formation Comments and that, therefore, dismissal of the groups is appropriate. In December 2025, the Board issued a determination in another Strategic group, Case No. 25-0595GC, based on Strategics response to a Show Cause Order involving a similar missed deadline. In the Board's determination in that case, the Board clearly stated that, **as a one-time courtesy,** it was using its discretion to allow the group case to remain open**.** Less than a month later, Strategic missed the Full Formation Comments deadline in three other groups, Case Nos. 25-1407GC, 25-1408GC and 25-1409GC. Again, the Board issued a Show Cause Order. In those cases, Strategic failed to respond to the Show Cause Order at all, resulting in dismissal of the three groups.

---

[6] *Id*. at 1-2.
[7] (Bold emphasis added.)
[8] Board Rule 41.2 Own Motion – The Board may dismiss a case or an issue on its own motion:
- if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
- upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868) . . .

Now, Strategic is making an argument that the missed deadline was caused because it was managing six other cases. But even in those cases, Strategic failed to **timely** respond to the Full Formation Comments by the due date. Further, two of those groups were deemed fully formed, but do not meet the minimum amount in controversy requirement.

In Strategic's Show Cause Order response it acknowledges that dismissal of a case is generally reserved "for egregious, r**epeated,** or highly prejudicial delays."[9] The Board finds that since there have been at least four other instances where Full Formation Comments were missed, this situation now falls under the category of a "**repeated delay**" as opposed to a simple case of administrative oversight.

Further, the question at hand is not only whether the delay was prejudicial to the MAC, but also whether the representative is following the Board Rules as required and operating in good faith. The Representative cannot continue to expect "courtesy" when it continually misses deadlines or complies with the Board's rules.[10]

The Board finds that Strategic has failed to meet its responsibilities per Board Rule 5.2, which requires the representative to meet Board deadlines and respond timely to correspondence or requests from the Board. The Rule specifically notes that, "[f]ailure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines."

In conclusion, given its discretionary authority in 42 C.F.R. § 405.1868 and Board Rule 41.2, which states the Board may dismiss a case upon failure of the group to comply with Board procedures or filing deadlines, the Board **dismisses Case Nos. 25-4690GC, 25-4705GC, 25-4706GC, 25-4707GC, 25-4708GC, 25-4709GC & 25-4714GC**.

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

Board Members Participating:
Kevin D. Smith, CPA
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For the Board:

7/13/2026

X Kevin D. Smith, CPA

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

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Pam VanArsdale, National Government Services (J-6)
Wilson C. Leong, Federal Specialized Services

[9] Provider's Response to Board Show Cause Order and Rule 18 Request for Information at 1.
[10] Strategic also recently missed a Board deadline for a preliminary position paper in Case No. 26-0338. This further supports the Board's position that Strategic has a history of not properly managing its docket.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision*** **– Medicaid Eligible Days Issues**
Vista Medical Center East (Provider No. 14-0084)
FYE 11/30/2018
Case No. 23-0428

Dear Mr. Ravindran and Mr. Lamprecht,

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

Background:

A. ***Procedural History for Case No. 23-0428***

On **July 7, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end November 30, 2018.

On **December 27, 2022**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained six (6) issues:

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

The Provider is commonly owned/controlled by Quorum Health and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, the Provider

[1] On June 30, 2026, this issue was withdrawn from the appeal.
[2] On March 28, 2023, this issue was transferred to PRRB Case No. 22-0977GC. The transfer was subsequently denied and on July 6, 2026, the issue was transferred to PRRB Case No. 26-2136GC.
[3] On July 14, 2023, this issue was transferred to PRRB Case No. 23-0395GC.
[4] On July 14, 2023, this issue was transferred to PRRB Case No. 23-0394GC.
[5] On July 14, 2023, this issue was transferred to PRRB Case No. 18-0900GC.

transferred Issues 2, 4, 5 and 6 to Quorum Health groups. After the withdrawal of Issue No. 1, there is one remaining issue in this appeal: Issue 3 (DSH Payment – Medicaid Eligible Days).

On **January 4, 2023**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

On **August 1, 2023**, the Provider timely filed its preliminary position paper.

On **October 4, 2023**, the Medicare Contractor requested from the Provider all documentation necessary to resolve Issue 3 (DSH Payment – Medicaid Eligible Days).

On **November 21, 2023**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 3. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **December 7, 2023**, the Medicare Contractor timely filed its preliminary position paper.

B. ***Description of Issue 3 in the Appeal Request***

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

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the

[6] (Emphasis added).

> Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 13, 14, S-D
>
> Estimated Reimbursement Amount: $53,973[7]

The following is the Provider's ***complete*** position on Issue 3 set forth in their preliminary position paper:

> **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

[7] Appeal Request at Issue 3.

> 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) [sic], Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its 2018 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[8]

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

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

> The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents that are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.
>
> Within its Provider's preliminary position paper, the Provider makes the broad allegation, ". . . the Provider contends that the total number of days reflected in its 2018 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions[.]" The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in

[8] Provider's Preliminary Position Paper at 9-10.

> the Medicaid Percentage calculation at issue. The Provider merely repeats their appeal request.[9]

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.[10]

Provider's Jurisdictional Response

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." The MAC filed its Jurisdictional Challenge on November 21, 2023. The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed.

Board Analysis and Decision:

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

As set forth below, the Board hereby dismisses the Provider's Issue No. 3.

A. DSH Payment – Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider's Issue No. 3 is stated *supra*.

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

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

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

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[9] *Id*. at 12.
[10] *Id*. at 17.

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

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

> The provider must support the determination being appealed and the basis for its dissatisfaction for ***each*** issue under appeal consistent with 42 C.F.R. § 405.1835(b) or (d) as applicable. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Furthermore, 42 C.F.R. § 405.1853(b) addresses position papers and specifies in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[11]

Similarly, with regard to position papers,[12] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[13] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

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[11] (Emphasis added).
[12] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[13] (Emphasis added).

> *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.[14]

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

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

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

This appeal was initiated on December 27, 2022 (over 3 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expect to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[15] ***To-date, no listing has been provided—even after the MAC requested the listing***. Accordingly, the Provider has abandoned the issue by failing to properly develop its arguments and provide supporting documents, and by failing to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[16] Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.

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[14] (Emphasis added).
[15] Provider's Preliminary Position Paper at 10.
[16] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

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 the manner prescribed by the Board, and the request must include…
> . . .
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.[17]

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

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

[17] 42 C.F.R. § 405.1835(b).

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

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include, but are not limited to:
> . . .
>
> ***Section 1115 waiver days (program/waiver specific). . .***[18]

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

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

> (e) ***Adding issues to the hearing request***. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board only if –
> . . .
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

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

In this regard, the Board noted 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) (2022) states in pertinent part:

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[18] (Bold and italic emphasis added).
[19] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[20] 65 FR 47054, 47087 (Aug. 1, 2000).

> (4) ***Second computation***. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.[21]

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

Finally, even in the Provider's preliminary position paper, the Provider fails to identify what § 1115 waiver program(s) are involved and whether or not the § 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(4)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the final position paper is perfunctory in that it only makes perfunctory conclusions. Again, the Provider failed to so develop its position paper notwithstanding 42

[21] (Bold emphasis added).

C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Nov. 2021) as applied via Board Rule 27.2.

The Board's finding that neither the appeal request nor preliminary position paper met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[22] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[23] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[24] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[25] Here, the Board makes the same finding based on similarly *overly generalized language*.

****

In summary, the Board hereby dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for submitting fully developed and complete position papers in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 23-0428 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

7/13/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[22] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[23] *Id*. at *11.
[24] *Id.*
[25] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran, President
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
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RE: ***Board Decision – Dismissal of DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues***

Crossroads Community Hospital (Provider Number 14-0294), FYE 12/31/2018
Case Number: 23-0184

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0184. Set forth below is the background of the case and the Board's decision related to the issues challenging the SSI-Provider Specific and Medicaid Eligible Days issues.

Background:

A. ***Procedural History for Case No. 23-0184***

On **May 19, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2018.

On **November 8, 2022**, Quality Reimbursement Services filed an appeal on behalf of the Provider. The Appeal Request included six (6) issues:

1. SSI - Provider Specific
2. SSI - Unduly Narrow Definition of SSI Entitlement
3. Medicaid Eligible Days
4. SSI MCD PT C
5. SSI MCD Dual
6. Standardized Payment Amount

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

On **November 9, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates ("ACDD"), providing among other things, the filing deadlines for the parties' preliminary

position papers (*hereinafter* "PPP").[1] This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[2]

On **March 28, 2023,** QRS transferred Issue 2 related to ***SSI Unduly Narrow Definition of SSI Entitlement*** to a CIRP group pursuing the ***SSI Percentage*** issue. On June 22, 2026, the Board denied the transfer. On July 6, 2026, QRS subsequently transferred the issue to a CIRP group specific to the Unduly Narrow issue under Case No. 26-2136GC.

On **July 1, 2023,** QRS transferred Issue 4 (SSI MCD PT C) to Case No. 23-0395GC; Issue 5 (SSI MCD Dual) to Case No. 23-0394GC; and Issue 6 (Standardized Payment Amount) to Case No. 18-0900GC. As a result, there are two (2) remaining issues in this appeal: SSI-Provider Specific (Issue #1) and Medicaid Eligible Days (Issue #3).

On **July 3, 2023**, QRS filed the Provider's PPP. On **September 12, 2023,** the MAC filed its PPP. On **October 2, 2023**, the MAC filed a Jurisdictional Challenge over the SSI - Provider Specific and Medicaid Eligible Days issues.

On **February 25, 2026**, the case was scheduled for a hearing on August 10, 2026.

On **May 12, 2023,** the Provider filed its final PP. On **May 18, 2026**, the MAC filed a Motion to Dismiss the final two issues. On **June 2, 2026,** the MAC filed its final PP.

