DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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Washington, D.C. 20004

RE: ***Expedited Judicial Review Decision***
25-0090GC: *Mayo Clinic CY 2020 Capital DSH CIRP Group*
23-0427GC: *Corewell Health CY 2020 Capital DSH CIRP Group*
24-2037GC: *Kettering Health Network CY 2020 Capital DSH CIRP Group*
25-0503GC: *HonorHealth CY 2020 Capital DSH CIRP Group*
23-1513GC: *UPMC CY 2020 Capital DSH CIRP Group*
24-1435G: *Bass, Berry & Sims, PLC CY 2019 Capital DSH Group II*
24-1708G: *Bass, Berry & Sims, PLC CY 2020 Capital DSH Group II*

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the April 1, 2025 consolidated request for expedited judicial review[1] ("EJR") for the above-referenced optional and common issue related party ("CIRP") group appeals. The decision with respect to EJR is set forth below.[2]

Issue under Dispute

In these group cases, the Providers are challenging:

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

[1] Providers' Petition for Expedited Judicial Review, 1 (Apr. 1, 2025) ("Request for EJR").
[2] The Request for EJR encompasses ten (10) group cases. On April 23, 2025, the Board issued a Request for Information and Scheduling Order in Cases 25-0090GC, 23-0427GC, 24-2037GC, 25-0503GC, 23-1513GC, 24-1435G, and 24-1708G. That order stayed the 30-day period for the Board to rule on the Request for EJR in those cases. The Board issued a separate determination adjudicating Cases 24-1722GC, 24-1878GC, and 25-1180GC on April 29, 2025.
[3] Request for EJR at 1.

Background:

Under the inpatient prospective payment system ("IPPS"), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for operating costs ("operating IPPS") as set forth at § 1395ww(d); and one for capital costs ("capital IPPS") as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.[4] This case focuses on the capital IPPS.

1. Geographic Reclassification

In 1989, Congress created the Medicare Geographic Classification Review Board ("MGCRB") which implemented a geographic reclassification system in which IPPS hospitals can be reclassified to a different wage index area[5] for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.[6] This includes an IPPS hospital reclassifying from a rural to an urban labor market, or vice versa.

2. Operating DSH Adjustment Under Operating IPPS

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

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

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[4] Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), *available at* https://oig.hhs.gov/oas/reports/region1/11700500.pdf (last visited Oct. 20, 2022) ("*Significant Vulnerabilities*").
[5] *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).
[6] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). *See also Significant Vulnerabilities* at 4-5.
[7] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[8] *Id.*
[9] *See* 42 U.S.C. § 1395ww(d)(5).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

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

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

3. Capital DSH Adjustment Under Capital IPPS

A hospital's *capital* costs are paid separately under capital IPPS (*i.e*., separate and apart from payment for a hospital's *operating* costs under the operating IPPS). Specifically, on December 22,1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987 ("OBRA-87") and OBRA-87 § 4006(b) required the Secretary to establish the capital IPPS for cost reporting periods beginning in FY 1992.[13] OBRA-87 § 4006(b) was codified at 42 U.S.C. § 1395ww(g) which states, in pertinent part:

> **(g) Prospective payment for capital-related costs; return on equity capital for hospitals**
>
> (1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall,* for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .
>
> (B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;
>
> (ii) *may provide for <u>an adjustment</u> to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located*;
>
> (iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[12] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[13] Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).

> (iv) may provide for suitable adjustment to reflect hospital occupancy rate.
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> (C) In this paragraph, the term "capital-related costs" has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.[14]

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

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

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

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

[14] (Underline and italics emphasis added.)
[15] 42 C.F.R. § 412.320(a)(1). *See also* MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 2 (rev. Nov. 2021), *available at* https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Apr. 29, 2025).
[16] 56 Fed. Reg. 43358 (Aug. 30, 1991).