B. Description of Issue 1 in the Appeal Request

In its Individual Appeal Request, the Provider summarizes its SSI Percentage (Provider Specific) issue as follows:

> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.

[1] On March 22, 2023, a CDD notice was issued setting new PPP deadlines.
[2] (Emphasis added.)

> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[3]

On July 3, 2023, the Board received the Provider's PPP in Case No. 23-0184. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the

[3] Issue Statement (Issue 1) at 1 (Nov. 8, 2022).

> Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[4]

The amount in controversy listed for Issue 1 in the Provider's individual appeal request is $8,782.

Description of Issue 3 in the Appeal Request

In its Individual Appeal Request, the Provider questions whether the MAC properly excluded Medicaid eligible days from the DSH calculation. The Statement of the Legal Basis is as follows:

> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 8, 9, S-D
> Estimated Reimbursement Amount: $26,199[5]

In its PPP, the Provider argues that, pursuant to the *Jewish Hospital* case[6] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[7]

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

In its jurisdictional challenge, the MAC argues that the Board lacks jurisdiction over the SSI-Provider Specific issue, which has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment.[8] The MAC contends that "the first and third sub-issues should be dismissed because they are duplicative" of

[4] Provider's PPP at 8-9 (July 3, 2023).
[5] Issue Statement (Issue 3) at 3.
[6] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[7] Provider's PPP at 9.
[8] Medicare Contractor's Jurisdictional Challenge at 2 (Oct. 10, 2023).

the SSI Unduly Narrow issue that was transferred to the CIRP group. The component related to SSI realignment should be dismissed because "[t]here was no final determination over the SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies."[9] Finally, the MAC asserts that the Provider did not file a complete preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rule 25.[10] Subsequently, in the MAC's Motion to Dismiss, the MAC reiterated its request to dismiss the SSI Provider Specific issue. The MAC contends that the Provider failed to identify any additional SSI days, nor has it offered any explanation for why the required documentation is unavailable.[11]

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

The MAC also argues the Board lacks jurisdiction over the Medicaid Eligible Days issue. The MAC contends that the Provider failed to include a list of additional Medicaid eligible days they expect to be included with their appeal or with their preliminary position paper, even though the Provider advised that it would send a listing of additional Medicaid eligible days under separate cover. The MAC also challenges the Provider's attempt to untimely add the Section 1115 Waiver Days issue by including it in the narrative of the PPP.[12] Finally, the MAC argues the Provider has abandoned the issue because it failed to sufficiently develop and set forth the relevant facts and arguments in its preliminary position paper and because it neglected to include all supporting documentation.[13]

Provider's Jurisdictional Response:

Board Rule 44.4.3 specifies that "[p]roviders must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."[14] The Provider failed to file a timely response by the *November 1, 2023* deadline.

Board Analysis and Decision:

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

As set forth below, the Board hereby dismisses the Provider's Issue Nos. 1 and 3.

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[9] *Id.*
[10] *Id.*
[11] MAC Motion to Dismiss at 3 (May 8, 2026).
[12] Medicare Contractor's Jurisdictional Challenge at 10.
[13] *Id.* at 11 - 13.
[14] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

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,[15] 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 concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[16] 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)."[17] The Provider argues that "its'[sic] SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it "disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[18] The Board agrees with the MAC and finds that the Provider 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 this aspect of Issue 1 to explain the nature of any alleged "errors" in its PPP and failed to include *all* exhibits. Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable.

In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents[19]**
>
> If documents necessary to support your position are still unavailable, then provide the following information in the position papers:
>
> 1. I*dentify* 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.

[15] The Board notes that this aspect includes the first and third components identified by the MAC in its Jurisdictional Challenge – 1) SSI Data Accuracy and 3) individuals who are eligible for SSI but did not receive SSI payment.
[16] Issue Statement (Issue 1) at 1.
[17] *Id.*
[18] *Id.*
[19] PRRB Rules v. 3.1 (Nov. 2021)

> Once the documents become available, promptly forward them to the Board and the opposing party.[20]

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

> Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MEDPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year.[21]

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").

Additionally, in its PPP, the Provider states, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra [sic] (Appellants' reply brief included as Exhibit P-3)."[22] The Board finds that this incorporation by reference does not comply with the regulatory and Board rule requirements to *fully* develop the Provider's position in the PPP. Particularly, 42 C.F.R. § 405.1853(b) provides, in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[23]

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[20] (Italics and underline emphasis added.)
[21] 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (bold and italics emphasis added).
[22] Provider's PPP at 8-9.
[23] (Bold and italics emphasis added).

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

2. Second Aspect of Issue 1

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

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

B. DSH Payment – Medicaid Eligible Days

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

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days that affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) (2022), which places the burden of production on the provider, states, in pertinent part:

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

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

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

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

> The provider must support the determination being appealed and the basis for its dissatisfaction for ***each*** issue under appeal consistent with 42 C.F.R. § 405.1835(b) or (d) as applicable. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Furthermore, 42 C.F.R. § 405.1853(b) addresses position papers and specifies, in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[24]

Similarly, with regard to position papers,[25] Board Rule 25.2.1 requires that "the parties must exchange ***all*** available documentation as exhibits to fully support your position." This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides instruction on the content of position papers as it relates to unavailable documentation/exhibits, as discussed *supra*.

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

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

[24] (Emphasis added).
[25] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.

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

This appeal was initiated on November 8, 2022 (over 3.5 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expected to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's PPP indicated that it would be sending the eligibility listing under separate cover.[26] ***To-date, no listing has been provided.*** Accordingly, the Provider has abandoned the issue by failing to properly develop its arguments and provide supporting documents, and by failing to explain why it cannot produce those documents, as required by the regulations and the Board Rules. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.

C. 1115 Waiver Days

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

The regulations in effect when this appeal was filed with the Board in November of 2022 required the following:

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

[26] Provider's PPP at 10.

> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.[27]

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

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific) . . .***[28]

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.[29]

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

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

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

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

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

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[30] 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 a beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

[30] 65 Fed. Reg. 47054, 47087 (Aug. 1, 2000).

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

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

Finally, even in the Provider's PPP, the Provider fails to identify what § 1115 Waiver program(s) are involved and whether or not the § 1115 Waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(4)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the PPP is insufficient in that it only makes perfunctory conclusions. Again, the Provider failed to properly develop its position paper notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Nov. 2021) as applied via Board Rule 27.2.

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[31] In that case, the provider's issue was tied to improper calculation of the DSH payment and read, in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment."[32] 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."[33] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[34] Here, the Board makes the same finding based on similarly *overly generalized language.*

****

Based on the foregoing, the Board is dismissing all aspects of the SSI - Provider Specific - Issue No.1 and Medicaid Eligible Days (*including Section 1115 Waiver Days*)- Issue No. 3 from this case.

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[31] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[32] *Id*. at *5.
[33] *Id.*
[34] *Id.*

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:

7/15/2026

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Charity Gott
Silverstone Place
2735 Silverstone Drive
Rolla, MO 65401

RE: Notice of Dismissal
Silverstone Place (Provider Number 26-5851)
Federal Fiscal Year: 2025
Case Number: 25-0979

Dear Ms. Gott,

On July 8, 2026, the Provider Reimbursement Review Board ("Board") sent a Notice of Potential Dismissal letter requesting that you provide an update on the case and advise if the Provider was coming in for the live hearing scheduled for July 21, 2026. The Board advised "[t]he Provider Representative has until ***Monday, July 13, 2026,*** to respond to the Board in writing through the Office of Hearings Case Document and Management System (OH CDMS). If the Board does not receive a response from the Provider's Representative by this date, the Board will dismiss the appeal."[1]

Provider Reimbursement Review Board ("Board") Rule 5.2, Provider Case Representative Responsibilities, provides that the case representative is responsible for ***"[r]esponding timely to correspondence or requests from the Board or the opposing party."***[2]

In the instant case, Board staff sent an email to the parties in this appeal, Case No. 25-0979, on June 30, 2026, and July 2, 2026, requesting that the parties provide the Board with an update and advise the Board if they are coming in for the live hearing scheduled for July 21, 2026. The Board received a response from the Medicare Contractor's Representative but did not receive a response from the Provider's Representative.

On July 7, 2026, and July 8, 2026, Board staff contacted the Provider's Representative and left a voicemail asking the Provider's Representative to contact the Board and advise of the case status and whether the Provider intended to come in for the live hearing. On July 8, 2026, the Board sent a Notice of Potential Dismissal letter to the Provider Representative requesting a status update and requesting that the Provider advise ***in writing through OH CDMS*** if the Provider was coming in for the live hearing by ***July 13, 2026***.[3]

[1] Board Status Letter at 2 (Jul. 8, 2026).
[2] Board Rules (v. 3.2) (Dec. 15, 2023) (emphasis added).
[3] Board Status Letter at 2.

On July 8, 2026, Board staff received a phone call from you advising that you needed to talk to leadership to determine whether the Provider is coming in for the live hearing and that the Provider may request a video hearing or postponement.

On July 15, 2026, Board staff returned a phone call to Greg Spence, the Provider's owner. Mr. Spence stated that the Provider will not be coming in for the live hearing but may request a video hearing or postponement. Mr. Spence ***acknowledged receiving the Board's July 8th Notice of Potential Dismissal Letter requiring a responsive filing to the Board in OH CDMS by July 13, 2026, and missing the July 13th filing deadline***.

Board Rule 5.2 ***requires case representatives to respond timely to correspondences and requests from the Board***. Board Rule 41.2 provides the Board may dismiss a case on its own motion "***upon failure of the provider or group to comply with Board procedures or filing deadlines*** (*see* 42 C.F.R. § 405.1868)."

As the Provider failed to respond to the Board ***in writing*** through OH CDMS by the ***July 13, 2026*** filing deadline, the Board hereby dismisses the appeal in Case No. 25-0979.

Board Members Participating:

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

For the Board:

7/16/2026

X Kevin D. Smith, CPA

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

cc: Charles Moreland, Federal Specialized Services
Wilson Leong, Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Randall Gienko, Senior Consultant
Strategic Reimbursement Group
360 W. Butterfield Road, Suite 310
Elmhurst, IL 60126

RE: ***Dismissal – Failure to Respond to Comments Regarding Full Formation of CIRP Group***

Case Number: 25-4972GC - Renown Health CY 2021 SSI Calculation Error CIRP Group

Dear Mr. Gienko:

The Provider Reimbursement Review Board ("Board") has reviewed the subject common issue related party ("CIRP") group appeal which was filed by Strategic Reimbursement Group ("Strategic") on July 11, 2025, and for which Comments regarding Full Formation were due on July 11, 2026. The pertinent facts regarding the group, a discussion of the Rules; a brief history of Strategic's docket management and the Board's determination are set forth below.

Pertinent Facts:

On **July 14, 2025**, the Board acknowledged the referenced group case in a Case Acknowledgement and Critical Due Dates notification ("ACDD"). The Board's ACDD notice gave the Group Representative a **July 11, 2026** deadline to file the "Group's Comments Regarding Full Formation – The comments *must advise* the Board whether the group is complete, ***and if not***, *must specifically identify* which providers within the related party chain organization have not yet received a final determination for the appealed year. See Board Rule 19."[1]

As of the date of this notification, Strategic has not yet responded to the Comments Regarding Full Formation deadline.

Discussion & History of Strategic's Docket Management:

Board Rule 4.4.2 states the following:

[1] The July 14, 2025 notification also included the following dismissal warning:
"The parties are responsible for pursuing the appeal in accordance with the Board's Rules. The parties must meet the following due dates regardless of any outstanding jurisdictional challenges, motions, or subpoena requests. If the Group misses any of its due dates, the Board will dismiss the appeal. If the Medicare Contractor fails to meet its deadlines, the Board will take actions described under 42 C.F.R. § 405.1868."

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

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

In this case, the Group Representative effectively abandoned the appeal when it failed to timely respond to the Board's request for comments regarding the groups' full formation ("Full Formation Comments") status by the July 11, 2026 deadline. The Board is a bit perplexed as Strategic did timely respond to Full Formation Comments in the related CIRP groups for this issue, Case Nos. 25-4977GC and 25-4978GC (which were previously expanded to include an additional calendar year ("CY"); as well for as Case No. 25-4796GC.[4]

As Strategic is aware, the normal course of action in cases where the Full Formation Comments deadline has been missed is for the Board to deem the group(s) complete and to issue a Show Cause Order giving the Representative an opportunity to explain why dismissal of the group(s) would not be appropriate. One of the main factors the Board considers when reviewing the Representative's responses to a Show Cause Order in this type of situation is whether the failure to file is a limited instance of non-compliance or whether there is a pattern of missed deadlines.

Ironically, in its July 7, 2026 response to such a Show Cause Order, issued by the Board in Case No. 25-4705GC *et. al.*, Strategic acknowledged that "the Board has historically reserved the ultimate sanction of dismissal for egregious, ***repeated***, or highly prejudicial delays."[5] As demonstrated below, the Board finds that in the case of Strategic's docket management, non-compliance with Board deadlines is NOT a limited circumstance. In fact, as recently as July 13, 2026, the Board dismissed the following cases after Strategic filed LATE responses to Full Formation Comments:

Case No.	Group Name
25-4705GC	Sinai Health CY 2022 SSI Calculation Error CIRP Group

[2] (Bold and italics emphasis added.)
[3] Board Rule 41.2 Own Motion – The Board may dismiss a case or an issue on its own motion:
- if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
- upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868)
- 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.

[4] Case No. 25-4976GC was designated to be fully formed with only a single provider.
[5] Providers' Response to Board Show Cause Order and Rule 18 Request for Information in Case Nos. 25-4705GC *et.al.* (July 7, 2026). (Emphasis added).

25-4706GC	Sinai Health CY 2022 Unmatched Medicaid Days CIRP Group
25-4707GC	Sinai Health CY 2022 Understatement of PPS Standardized Amount CIRP Group
25-4708GC	Sinai Health CY 2022 IMPROPER CARRY-FORWARD OF 1985 BNA CIRP Group
25-4709GC	Sinai Health CY 2022 Area Wage Index Lowest Quartile CIRP Group
25-4714GC	Sinai Health CY 2022 Indirect Medical Education (IME) Labor & Delivery Bed Count CIRP Group
25-4690GC	Adventist Health CY 2021 IME Labor & Delivery Bed Count CIRP Group

In the Board's July 13, 2026 dismissal, it referred Strategic to Case No. 25-0595GC, where the Board had granted a "one time courtesy," in December, 2025, to allow the group to remain open after Strategic had missed the Full Formation Comments deadline. The Board also identified Case Nos. 25-1407GC, 25-1408GC and 25-1409GC, which were all dismissed for failure to timely file Full Formation Comments, after Strategic not only missed the initial deadline, but then failed to respond to the deadline in the Board's Show Cause Order.[6]

Relatedly, Strategic has missed other Board deadlines, as well. The following cases were dismissed for Strategic's failure to timely file preliminary position papers ("PPPs"):

- **Case No. 25-4676** was dismissed on February 5, 2026. Although Strategic filed a request for reinstatement admitting the failure to file the PPP was due to an inadvertent clerical error, the Board denied the reinstatement on February 12, 2026.

- **Case No. 26-0338** was dismissed on July 7, 2026;

- **Case No. 25-2154** was dismissed on October 30, 2025;

- **Case No. 24-0515** was dismissed on August 15, 2024;

Strategic has also been known to file duplicative appeals and untimely appeals. Specifically, in Case No. 24-2031, Strategic filed a duplicate individual appeal for Hollywood Presbyterian Medical Center (Prov. No. 05-0063) for its fiscal year end ("FYE") 12/31/2019. Not only was Strategic's appeal late – as it was filed 189 days after receipt of the final determination, but it was also found to be a duplicate appeal as Case No. 24-1924 had been timely filed by another Representative for the same provider and same FYE.

Finally, although not specifically related to a missed deadline, the Board notes that there have been many instances where Strategic has designated a CIRP group to be fully formed where there is only a single participant, or where the aggregate amount in controversy is less that the required $50,000.[7]

[6] Board Determination on Representative's Response to Show Cause Order – Late Group Full Formation Comments at 3 (Jul. 13, 2026).
[7] The Board recently advised that Case Nos. 25-4705GC and 25-4706GC, each had a jurisdictional impediment in that neither met the minimum amount in controversy threshold. The groups were ultimately dismissed for failure to

The Board is aware that there have been a number of instances where it has advised Strategic that the Board's preferred method of handling a "*deficient"* fully formed CIRP group *(whether it be related to failing to meet the minimum no. of providers or the aggregate amount in controversy is less than the $50k threshold)* would be to merge the deficient CIRP group with a related CIRP group for another year. Most often, it is left to the Board staff to search its database to find potential related appeals which could be expanded in order to consolidate a deficient group. Once it identifies potential groups, the Board must then issue a Rule 18 Request for Information and await Strategic's comments regarding the proposal. This whole process can be time consuming and results in a delay prior to taking action to remedy the deficient group(s).

In the future, the Board expects that if Strategic is designating a CIRP group to be fully formed and either the minimum group participant or minimum threshold amount requirements are not met, Strategic should immediately file a proposal to remedy the deficient group. That remedy could include a request to expand a later or earlier year CIRP group for the same issue OR a request to transfer the deficient issue(s) back to the Provider(s) individual appeals (or should there not be an individual appeal, provided the $10K threshold has been met, that a new individual appeal be established for the provider(s).[8] In the case of an expansion/consolidation request, Strategic must include a statement indicating that the group issues are identical and certifying that there are no factual or regulatory differences for the issue between the years in question.

Board Determination:

As evidenced above, the Board has established that this is not Strategic's first instance where it has failed to meet the Full Formation Comments for a group appeal. Consequently, the Board finds the issuance of a Show Cause Order in this case would be futile. Therefore, in accordance with Board Rule 41.2, the Board hereby dismisses Case No. 25-4972GC. The Board finds that there is a reasonable basis to believe that the group has been abandoned, as a result of Strategic's failure to comply with the July 11, 2026 filing deadline.[9]

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

For the Board:

7/16/2026

X Kevin D. Smith, CPA

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

timely file Full Formation Comments. In addition, Strategic recently designated a related Renown Health CY 2021 Understatement of PPS Standardized Amount CIRP Group, under Case No. 25-4976GC, to be complete on July 13, 2026, but the group includes only a single provider.

[8] If the proposed group to be expanded is already fully formed, Strategic must include a request to reopen the status of the fully formed group in its request.

[9] Although the July 11, 2026 deadline fell on Saturday, pursuant to 42 C.F.R. § 405.1801(d)(3), "If the last day of the designated time period is a Saturday, a Sunday, a Federal legal holiday (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the reviewing entity is unable to conduct business in the usual manner, the deadline becomes the next day that is not one of the aforementioned days. Strategic failed to file the Full Formation Comments by Monday, July 13, 2026.

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran, President
Quality Reimbursement Services, Inc.
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Arcadia, CA 91006

RE: ***Board Decision – Dismissal of Medicaid Eligible Days Issue***

Merit Health Biloxi (Provider Number 25-0007), FYE 09/30/2018
Case Number: 23-0236

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0236. Set forth below is the background of the case and the Board's decision related to the issue challenging the Medicaid Eligible Days.

Background:

A. Procedural History for Case No. 23-0236

On **June 2, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2018.