> for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME) exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should reflect only the higher Medicare costs associated with teaching activity and treating low income patients.[17]

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more than 100 beds. The proposal was described as follows:

> In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to ({1 +DSHP)$^{0-4176}$ - 1)), where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.
>
> Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.[18]

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

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

[17] *Id.* at 43369-70 (emphasis added).
[18] *Id* at 43377.

> with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level than other hospitals. For FY 1992, the minimum payment level is 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also be eligible for the higher minimum payment level. We are not extending the special protection to other hospitals that receive disproportionate share payments under the operating prospective payment system. In urban areas, we believe that our criteria properly focuses on those hospitals that serve a large disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries**.[19]

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

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

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

> share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(l){ii) of the regulations.[20]

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

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

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

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

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

> We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section

[20] *Id.* at 43377.
[21] *Id.* at 43378.
[22] *Id.* at 43379.

> 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We believe that it is appropriate for Medicare's payment to recognize these higher Medicare patient care costs.[23]

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

> *Comment*: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.
>
> *Response*: Any hospital that is reclassified to an urban area by the MGCRB for purposes of its standardized amount is considered to be urban for all prospective payment purposes other than the wage index. As such, if any hospital reclassified by the MGCRB to an urban area for purposes of the standardized amount has at least 100 beds, it would be eligible for capital disproportionate share payments. We note that a rural hospital reclassified for purposes of the wage index only is still considered a rural hospital, and as such, will not be eligible for capital disproportionate share payments.[24]

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

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).
>
> (b) *Payment adjustment factor*. (1) <u>If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments</u>, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital's disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the

[23] (Emphasis added.)
[24] *Id.* at 43379.

> natural antilog of 1.
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> (2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.[25]

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

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA") and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.[26] IPPS hospitals are reclassified per BBRA § 401 are often referred to as "§ 401 hospitals."
On August 1, 2000, the Secretary published the interim final rule to, in part, implement BBRA § 401 and stated in the preamble that a hospital reclassified as rural pursuant to § 401 is treated as rural for ***all*** purposes under operating IPPS, including the DSH adjustment for operating IPPS:

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

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

> In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. ***That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes***. In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the

[25] *Id*. at 43452-53.
[26] BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).
[27] 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added.)

other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.

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

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

> section 1886(h) of the Act.)
>
> Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.
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> ****
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> We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.
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> ****
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> *We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary*. ***Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify***. As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.[28]

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

> **§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural**.
>
> (a) *General criteria*. A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
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> 1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration which is available via the ORHP website

[28] 65 Fed. Reg. 47054, 47087-89 (Aug. 1, 2000).

> at http:// www.nal.usda.gov/orph or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857.
>
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
>
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.[29]

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

> (a) *General rule*. (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.
>
> (2) **Each such rate is determined for hospitals located in urban <u>or</u> rural areas** within the United States and within each such region respectively, **as described in paragraphs (b)** through (g) of this section.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, **except that**, effective January 1, 2000, **a hospital reclassified as rural may mean** a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or **a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103**.[31]

The specific reference in § 412.63(b) to urban to rural reclassifications made under § 412.103 makes clear that capital DSH adjustments would not apply to hospitals reclassified from urban to

[29] 65 Fed. Reg. 7026, 47048.
[30] 56 Fed. Reg. at 43452.
[31] (Bold and underline emphasis added.)

rural pursuant to BBRA § 401 which as noted above was implemented at § 412.103.

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

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

The Office of Management and Budget publishes information on core-based statistical areas ("CBSAs") and the Secretary has used this information for purposes of defining labor market areas for use in the wage index for operating IPPS.[33] On June 6, 2003, OMB announced the new CBSAs, comprised of metropolitan statistical areas ("MSAs") and the new Micropolitan Areas based on Census 2000 data.[34]

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

> **§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.**
>
> (a) *General rule*. CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the following definitions apply:
>
> (i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.
>
> (ii) The term *urban area* means—

[32] Pub. L. 108–173.
[33] 69 Fed. Reg. 48916, 49026 (Aug. 11, 2004).
[34] *Id.*
[35] 69 Fed. Reg. 48916 (Aug. 11, 2004).

> (A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or
>
> (B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.
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> (C) The term *rural area* means any area outside an urban area.
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> (D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.
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> (2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.
>
> (3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.
>
> (4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result of redesignation of an MSA by the Executive Office of Management and Budget.[36]

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

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

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

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a ''disproportionate share hospital'' for the purposes of capital prospective payments <u>if either of the following conditions is met</u>:
>
> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) <u>For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64</u>.[38]

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

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

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

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

> geographic classifications at proposed new § 412.64.
>
> ****
>
> The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.
>
> ****
>
> As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.[39]

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

In the FY 2007 Proposed IPPS Rule, the Secretary[40] announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as

[39] 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004).
[40] of the Department of Health and Human Services.

rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.[41]

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and Budget's ("OBM's") new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005.[42]

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

> These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.
>
> These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).
>
> We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be

[41] 71 Fed. Reg. 23996, 24122 (Apr. 25, 2006).
[42] *Id.*

> considered rural.[43]

In adopting these changes, the Secretary noted that it did not receive any public comments on the proposed change as published in the proposed rule published on May 17, 2006.[44]

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

> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if either of the following conditions is met:
>
> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.
>
> **(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.[45]**

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

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

> Toledo Hospital contends that the Secretary's 2006 rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a

[43] 71 Fed. Reg. 47870, 48104-448105 (Aug. 18, 2006)
[44] *Id.*
[45] (Bold emphasis added.)
[46] 621 F.Supp.3d 13 (D.D.C. 2021).

> previously implemented policy. Second, the hospital argues that the Secretary failed to "take into account" relative costs of capital for various hospital types and areas of location, as subsection (g) requires.[47]

In *Toledo*, U.S. District Court for the District of Columbia ("D.C. District Court") outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.[48] The Court also noted how Congress enacted legislation in 1999[49] allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into an urban labor market area for the purposes of fixing its wage index.[50] The Court also noted the separate IPPS payment for a hospital's *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R. § 412.320 for large urban hospitals (the capital DSH payment).[51] The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.[52]

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

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

1. "if the Secretary had any policy concerning Section 401 reclassifications before 2006, he never announced such a policy, much less explained the basis for it."[55]

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[47] *Id.* at *25 (citations omitted).
[48] *Id.* at *18-19.
[49] 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a "§ 401" hospital.
[50] *Toledo* at *19.
[51] *Id.* at *19-20.
[52] *Id.* at *21.
[53] *Id.* at *22.
[54] *Id.* at *23-25.
[55] *Id.* at *29.

2. The Secretary's decision not to provide a capital DSH adjustment was arbitrary because:

   - "The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006."[56]

   - "[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements."[57]

   - "The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp*., 797 F.3d at 1161 (upholding Secretary's regulation where the Secretary explained why 'added precision' 'would not justify the added complication') (quotation omitted)."[58]

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

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

Providers' Request for EJR

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

The Providers are challenging the validity of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent

[56] *Id.*
[57] *Id.*
[58] *Id.*
[59] *Id.*
[60] *Id.* at *30.
[61] *Id.*
[62] Request for EJR at 7.

with the underlying operating PPS statute, in particular 42 U.S.C. § 1395ww(d)(8)(B), which states that hospitals that have undergone a rural reclassification are rural only for purposes of this subsection 1395ww(d). The Providers note that "[t]he capital PPS provisions are located in an entirely different section of the statute, in 42 U.S.C. § 1395ww(g), and therefore a rural reclassification under the subsection (d) operating PPS provisions does not apply for subsection (g) capital PPS purposes."[63]