On **November 15, 2022**, the Board received the Provider's individual appeal request. The Appeal Request was filed by Community Health Systems, Inc. ("CHS") and included five (5) issues:

1. DSH Pymt/SSI % (Provider Specific)
2. DSH/SSI - Unduly Narrow Definition of SSI Entitlement
3. DSH Pymt - Medicaid Eligible Days
4. Medicare Managed Care Part C – SSI & Medicaid Fractions
5. Dual Eligible Days – SSI & Medicaid Fractions

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

On **November 18, 2022**, the Board issued the Acknowledgement and Critical Due Dates ("ACDD") notice providing, among other things, the filing deadlines for the parties' preliminary

position papers (*hereinafter* "PPP").[1] This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[2]

On **June 9, 2023,** CHS transferred Issues 2, 4 and 5 to CIRP groups. As a result, there were two (2) remaining issues in this appeal at that time: DSH Pymt/SSI % (Provider Specific) (Issue #1) and DSH Pymt - Medicaid Eligible Days (Issue #3).

On **June 23, 2023**, CHS filed the Provider's PPP. On **August 31, 2023**, the Medicare Contractor uploaded a copy of its request to the Provider for a DSH package including a listing of Medicaid Eligible days. On **September 27, 2023,** the MAC filed its PPP.

On **October 23, 2023**, the MAC filed a Jurisdictional Challenge over Issues 1 and 3: the DSH Pymt/SSI % (Provider Specific) and DSH Pymt - Medicaid Eligible Days issues.

On **October 24, 2023**, CHS requested a change in representation to Quality Reimbursement Services, Inc. ("QRS") which the Board confirmed the following day.

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

On **June 17, 2026**, QRS withdrew Issue 1, the DSH Pymt/SSI % (Provider Specific) issue from the appeal.

B. Description of Issue 3 in the Appeal Request

In its Individual Appeal Request, the Provider questions whether the MAC "properly excluded Medicaid eligible days from the [DSH] calculation." The Statement of the Legal Basis is as follows:

> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the

[1] On March 23, 2023 a revised Critical Due Dates notice was issued updating the PPP deadlines.
[2] (Emphasis added.)

> disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 5, 21, 22, 23, S-D
>
> Estimated Reimbursement Amount: $38,337[3]

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[4] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[5]

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

In its jurisdictional challenge, the MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. However, as noted above, the Provider withdrew Issue 1 in June, 2026, making the challenge moot.

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

The MAC also argues the Board lacks jurisdiction over the Medicaid Eligible Days issue. The MAC contends that the Provider failed to include a list of additional Medicaid eligible days they expected to be included with their appeal or with their preliminary position paper.[6]

The MAC also challenges the Provider's attempt to untimely add the Section 1115 Waiver Days issue by including it in the narrative of the PPP.[7]

Finally, the MAC argues the Provider has abandoned the Medicaid Eligible days issue because it failed to sufficiently develop and set forth the relevant facts and arguments in its preliminary position paper and because it neglected to include all supporting documentation.[8]

---

[3] Issue Statement (Issue 3) at 3 (Nov. 15, 2022).
[4] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[5] Provider's PPP at 8 (June 23, 2023).
[6] Medicare Administrative Contractor Jurisdictional Challenge at 15-16 (Oct. 23, 2023).
[7] *Id.* at 10.
[8] *Id*. at 15.

Provider's Jurisdictional Response

Board Rule 44.4.3 specifies: "[p]roviders must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."[9] The Provider failed to file a timely response by the *November 22, 2023* deadline.

Board Analysis and Decision:

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

As set forth below, the Board hereby dismisses the Provider's Issue No. 3.

A. DSH Payment – Medicaid Eligible Days

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

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

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

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

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

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

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

> The provider must support the determination being appealed and the basis for its dissatisfaction for ***each*** issue under appeal consistent with 42 C.F.R. § 405.1835(b) or (d) as applicable. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Furthermore, 42 C.F.R. § 405.1853(b) addresses position papers and specifies, in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[10]

Similarly, with regard to position papers,[11] Board Rule 25.2.1 requires that "the parties must exchange ***all*** available documentation as exhibits to fully support your position." This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides instruction on the content of position papers as it relates to unavailable documentation/exhibits, as discussed *supra*.

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

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
- upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868);

[10] (Emphasis added).
[11] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.

- if the Board is unable to contact the provider or representative at the last known address; or
- upon failure to appear for a scheduled hearing.

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

This appeal was initiated on November 15, 2022 (over 3.5 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expected to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's PPP indicated that it would be sending the eligibility listing under separate cover.[12] ***To date, no listing has been provided.*** Accordingly, the Provider has abandoned the issue by failing to properly develop its arguments and provide supporting documents, and by failing to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[13] Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.

B. 1115 Waiver Days

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

The regulations in effect when this appeal was filed with the Board in November of 2022 required the following:

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

[12] Provider's PPP at 9 (June 23, 2023).
[13] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.[14]

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

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

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

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[15]

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.[16]

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

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

[14] 42 C.F.R. § 405.1835(b).
[15] (Bold and italic emphasis added).
[16] *See* 73 Fed. Reg. 30190 (May 23, 2008).

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

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider 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.[17] 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 A 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**

[17] 65 FR 47054, 47087 (Aug. 1, 2000).

> **populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

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

Finally, even in the Provider's PPP, the Provider fails to identify what § 1115 Waiver program(s) are involved and whether or not the § 1115 Waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(4)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the PPP is insufficient in that it only makes perfunctory conclusions. Again, the Provider failed to properly develop its position paper notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Nov. 2021) as applied via Board Rule 27.2.

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[18] 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."[19] 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."[20] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[21] Here, the Board makes the same finding based on similarly *overly generalized language.*

[18] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[19] *Id*. at *5.
[20] *Id.*
[21] *Id.*

Based on the foregoing, the Board is dismissing the Medicaid Eligible Days (*including Section 1115 Waiver Days*) - Issue No. 3 from this case.

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

Board Members Participating:

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

For the Board:

7/16/2026

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Notice of Dismissal***
PRRB Case No. 22-1075 - University Medical Center, Prov. No. 45-0686, FYE 12/31/2017

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-1075. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days issue.

Background

On **January 26, 2022**, the Medicare Contractor ("MAC") issued a Notice of Program Reimbursement ("NPR") for University Medical Center for its fiscal year end ("FYE") December 31, 2017.

On **June 1, 2022**, Quality Reimbursement Services, Inc. ("QRS") filed an individual appeal on behalf of University Medical Center. The Individual Appeal Request included six issues:

1. SSI Percentage (Provider Specific)[1]
2. SSI Percentage (Systemic Errors)[2]
3. Medicaid Eligible Days
4. SSI MCD PT C[3]
5. SSI MCD Dual[4]
6. Standardized Payment Amount[5]

On **June 2, 2022**, the Board issued the Acknowledgement and Critical Due Dates ("ACDD") notice, providing among other things, the filing deadlines for the parties' preliminary position papers (hereinafter "PPP"). This notice also gave the following instructions to the Provider regarding the content of its PPP:

[1] On May 1, 2026, this issue was withdrawn.
[2] On December 13, 2022, this issue was transferred to Case No. 22-1457G.
[3] On December 13, 2022, this issue was transferred to Case No. 23-0212G.
[4] On December 13, 2022, this issue was transferred to Case No. 23-0213G.
[5] On December 13, 2022, this issue was transferred to Case No. 22-0276G.

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

On **February 27, 2023**, the Board issued a revised Critical Due Dates notice("CDD")

On **June 15, 2023**, the QRS timely filed the Provider's PPP.

On **October 20, 2023**, the Medicare Contractor ("MAC") timely filed its PPP.

On **February 2, 2026**, the Board issued a Notice of Hearing scheduling the case for August 3, 2026.

On **May 5, 2026**, QRS filed the Provider's final PP.

On **May 22, 2026**, the MAC filed its final PP.

On **June 4, 2026**, the MAC filed a Jurisdiction Challenge.

On **July 14, 2026**, QRS filed the Providers responsive jurisdictional brief.

MAC's Motion to Dismiss DSH – Medicaid Eligible Days

The MAC contends the Provider failed to file complete position papers in violation of Board 42 CFR § 405.1835(b)(2) and Board Rules 25 and 27. Based on its failure to provide the necessary documentation (i.e., auditable list of additional Medicaid Eligible days or any supporting documentation) the Provider has abandoned its claim for additional Medicaid Eligible days. In addition, the Provider is attempting to untimely and improperly add the Section 1115 Waiver days issue via its PPP submission.

Provider's Jurisdictional Response

Board Rule 44.4.3 requires that "Providers must file a response within thirty (30) days of the Medicare Contractor's jurisdictional challenge. Failure to respond will result in the Board's making a determination with the information contained in the record." The Provider did not file a timely response to the MAC's jurisdiction challenge as the due date for doing so was July 4,

[6] (Emphasis added.)

2026 and the Provider's response was received 10 days later, on July 14, 2026. Therefore, a jurisdictional determination will be made based on the information contained in the record.

Decision of the Board

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

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

A. DSH Payment – Medicaid Eligible Days

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

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Nov. 2021) states:

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

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

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits 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.[7]

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

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

Rule 25 - Preliminary Position Papers[8]

> **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

---

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

25.2.1 General

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

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The June 2, 2022 Acknowledgement and Critical Due Dates notice issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the

Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[9]

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

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

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

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

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

On June 15, 2023, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[10] Significantly, the PPP did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $69,808 based on an estimated 200 days). The Provider's complete briefing of this issue in its PPP is as follows:

[9] (Emphasis added.)
[10] Provider's PPP at 10 (June 15, 2023).

Calculation of Medicaid Eligible Days

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

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

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

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

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

Based on the listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days

> reflected in its' 2017 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.
>
> With respect to section 1115 waiver days, the courts have firmly rejected CMS's interpretation of the 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*, 246 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 21 (D.C. Cir. 2020). CMS has acquiesced in *Bethesda* and is now following the statute and the plain meaning of its own regulations (which regulations represent the official policy of CMS all along). *See* CMS Manual Instructions System, Change Request 12669, Transmittal No. 11912 (March 163, 2023)(Transmittal 11912") attached as Exhibit P-4.