The Providers believe that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(g), and the regulation must be found invalid.[64] The Providers assert that "the Secretary has implicitly acknowledged that he cannot apply rural status for hospitals that have undergone a rural reclassification to payment provisions outside of subsection (d)", and provides as an example, that "the Secretary has stated with respect to direct graduate medical education ("GME") that no adjustments to the direct GME cap are available for urban hospitals that have reclassified as rural because subsection (d) reclassification 'affects only payments under section 1886(d) of the Act,' and 'payments for direct GME are made under section 1886(h) of the Act."[65] Further, the regulation fails to take into account any variation in cost based on location, as the capital PPS statute permits at 42 U.S.C. § 1395ww(g)(1)(B)(ii).[66]

The Providers assert that the Secretary's adoption of the regulation was arbitrary and capricious and violates the Administrative Procedure Act because he "failed to establish that adoption of the exception to the capital DSH adjustment, for providers that reclassified as rural, took 'into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located.'"[67]

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

The Providers further contend that since the Board is bound by the regulation being challenged,[71]

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[63] *Id.* at 7.
[64] *See id.* at 7-8.
[65] *Id.* at 8 (citing 70 Fed. Reg. 47278, 47437 (Aug. 12, 2005)).
[66] *Id.*
[67] *Id.* at 9.
[68] *Id.* at 9-12.
[69] *Id.* at 10 (citing 88 Fed. Reg. 58640, 59117, 59334 (Aug. 28, 2023)).
[70] *Id.*
[71] *See* 42 C.F.R. § 405.1867.

namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), it lacks the authority to decide the legal question presented in the Providers' Request for EJR. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.[72]

Board Decision

1. Jurisdiction

Based on its review of the record, the Board finds that it has jurisdiction over each Provider in each case. The Providers have appealed from original NPRs or from the failure of the Medicare Contractor to timely issue an NPR. Each of the participants in these group appeals filed their appeals within 180 days of the issuance of their respective final determinations, or within 180 days after the twelve month period in which the Medicare Contractor was to issue a final determination,[73] as required by 42 C.F.R. § 405.1835; that the providers in each case appealed the issue in their respective appeals and that the Board is not precluded by regulation or statute from reviewing the issue in these appeals. Finally, in each case, the amount in controversy meets the $50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3).

The Board lacks the authority to decide the legal question presented here because it is a challenge to the validity of a regulation, namely 42 C.F.R. § 412.320(a)(1)(iii).[74] All of the providers in these seven (7) groups, however, are subject to the substantive claim regulations at 42 C.F.R. §§ 413.24 and 405.1873.

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

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[75] the Secretary finalized

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[72] Request for EJR at 10-12.

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

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

[74] 42 C.F.R. § 405.1842(f)(1)(ii).

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

new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[76] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement ("NPR") issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). Since all the participants in cases 25-0090GC, 23-0427GC, 24-2037GC, 25-0503GC, 23-1513GC, 24-1435G & 24-1708G have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

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

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

> (1) In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), must include an appropriate claim for the specific item, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider 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.

[76] *Id.* at 70555.

> (2) Self-disallowance procedures. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.

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

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider must include in its cost report an appropriate claim for the specific item (as prescribed in § 413.24(j) of this chapter). **If** the provider files an appeal to the Board seeking reimbursement for the specific item and **any party** to such appeal **questions whether the provider's cost report included an appropriate claim for the specific item**, the Board must address such question in accordance with the procedures set forth in this section.

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

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[77] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument)

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

if a party to the appeal questions whether there was an appropriate claim made. [78]

4. Substantive Claim Challenges

In all these group cases, the Providers' Rule 20 certification was filed concurrently with the Request for EJR on April 1, 2025. Thus, pursuant to Board Rule 44.6, the Medicare Contractor had five business days (*i.e.*, until April 8, 2025) to either file any Substantive Claim Challenges or certify that it would be filing a challenge. On April 7, 2025, the Medicare Contractor's designated representative, Federal Specialized Services ("FSS"), filed a Response to Providers' EJR Request, noting that substantive claim challenges would be filed "as to many of the providers."

Based on this timely certification, the deadline for any Substantive Claim Challenges in these cases was Monday, April 21, 2025. The Board notes that FSS filed timely Substantive Claim Challenges in the seven (7) group cases noted in this EJR decision.

Based on the foregoing, and pursuant to Board Rule 44.6, the Board issued a Scheduling Order to set a deadline (Wednesday, May 14, 2025) for the Providers' responses to the seven (7) Substantive Claim Challenges filed in cases 25-0090GC, 23-0427GC, 24-2037GC, 25-0503GC, 23-1513GC, 24-1435G, & 24-1708G. The Board notes that the Providers filed timely responses in each case on May 13, 2025.

A. Medicare Contractor's Challenges

FSS filed Substantive Claim Challenges over a number of participants in each case as outlined below, which will collectively be referred to as "the Challenged Participants."

i. Case 25-0090GC

FSS asserts the following four (4) Providers did not make an appropriate claim for the Rural Capital DSH issue on their cost reports:

- Mayo Clinic (Provider No. 10-0151, FYE 12/31/2020)
- Mayo Clinic Hospital (Provider No. 03-0103, FYE 12/31/2020)
- Mayo Clinic Health System Mankato (Provider No. 24-0093, FYE 12/31/2020)
- Mayo Clinic Health System Franciscan Medical Center La Crosse (Provider No. 52-0004, FYE 12/31/2020)

FSS argues that each Provider filed its relevant cost report identifying a specific amount in Part A Protested Amounts, as well as a Summary of Protested Amounts. These documents, however, did not establish a self-disallowed item for the Rural Capital DSH in the cost report, and therefore each provider failed to include an appropriate claim for the specific item sought as

[78] *See* 42 C.F.R. § 405.1873(a).

prescribed in 42 C.F.R. § 413.24(j).[79]

ii. Case 23-0427GC

FSS asserts the following four (4) Providers did not make an appropriate claim for the Rural Capital DSH issue on their cost reports:

- Corewell Health Troy Hospital (Provider No. 23-0269, FYE 12/31/2020)
- Corewell Health Dearborn Hospital (Provider No. 23-0020, FYE 12/31/2020)
- Corewell Health Farmington Hills Hospital (Provider No. 23-0151, FYE 12/31/2020)
- Corewell Health Royal Oak Hospital (Provider No. 23-0130, FYE 12/31/2020)

FSS argues that each Provider filed its relevant cost report **without** identifying a specific amount in Part A Protested Amounts or a Summary of Protested Amounts. Therefore, each provider failed to include an appropriate claim for the specific item sought as prescribed in 42 C.F.R. § 413.24(j).[80]

iii. Case 24-2037GC

FSS asserts the following four (4) Providers did not make an appropriate claim for the Rural Capital DSH issue on their cost reports:

- Kettering Health Main Campus (Prov. No. 36-0079, FYE 12/31/2020)
- Soin Medical Center (Prov. No. 36-0360, FYE 12/31/2020)
- Kettering Health Dayton (Prov. No 36-0133, FYE 12/31/2020)
- Kettering Health Miamisburg (Prov. No. 36-0239, FYE 12/31/2020)

FSS argues that each Provider filed its relevant cost report identifying a specific amount in Part A Protested Amounts, as well as a Summary of Protested Amounts. These documents, however, did not establish a self-disallowed item for the Rural Capital DSH in the cost report, and therefore each provider failed to include an appropriate claim for the specific item sought as prescribed in 42 C.F.R. § 413.24(j).[81]

iv. Case 25-0503GC

FSS asserts the following four (4) Providers did not make an appropriate claim for the Rural Capital DSH issue on their cost reports:

- Scottsdale Shea Medical Center (Prov. No. 03-0087, FYE 12/31/2020)
- Scottsdale Osborn Medical Center (Prov. No. 03-0038, FYE 12/31/2020)
- Deer Valley Medical Center (Prov. No. 03-0092, FYE 12/31/2020)

[79] Case No. 25-0090GC, Medicare Administrative Contractor Substantive Claim Challenge (Apr. 21, 2025).
[80] Case No. 23-0427GC, Medicare Administrative Contractor Substantive Claim Challenge (Apr. 15, 2025).
[81] Case No. 24-2037GC, Medicare Administrative Contractor Substantive Claim Challenge (Apr. 21, 2025).