In its June 4, 2026 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid Eligible days issue because:

(1) the Provider was in violation of Board Rules 25.3 and 27.2 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary and final position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.; and
(2) the Provider failed to furnish an unredacted, auditable list of additional Medicaid eligible days with its preliminary position paper, or to explain why it failed to produce those documents, in violation of Board Rules 25.2.1 and 25.2.2. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents as required by the Board Rules.[11]
(3) In addition, the MAC argued the Provider was attempting to untimely, and improperly, add the Section 1115 waiver days issue by including it in the narrative of its PPP and final PP submissions.

The Board notes that on May 5, 2026, QRS did include 2 redacted listings of "Additional Medicaid Eligible Days- High Strata" and Additional Medicaid Eligible Days- Low Strata" as an exhibit to its final position paper. The 2 listings shows a total of 131 additional days but does not

[11] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

explain why the listing was being submitted so late as it was ***almost 3 years past the deadline for including it with the Provider's PPP*** for which the deadline was June 27, 2023.

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

The Board rejects the Provider's attempts to include the eligible days listing as an exhibit to its final PP on May 5, 2026 because:

1. The upload was filed almost ***3 years*** *after the deadline* for the exhibits to be included with the PPP filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)).

2. The uploaded exhibit fails to explain (a) *why* it was being filed so late (*i.e.*, upon what basis or authority should the Board accept the late filing); and (b) *why* the listing of the roughly 131 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 almost 4 years after this appeal was filed and more than 8 years after the fiscal year at issue had closed).

3. Neither the Board Rules, nor the June 2, 2022 Case Acknowledgment and Critical Due Dates notice, permit the Provider to file a "Supplement" to its PPP (nor did the Provider allege in the upload that they do).

4. Given that the *material* facts (*e.g.*, the days at issue) and all available exhibits were required to be part of the PPP filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its PPP or a supplement of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the appeal request, nor the PPP, identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the uploaded listing cannot be considered a refinement of the position paper since no specific days or listing were included with the PPP.[12]

5. Finally, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[13] 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

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

> Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provide the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

B. Section 1115 Waiver Days

The Board has determined that the Section 1115 Waiver days issue is not a part of this appeal as it was not properly or timely added.[14] While the Provider appealed Medicaid Eligible days, this issue is separate and distinct from the Section 1115 Waiver days.

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

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[15]

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

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>   - the adjustment, including the adjustment number,
>   - the controlling authority,
>   - why the adjustment is incorrect,
>   - how the payment should be determined differently,
>   - the reimbursement effect, and
>   - the basis for jurisdiction before the [Board].

[14] In the Provider's *late* responsive Jurisdictional Brief filed on July 14, 2026, QRS withdrew the Section 1115 waiver days issue.
[15] 42 C.F.R. § 405.1835(b).

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

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[16]

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.[17]

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

> (e) Adding issues to the hearing request. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
> . . .
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

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

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid Eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.[18] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying Section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a Section 1115 Waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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[16] (Bold and italic emphasis added).
[17] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[18] 65 FR 47054, 47087 (Aug. 1, 2000).

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

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

Regardless, even if the Provider had included in its appeal request (***which it did not***), the Provider failed to properly develop the issue in its PPP filing. Although the Provider's PPP *mentions* Section 1115 Waiver days, it does not identify the specific 1115 Waiver day program(s) at issue). In addition, the PPP does not discuss whether or not the Section 1115 Waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the final PP is perfunctory in that it only makes cursory conclusions.[19] Again, the

[19] 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

Provider failed to so develop its PPP, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Nov. 2021).

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

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[20] 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 . . ."[21] 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."[22] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[23] Here, the Board makes the same finding based on similar *overly generalized language.*

* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible Days (Issue No. 3), including Section 1115 Waiver days. As no issues remain, the Board hereby closes Case No. 22-1075 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.

---

who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." However, QRS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is QRS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? QRS fails to brief the merits of its claims and fails to establish the Board's jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the PPP references "uncompensated care pool."

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

[21] *Id*. at *11.

[22] *Id.*

[23] *Id.*

Board Members Participating:

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

For the Board:

7/20/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Board Determination on Provider's Motion to Vacate Dismissal & Reinstate Appeal***
University of Illinois Hospital and Clinics (Provider Number 14-0150), FYE 6/30/2020
Case Number: 26-0163

Dear Mr. Perkins:

The Provider Reimbursement Review Board (the "Board") has reviewed the above-captioned appeal in response to the June 23, 2026 Motion to Vacate Dismissal & Reinstate Appeal ("Motion") filed by Polales, Horton & Leonardi, LLP ("PH&L"/ "Representative"). In its Motion, PH&L requests that the Board find good cause and reinstate the subject appeal. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

On **October 20, 2025,** PH&L filed an individual appeal on behalf of University of Illinois Hospital and Clinics ("Provider"), based on the April 23, 2025 "Notice of Program Reimbursement ("NPR") for its fiscal year end ("FYE") 6/30/2020 under Case No. 26-0163.

On **October 29, 2025,** the Board issued a "Case Acknowledgement and Critical Due Dates Notice" ("ACDD") setting the Provider's preliminary position paper ("PPP") deadline for **June 17, 2026** and the Medicare Contractor's PPP deadline for **October 15, 2026**.

On **June 22, 2026**, *five days after the expiration of the Provider's PPP deadline*, the Board dismissed Case No. 26-0163, pursuant to Board Rule 23.4, which indicates the Board will dismiss a case where the Provider fails to timely file its PPP.[1]

On **June 23, 2026**, PH&L filed a Motion to Vacate the Dismissal and Reinstate the Appeal along with a copy of the Provider's PPP as required by Board Rule 47.3. In its Motion, PH&L acknowledged that its "failure to meet the June 17, 2026, deadline was entirely the result of an inadvertent and unintentional clerical data-entry error."[2] PH&L admits that it mistakenly logged the wrong due date when it calendared the case on its internal docket. The Representative requests that the Board find, however, there is good cause pursuant to 42 C.F.R. §

[1] Board Rules v 3.2 (Dec. 2023).
[2] Provider's Motion to Vacate Dismissal and Reinstate at 2 (Jun. 23, 2026).

405.1868(b)(2). PH&L contends that although dismissal and reinstatement are both at the Board's discretion, the decision to dismiss can be tempered by an excusable mistake standard.[3] Therefore, PH&L requests that the Board find the "'mis-dated' deadline here be judge[d] under an equitable determination that considers relevant circumstances, including prejudice to the opposing party, the length of the delay, its potential impact on the proceedings, the reason for the delay, and whether the movant acted in good faith."[4]

Board Determination:

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

PH&L has filed a *Motion* requesting that the Board reinstate the case. Board Rule 47.1 governs motions for reinstatement of an issue or case, and states:

> **47.1 Motion for Reinstatement**
>
> A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s) (*see* 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (*see* Rule 44 governing motions). The Board will ***not*** reinstate an issue(s)/case if the provider was at fault. If an issue(s)/case was remanded pursuant to a CMS ruling (*e.g.*, CMS Ruling 1498-R), the provider must address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board reinstates an issue(s) or case, the provider will have the same rights (no greater and no less) that it had in its initial appeal. . . .[5]

Thus, Board Rule 47.1 states that the Board will not reinstate if the provider was at fault. Board Rule 47.3 further clarifies that, when the dismissal is based on the failure to comply with Board Procedures (such as filing a required position paper), the Board may reinstate for good cause which does ***not*** include administrative oversight.

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[3] *Id*. at 2-3.
[4] *Id*. at 2.
[5] (Bold and italics emphasis added.) Rule 47.1 references Rule 44 governing motions. With respect to the Motion to Reinstate in this case, contrary to Rule 44, PH&L's motion for reinstatement is deficient because it failed to include a statement confirming it had contacted the Medicare Contractor prior to filing the motion to see if the Medicare Contractor would concur or oppose the motion.

> **47.3 Dismissals for Failure to Comply with Board Procedures**
>
> *Upon written motion demonstrating good cause*, the Board *may reinstate* a case dismissed for failure to comply with Board procedures. *Generally, administrative oversight*, settlement negotiations or a change in representative *will not be considered good cause to reinstate*. If the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, the motion for reinstatement must, as a prerequisite, include the required filing before the Board will consider the motion.[6]

Here, the Board finds that the Provider was at fault since it failed to meet the PPP deadline due to its own admitted error whereby it inadvertently logged the wrong deadline on its internal calendar.

The Board has considered the facts in this case, as well as the Representative's arguments in support of reinstatement, and DENIES the requested reinstatement. In denying the request, the Board notes that the ACDD Notice clearly stated that Provider was required to file the PPP and that failure to do so would result in dismissal. Specifically, it stated that "[t]he parties must meet the following due dates regardless of any outstanding jurisdictional challenges, motions, or subpoena requests. If the provider misses any of its due dates, the Board will dismiss the appeal." Similarly, Board Rule 23.4 states: "The provider's preliminary position paper due date will be set on the same day as the PJSO due date. Accordingly, if neither a PJSO nor the provider's preliminary position paper is filed by the filing due date, *the Board will dismiss the case*."[7]

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

> **5.2 Responsibilities**
>
> *The case representative is responsible for being familiar with the following rules and procedures for litigating before the Board*:
>
> - The Board's governing statute at 42 U.S.C. § 1395oo;
> - The Board's governing regulations at 42 C.F.R. Part 405, Subpart R; and
> - These Rules, which include any relevant Orders posted at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-rules-and-board-orders (*see* Rule 1.1).

[6] (Italics emphasis added.)
[7] (Italics emphasis added.)

Further, the case representative is responsible for:

- Ensuring his or her contact information is current with the Board, including a current email address and phone number;
- *Meeting the Board's deadlines*; and
- *Responding timely to correspondence or requests from the Board* or the opposing party.

Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.[8]

In summary, pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b), the Board *DENIES* PH&L's request for reinstatement of Case No. 26-0163. The Board finds that the Provider was at fault and failed to establish good cause under Board Rules 47.1 and 47.3 as it admitted fault. Therefore, the Board declines to exercise its discretion to reinstate Case No. 26-0163 and it thereby remains closed. The Board denial is consistent with numerous cases in which federal courts have upheld the Board's authority to dismiss cases for failure of the provider to timely file position papers or other Board filings.[9]

Board Members Participating:

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

For the Board:

7/22/2026

X Kevin D. Smith, CPA

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

[8] (Bold emphasis in original and italics and underline emphasis added.)

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran, President
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Arcadia, CA 91006

RE: ***Notice of Dismissal***
Baylor Scott & White Medical Center - Waxahachie (Prov. No. 45-0372), FYE 06/30/2018
Case No. 22-0173

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-0173. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days issue.

Background:

A. ***Procedural History for Case No. 22-0173***

On **May 25, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2019.

On **November 17, 2022**, the Board received the Provider's individual appeal request. The Appeal Request was filed by the parent organization, Community Health Systems, Inc. (hereinafter "CHS") and included five (5) issues:

1. DSH Pymt/SSI % (Provider Specific)[1]
2. DSH/SSI Unduly Narrow Definition of SSI Entitlement[2]
3. DSH Pymt - Medicaid Eligible Days
4. Medicare Managed Care Part C Days – SSI & Medicaid Fraction[3]
5. SSI & Medicaid Fraction Dual Eligible Days[4]

[1] On May 12, 2026, this issue was withdrawn.
[2] On June 9, 2023, this issue was transferred to Case No. 22-1031GC which is an SSI Systemic Group. The transfer is still in procedural review because the issues are not the same and the Board has recently denied such requests.
[3] On June 9, 2023, this issue was transferred to Case No. 23-0078GC.
[4] On June 1, 2023, this issue was bifurcated into separate SSI Fraction & Medicaid Fraction issues. The Board advised CHS to effectuate the transfers (specifically directing that the SSI Fraction DE issue be transferred to Case No. 22-1006GC). On June 15, 2026, the bifurcated Medicaid fraction DE issue was transferred to Case Nos. 23-0079GC.

On **March 22, 2023**, the Board issued the Acknowledgement and Critical Due Dates ("ACDD") notice, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter*, "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[5]

On **June 9, 2023,** CHS transferred Issues 2, 3, and 4, respectively, to CHS CIRP groups in accordance with the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). On **May 12, 2026** CHS withdrew Issue 1, and on June 15, 2026 QRS transferred the bifurcated issue(s) #5 and #6 to CHS CIRP groups.[6]

On **June 23, 2023**, CHS filed the Provider's PPP.

On **October 20, 2023**, the MAC filed its PPP.

On **February 25, 2026**, the Board issued a Notice of Hearing.

On **May 12, 2026**, CHS filed the Provider's final PP.

On **May 18, 2026**, the MAC filed its final PP.

On **June 9, 2026**, CHS requested a change of representation to Quality Reimbursement Services, Inc. ("QRS").

On **June 23, 2026**, the MAC filed a Motion to Dismiss the last issue in the case.

B. ***Description of Issue 3 in the Individual Appeal Request***

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

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[5] (Emphasis added.)

[6] QRS requested the transfer of the SSI Fraction DE issue to a new CIRP, Case No. 26-2713GC. It was subsequently determined that on 11/21/2022, the Provider had already been directly added to Case No. 22-1006GC (a pending CHS CY 2019 DSH Dual Eligible Days CIRP Group for the SSI Fraction DE issue.) Therefore, there is a letter denying the transfer of the issue to Case No. 26-2713GC and the issue is being dismissed from Case No. 23-0172. Case No. 26-2713GC is also being written up as a duplicate of Case No. 22-1006GC under separate cover.

Statement of Issue

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

Statement of the Legal Basis

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

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

Audit Adjustment Number(s): 4, 20, 22, 23, S-D

Estimated Reimbursement Amount: $62,104

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[7] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[8]

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

In its Jurisdicitional Challenge, the MAC argues the Board lacks jurisdiction over the Medicaid Eligible Days issue.[9] The MAC contends that the Provider failed to include a list of additional Medicaid eligible days they expect to be included with their appeal, their PPP or their final PP (even though the Provider advised that it would send a listing of additional Medicaid eligible days under separate cover.)[10] Finally, the MAC argues the Provider has abandoned this issue because it failed to sufficiently develop and set forth the relevant facts and arguments in its final

[7] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[8] Provider's PPP at 7 (July 9, 2022).
[9] The MAC's Jurisdictional Challenge also noted the improper and late addition of the Section 1115 Waiver Days issue, but this issue was withdrawn by the Provider in its Jurisdictional Responsive Brief filed on July 9, 2026.
[10] MAC's Jurisdictional Challenge at 2 (July 7, 2026).

PP and because it neglected to include all supporting documentation (per 42 CFR 405.1853(b)(2) and Board Rules 25.2.2, 25.3 and 27.2).[11]

Provider's Jurisdictional Response – Medicaid Eligible Days & Section 1115 Waiver Days

QRS timely filed a jurisdictional response to the MACs challenge in which it withdrew the Section 1115 Waiver days issue. In addition, QRS requested the MAC to audit the Additional Medicaid Eligible Days. According to QRS, the Provider sent the additional days to the MAC on July 9, 2026.

Board Analysis and Decision

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

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

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

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

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

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

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

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

[11] *Id.* at 3.

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

Furthermore, 42 C.F.R. § 405.1853 addresses position papers and specifies in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[12]

Similarly, with regard to position papers,[13] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[14] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> **25.2.2 Unavailable and Omitted Documents[15]**
>
> 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.[16]

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

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned;

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[12] (Emphasis added).
[13] The minimum requirements for Final PP narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.
[14] (Emphasis added).
[15] PRRB Rules v. 3.1 (Nov. 2021)
[16] (Italics and underline emphasis added.)

- upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868);
- if the Board is unable to contact the provider or representative at the last known address; or
- upon failure to appear for a scheduled hearing.

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

This appeal was initiated on November 22, 2021 (more than 4.5 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expected to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, both the Provider's PPP and final PP indicated that it would be sending the eligibility listing under separate cover. According to the Provider's Jurisdictional Responsive Brief, it admits that the auditable listing was not forwarded to the MAC until July 9, 2026 – well after the time frame for such submission.

In summary, the Board finds that the Provider failed to satisfy the requirements of Board Rules 25.2.1 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. Accordingly, the Board finds that the Provider abandoned the Medicaid Eligible days issue by failing to properly develop its arguments and provide supporting documents, and by failing to explain why it did not produce those documents, as required by the regulations and the Board Rules.[17]

****

Based on the foregoing, the Board is dismissing the last remaining issue in this case: "DSH - Medicaid Eligible Days" - Issue 3. As no issues remain, the Board hereby closes Case No. 22-0173 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: For the Board:

[17] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

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

7/22/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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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***
San Angelo Community Medical Center, Prov. No. 45-0340, FYE 08/31/2018
Case No. 22-0394

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-0394. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 22-0394*

On **July 23, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end August 31, 2018.

On **January 11, 2022**, Community Health Services ("CHS") filed an appeal on behalf of the Provider which included five (5) issues:

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

As the Provider is commonly owned/controlled by Community Health Systems (*hereinafter* "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 **December 8, 2025**, the Provider transferred Issues 3, 4 and 5 to various CHS CIRP groups.

[1] On March 23, 2026, this issue was withdrawn.
[2] On August 15, 2022, this issue was transferred to Case No. 21-1206GC.
[3] On August 15, 2022, this issue was transferred to Case No. 20-2149GC.
[4] On August 15, 2022, this issue was transferred to Case No. 21-0066GC.

On **January 12, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates ("ACDD"), providing among other things, the filing deadlines for the parties' preliminary position papers ("PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[5]

On **August 24, 2022**, CHS filed the Provider's PPP and on **January 3, 2023**, the MAC filed its PPP.

On **September 23, 2025** the Board issued a Notice of Hearing scheduling the case for a hearing on June 22, 2026. On **May 19, 2026**, the case was rescheduled for a hearing on **August 20, 2026.**

On **March 20, 2026,** CHS requested a change in representation to Quality Reimbursement Services, Inc. ("QRS"), which the Board acknowledged on the same day.

On **March 23, 2026**, QRS filed the Provider's final PP and on **April 14, 2026**, the MAC filed its final PP.

On **May 18, 2026**, the MAC filed a Motion to Dismiss the Medicaid Eligible Days issue to which QRS responded on **May 21, 2026**.

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

In its Motion to Dismiss, the MAC contends the Provider failed to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was unavailable. In addition, the Provider failed to properly develop its argument within its PPs in accordance with Board Rules 7, 25.2.1 and 25.2.2. Therefore, the MAC maintains that the Provider has abandoned its claim for this issue.[6]

[5] (Emphasis added.)
[6] Although not referenced in the MAC's Motion to Dismiss, the Provider untimely and improperly added the Section 1115 Waiver Days issue by including it in its final position paper submission.

Provider's Jurisdictional Response

QRS timely responded to the MAC's Motion to Dismiss and advised that it has submitted the "encounter level detail support requested by the MAC." As background, QRS explained that on May 19, 2026, it sent a communication to the MAC and Federal Specialized Services ("FSS") indicating it had previously complied with the MAC's earlier request for documentation for which the MAC had established a May 1, 2026 deadline. According to QRS, upon receipt of the MAC's Motion to Dismiss, it reached out to the MAC and was told that the eligibility information from the State was not in their possession. Upon finding out that the MAC did not have the documentation, QRS indicates that it immediately forwarded the State eligibility data to the MAC via email. Therefore, QRS believes the MAC's Motion to Dismiss should be withdrawn and the MAC should continue the audit of the additional Medicaid Eligible days.

Decision of the Board

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

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

A. DSH Payment – Medicaid Eligible Days

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

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

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

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

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the

> appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[7]

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

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

Rule 25 - Preliminary Position Papers[8]

> **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,

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

agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.

B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The January 12, 2022 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

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

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[9]

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

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

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

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

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

[9] (Emphasis added.)

the last known address, or
- upon failure to appear for a scheduled hearing.

On August 24, 2022, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[10] Significantly, the PPP did ***not*** include *the material fact* of how many Medicaid Eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $55,586 based on an estimated 100 days). The Provider's complete briefing of this issue in its PPP is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [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.

[10] Provider's PPP at 8.

> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2018 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[11]

In its May 18, 2026 Motion to Dismiss, the MAC requested dismissal of the Medicaid Eligible days issue because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish an unredacted, auditable list of additional Medicaid eligible days with its PPP in violation of Board Rules 7, 25.2.1 and 25.2.2. Thus, the MAC asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the Board Rules.[12]

In response to the MAC's Motion to Dismiss, QRS argues that the Provider previously provided the "encounter level detail support" to a contact at the MAC, which it later discovered, was no longer there. Upon receipt of the MAC's Motion to Dismiss, the Representative reached out to the MAC to explain that it had responded to the MAC's earlier May 1, 2026 deadline. However, the MAC advised QRS that it couldn't proceed as the "Medicaid eligibility [information] from the State was not in their possession." Upon receiving that notification, QRS contends that it immediately forwarded the State eligibility data to the MAC via email.

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

The Board rejects the Provider's explanation regarding its attempt to file the Eligible Days listing with the MAC on May 1, 2026 because:

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[11] Provider's PP at 7-8.

[12] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

1. The listing would still have been filed past the deadline for the exhibits to be included with the PPP filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)) (***which was due on September 8, 2022***).

2. Given that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the PPP, if the Board were to accept the May 1, 2026 filing (which the MAC asserts it did not have AND a redacted copy of which was **not** uploaded in OH CDMS)," it would need to be either be a *refinement* of its PPP or a supplement of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. The Board takes note that the Provider did include a redacted listing of "Additional Medicaid Days" as an exhibit to its final PP. However, neither the PPP, nor the subsequent listing included as an exhibit identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the redacted listing included with the final PP cannot be considered a refinement of the PPP since no specific days or listing were included with the PPP.[13]

3. Finally, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[14] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its PP filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the PPP filing (much less provider the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

B. Section 1115 Waiver Days

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

The appeal was filed with the Board in January 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…

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

> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[15]

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

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
> - the adjustment, including the adjustment number,
> - the controlling authority,
> - why the adjustment is incorrect,
> - how the payment should be determined differently,
> - the reimbursement effect, and
> - the basis for jurisdiction before the [Board].

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

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[16]

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.[17]

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

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[15] 42 C.F.R. § 405.1835(b).
[16] (Bold and italic emphasis added).
[17] *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 properly or timely added the Section 1115 Waiver days issue to the case.

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid Eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.[18] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying Section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a Section 1115 Waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

[18] 65 FR 47054, 47087 (Aug. 1, 2000).

> **populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

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

Regardless, even if the Provider had included in its appeal request (***which it did not***), the Provider failed to properly develop the issue in its PPP filing. It was not until the Provider's final PP filing that it even *mentioned* Section 1115 Waiver days, and even then, it does not identify the specific 1115 Waiver day program(s) at issue). In addition, the final PP does not discuss whether or not the Section 1115 Waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the final PP is perfunctory in that it only makes cursory conclusions.[19] Again, the Provider failed to so develop its PPs, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Nov. 2021).

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

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

The Board's finding that neither the appeal request nor the PPs met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[20] 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 . . ."[21] 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."[22] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[23] Here, the Board makes the same finding based on similar *overly generalized language.*

* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible days (Issue #3) including Section 1115 Waiver days. As no issues remain, the Board hereby closes Case No. 22-0394 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

7/22/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[20] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[21] *Id*. at *11.
[22] *Id.*
[23] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Notice of Dismissal***
PRRB Case No. 22-1207 -Norwalk Hospital Association, Prov. No. 07-0034, FYE 09/30/2019

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-1207. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days issue.

Background

A. *Procedural History for Case No. 22-1207*

On **February 10, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2019.
On **July 26, 2022**, Quality Reimbursement Services, Inc. ("ARS") filed an appeal on behalf of the Provider which included five (5) issues:

1. SSI Provider Specific[1]
2. SSI Systemic Errors[2]
3. SSI MCD PT C[3]
4. SSI MCD Dual[4]
5. Standardized Payment Amount[5]

On August 4, 2022, QRS added one more issue to the appeal:

6. Medicaid Eligible Days

As the Provider is commonly owned/controlled by Nuvance Health (*hereinafter* "Nuvance), the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42

[1] On May 4, 2026, this issue was withdrawn.
[2] On February 8, 2023, this issue was transferred to the "Nuvance Health CY 2019 DSH SSI Unduly Narrow Definition of SSI Entitlement CIRP Group," Case No. 23-0798GC. (Although issue was titled as "SSI Systemic Errors" in individual appeal, the issue statement uploaded for Issue #2 is identical to the issue statement in the DSH SSI Unduly Narrow Definition of SSI Entitlement group.
[3] On February 8, 2023, this issue was transferred to Case No. 23-0800GC.
[4] On February 8, 2023, this issue was transferred to Case No. 23-0799GC.
[5] On February 8, 2023, this issue was transferred to Case No. 22-1313GC.

C.F.R. § 405.1837(b)(1). For that reason, on **February 8, 2023**, the Provider transferred Issues 2,3, 4 and 5 to various CHS CIRP groups.

On **July 28, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates ("ACDD"), providing among other things, the filing deadlines for the parties' preliminary position papers ("PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

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

On **March 20, 2023**, QRS filed the Provider's PPP and on **June 23, 2023**, the Medicare Contractor ("MAC") filed its PPP.

On **February 6, 2026** the Board issued a Notice of Hearing scheduling the case for a hearing on **September 16, 2026.**

On **April 28, 2026**, the MAC filed a Motion to Dismiss the SSI Provider Specific (*which was subsequently withdrawn on May 4, 2026*) and Medicaid Eligible Days issue to which QRS responded on **July 21, 2026**.

On **June 16, 2026**, QRS filed the Provider's final PP and on **July 15, 2026**, the MAC filed its final PP.

MAC's Motion to Dismiss Issue No. 6: DSH –Medicaid Eligible Days

The MAC contends the Provider failed to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was unavailable and failed to properly develop its argument within its PPs in accordance with Board Rules 7, 25.2.1 and 25.2.2. Therefore, the MAC maintains the Provider has abandoned its claim for this issue.

Provider's Jurisdictional Response

Board Rule 44.4.3 requires that "Providers must file a response within thirty (30) days of the Medicare Contractor's jurisdictional challenge. Failure to respond will result in the Board's making a determination with the information contained in the record." The Provider did not file a timely response to the MAC's jurisdiction challenge as the due date for doing so was May 28, 2026 and the Provider's response was received 54 days later, on July 21, 2026. Therefore, a jurisdictional determination will be made based on the information contained in the record.

[6] (Emphasis added.)

Decision of the Board

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

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

A. DSH Payment – Medicaid Eligible Days

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

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Nov. 2021) states:

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

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

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits 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.[7]

The regulations require the parties to fully brief the merits of each issue in their PP (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.

[7] (Bold emphasis added.)

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

Rule 25 - Preliminary Position Papers[8]

> **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.

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

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The July 28, 2022 ACDD notice issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue No. 6, 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.[9]

[9] (Emphasis added.)

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

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

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

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

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

On March 20, 2023, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[10] Significantly, the PPP did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $48,773 based on an estimated 100 days). The Provider's complete briefing of this issue in its PPP is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041

[10] Provider's PPP at 9 (March 20, 2023).

> (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 [or Providers'] Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's [or Providers'] Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).
>
> Based on the listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2019 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its April 28, 2026 Motion to Dismiss, the MAC requested dismissal of the SSI Provider Specific issue (*which was subsequently withdrawn*) and the Medicaid Eligible days issue because:

- the Provider has failed to furnish documentation in support of its claim for additional Medicaid days or describe why such documentation was unavailable in violation of Board Rules 7, 25.2.1 and 25.2.2;
- the Provider was in violation of Board Rules 25.3 and 27.2 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary and final position paper; and
- the Provider failed to furnish an unredacted, auditable list of additional Medicaid eligible days to the MAC. Therefore, the MAC asserts that the Provider has

> essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents as required by the Board Rules.[11]

In addition, although not addressed in the MAC's Motion to Dismiss, the Provider has attempted to untimely and improperly add the Section 1115 waiver days issue by including it in the narrative of its PPP and final PP submissions.

The Board notes that on June 18, 2026, QRS did include 2 redacted listings of "Additional Medicaid Eligible Days- High Strata" and Additional Medicaid Eligible Days- Low Strata" as an exhibit to its final position paper. The 2 listings show a total of 650 additional days but does not explain why the listing was being submitted so late as it was ***more than 3 years past the deadline for including it with the Provider's PPP*** for which the deadline was March 23, 2023.

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

The Board rejects the Provider's attempts to include the eligible days listing as an exhibit to its final PP on June 17, 2026 because:

1. The upload was filed *more than **3 years** after the deadline* for the exhibits to be included with the PPP filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)).

2. The uploaded exhibit fails to explain (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); and (b) *why* the listing of the roughly 650 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 almost 4 years after this appeal was filed and more than 6.5 years after the fiscal year at issue had closed); and (c) why the listing of 650 days was so much larger than the original estimate of 100 days included in the appeal request.

3. Neither the Board Rules, nor the July 28, 2022 Case Acknowledgment and Critical Due Dates notice, permit the Provider to file a "Supplement" to its PPP (nor did the Provider allege in the upload that they do).

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[11] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

4. Given that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the PPP filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its PPP or a supplement of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the appeal request, nor the PPP, identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the uploaded listing cannot be considered a refinement of the position paper since no specific days or listing were included with the PPP.[12]

5. Finally, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[13] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provide the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

B. Section 1115 Waiver Days

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

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

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[14]

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

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[12] *See, e.g.,* Board Rule 27.3 (Nov. 2021) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."
[13] (Emphasis added.)
[14] 42 C.F.R. § 405.1835(b).

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>   - the adjustment, including the adjustment number,
>   - the controlling authority,
>   - why the adjustment is incorrect,
>   - how the payment should be determined differently,
>   - the reimbursement effect, and
>   - the basis for jurisdiction before the [Board].

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

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[15]

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.[16]

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

> (e) Adding issues to the hearing request. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
> . . .
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

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

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid Eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.[17] Rather, these days relate to Medicaid expansion programs and are only includable in the

[15] (Bold and italic emphasis added).
[16] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[17] 65 FR 47054, 47087 (Aug. 1, 2000).

DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying Section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a Section 1115 Waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

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

Regardless, even if the Provider had included in its appeal request (***which it did not***), the Provider failed to properly develop the issue in its PPP filing. Although the Provider's PPP *mentions* Section 1115 Waiver days, it does not identify the specific 1115 Waiver days program(s) at issue). In addition, the PPP does not discuss whether or not the Section 1115 Waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for

Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the final PP is perfunctory in that it only makes cursory conclusions.[18] Again, the Provider failed to so develop its PPP, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Nov. 2021).

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

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[19] 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 . . ."[20] 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."[21] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[22] Here, the Board makes the same finding based on similar *overly generalized language.*

* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible Days (Issue No. 6), including Section 1115 Waiver days. As no issues remain, the Board hereby closes Case No. 22-1207 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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

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

[20] *Id*. at *11.

[21] *Id.*

[22] *Id.*

Board Members Participating:

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

For the Board:

7/24/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
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RE: ***Notice of Dismissal***
Eastern New Mexico Medical Center, Prov. No. 32-0006, FYE 05/31/2019
Case No. 23-0910

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0910. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 23-0910*

On **August 30, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2019.

On **February 7, 2023**, the parent organization, Community Health Systems, Inc. (hereinafter "CHS") filed the Provider's individual appeal request which included five (5) issues:

1. SSI Percentage (Provider Specific)[1]
2. DSH SSI – Unduly Narrow Definition of SSI Entitlement[2]
3. DSH Pymt - Medicaid Eligible Days
4. Medicare Managed Care Part C – SSI & Medicaid Fractions[3]
5. Dual Eligible Days – SSI & Medicaid Fractions[4]

[1] On June 18, 2026, this issue was withdrawn.
[2] On September 13, 2023, this issue was transferred to Case No. 22-1031GC, which is a group appeal for the SSI Percentage issue. The Parties received correspondence denying the transfer of this issue under separate cover. The Provider subsequently requested to transfer the issue to Case No. 26-2711GC on July 23, 2026.
[3] On September 13, 2023, this issue was transferred to Case No. 23-0078GC.
[4] The SSI and Medicaid Fraction Dual Eligible ("DE") Days issue was filed as a single issue but was subsequently bifurcated. The SSI Fraction DE portion remained at Issue 5 and Issue 6 was created for the Medicaid Fraction DE portion. On December 20, 2023, this SSI Fraction DE issue was transferred to Case No. 22-1006GC and the Medicaid Fraction DE issue was transferred to Case No. 23-0079GC.

On **February 9, 2023**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter*, "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[5]

On **October 3, 2023**, CHS filed the Provider's PPP.

On **November 20, 2023**, the Medicare Contractor ("MAC") uploaded a copy of its "Final Request for Information" for a DSH package.

On **November 21, 2023**, CHS requested a change of representation to Quality Reimbursement Services, Inc. ("QRS"), which the Board granted the following day.

On **December 28, 2023**, the MAC filed a Jurisdictional Challenge over the SSI Provider Specific issue (which was subsequently withdrawn) and the Medicaid Eligible Days issue.

On **January 9, 2024**, the MAC filed its PPP.

On **April 36, 2026**, the Board issued a Notice of Hearing scheduling the case for a **September 21, 2026** hearing**.**

On **June 19, 2026**, the Provider filed its final PP.

On **July 17, 2026**, the MAC filed its final PP.

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

In its Jurisdictional Challenge, the MAC argues the Board lacks jurisdiction over the Medicaid Eligible Days issue. The MAC contends that the Provider failed to include a list of additional Medicaid eligible days they expect to be included with their appeal or their PPP (even though the Provider advised that it would send a listing of additional Medicaid eligible days under separate cover.)[6] The MAC argues the Provider has abandoned this issue because it failed to sufficiently develop and set forth the relevant facts and arguments in its PPs and because it neglected to

[5] (Emphasis added.)
[6] MAC's Jurisdictional Challenge at 2 and 11.

include all supporting documentation.[7] In addition, the MAC contends the Provider is attempting to untimely add the issue of Section 1115 waiver days by including the issue in its PPP.[8]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must be filed within thirty (30) days from the date the challenge was sent to the Board and the opposing party.[9] The Provider's response to the Jurisdictional Challenge was filed beyond the 30 days deadline which elapsed on January 27, 2024 (30 days after it was filed on December 28, 2023). Therefore, the Board will make ". . . a jurisdictional determination with the information contained in the record."

Decision of the Board

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

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

A. DSH Payment – Medicaid Eligible Days

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

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

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

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

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper**

[7] *Id.* at 6-7.
[8] *Id* at 2, 11 and 13-14.
[9] Board Rule 44.4.3, v. 3.1 (Nov.1, 2021).

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

Rule 25 - Preliminary Position Papers[11]

> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will 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

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

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

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The February 9, 2023 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

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

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[12]

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

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

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

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

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

[12] (Emphasis added.)

the last known address, or
- upon failure to appear for a scheduled hearing.

On October 3, 2023, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[13] Significantly, the PPP did ***not*** include *the material fact* of how many Medicaid Eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $59,489 based on an estimated 100 days). The Provider's complete briefing of this issue in its PPP is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [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.

[13] Provider's PPP at 10.

> Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2019 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.
>
> With respect to section 1115 waiver days, the courts have firmly rejected CMS's interpretation of its regulations, holding instead that the plain language of the statute and the regulations require inclusion in the Medicaid Fraction of the days belonging to individuals who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool. See Forrest General Hospital, 926 F.3d 221 (5th Cir. 2019); HealthAlliance Hospitals, Inc. v. Azar, 346 F. Supp. 3d 43(D.D.C. 2018); Bethesda Health Inc., v. Azar, 389 F. Supp. 3d 32, (D.D.C. 2019), aff'd, 980 F.3d 121 (D.C. Cir. 2020). CMS has acquiesced in Bethesda and is now following the statute and the plain meaning of its own regulations (which regulations represent the official policy of CMS all along). See CMS Manual Instructions System, Change Request 12669, Transmittal No. 11912 (March 16, 2023) ("Transmittal 11912"), attached as Exhibit P-4.[14]

In its December 28, 2023 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid Eligible days issue because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish an unredacted, auditable list of additional Medicaid eligible days with its PPP in violation of Board Rules 7, 25.2.1 and 25.2.2. Thus, the MAC asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as

[14] Provider's PP at 9-10.

required by the Board Rules.[15] In addition, the MAC indicates the Provider is attempting to untimely add the issue of Section 1115 Waiver days by including the issue in its PPP.

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

Further, the Board rejects the Provider's attempt to file the Eligible Days listing as part of the final PP on June 19, 2026 because:

1. The listing was filed past the deadline for the exhibits to be included with the PPP filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)) (***which was due on October 5, 2023***).

2. Given that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the PPP, if the Board were to accept the June 19, 2026 listing of days submitted as an exhibit to the final PP (an auditable copy of which the MAC asserts it does not have, it would need to be either be a *refinement* of its PPP or a supplement of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the PPP, nor the subsequent listing included as the PP exhibit identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the redacted listing included with the final PP cannot be considered a refinement of the PPP since no specific days or listing were included with the PPP.[16]

3. Finally, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[17] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its PP filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the PPP filing (much less provider the § 412.106(b)(4)(iii) supporting documentation),

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[15] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

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

[17] (Emphasis added.)

notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

B. Section 1115 Waiver Days

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

The appeal was filed with the Board in February of 2023 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[18]

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

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
> - the adjustment, including the adjustment number,
> - the controlling authority,
> - why the adjustment is incorrect,
> - how the payment should be determined differently,
> - the reimbursement effect, and
> - the basis for jurisdiction before the [Board].

[18] 42 C.F.R. § 405.1835(b).

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

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[19]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[20]

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

> (e) Adding issues to the hearing request. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
> . . .
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

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

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid Eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.[21] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying Section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a Section 1115 Waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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[19] (Bold and italic emphasis added).
[20] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[21] 65 FR 47054, 47087 (Aug. 1, 2000).

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

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

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

makes cursory conclusions.[22] Again, the Provider failed to so develop its PPs, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Nov. 2021).

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

The Board's finding that neither the appeal request nor the PPs met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[23] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[24] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[25] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[26] Here, the Board makes the same finding based on similar *overly generalized language.*

* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible days (Issue #3) including Section 1115 Waiver days. As no issues remain, the Board hereby closes Case No. 23-0910 and removes it from the Board's docket.

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

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

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

[24] *Id*. at *11.

[25] *Id.*

[26] *Id.*

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For the Board:

7/29/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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