- John C. Lincoln Medical Center (Prov. No. 03-0014, FYE 12/31/2020)

FSS argues that each Provider filed its relevant cost report identifying a specific amount in Part A Protested Amounts, as well as a Summary of Protested Amounts. These documents, however, did not establish a self-disallowed item for the Rural Capital DSH in the cost report, and therefore each provider failed to include an appropriate claim for the specific item sought as prescribed in 42 C.F.R. § 413.24(j).[82]

v. Case 23-1513GC

FSS asserts the following three (3) Providers did not make an appropriate claim for the Rural Capital DSH issue on their cost reports:

- University of Pittsburgh Medical Center Hamot (Provider No. 39-0063, FYE 6/30/2020)
- University of Pittsburgh Medical Center Williamsport (Provider No. 39-0045, FYE 6/30/2020)
- University of Pittsburgh Medical Center Presbyterian Shadyside (Provider No. 39-0164, FYE 6/30/2020)

FSS argues that each Provider filed its relevant cost report identifying a specific amount in Part A Protested Amounts, as well as a Summary of Protested Amounts. These documents, however, did not establish a self-disallowed item for the Rural Capital DSH in the cost report, and therefore each provider failed to include an appropriate claim for the specific item sought as prescribed in 42 C.F.R. § 413.24(j).[83]

vi. Case 24-1435G

FSS asserts the following six (6) Providers did not make an appropriate claim for the Rural Capital DSH issue on their cost reports:

- Corewell Health Grand Rapids Hospital (Provider No. 23-0038, FYE 12/31/2019)
- Baptist Health Medical Center-Jacksonville (Provider No. 10-0088, FYE 09/30/2019)
- Novant Health New Hanover Regional Medical Center (Provider No. 34-0141, FYE 09/30/2019)
- Tucson Medical Center (Provider No. 03-0006, FYE 12/31/2019)
- University of Michigan Health-West (Provider No. 23-0236, FYE 06/30/2019)
- Baptist Hospital (Provider No. 10-0093, FYE 09/30/2019)

With one exception, FSS argues that each Provider filed its relevant cost report identifying a specific amount in Part A Protested Amounts, as well as a Summary of Protested Amounts. These documents, however, did not establish a self-disallowed item for the Rural Capital DSH in the cost report, and therefore each provider failed to include an appropriate claim for the specific

[82] Case No. 25-0503GC, Medicare Administrative Contractor Substantive Claim Challenge (Apr. 17, 2025).
[83] Case No. 23-1513GC, Medicare Administrative Contractor Substantive Claim Challenge (Apr. 16, 2025).

item sought as prescribed in 42 C.F.R. § 413.24(j).[84]

The Medicare Contractor noted that "[f]or Provider No. 23-0236, the group representative cited Adjustment No. 2 as a basis for appeal. This adjustment was made to clear a Level I edit error on Worksheet S-2. The Provider had answered 'Yes' to the question of whether the facility qualified for a capital DSH payment. The MAC contends that the Provider did not answer this question properly on the cost report, which is the reason it was adjusted. The Providers' disagreement in this appeal is with the validity of the regulations, but given the regulations, the Provider should not have been claiming to qualify for capital DSH payments. The Provider, instead of answering the question incorrectly, should have protested the item on its filed cost report. The MAC contends that this adjustment does not demonstrate that the Provider attempted to claim full reimbursement for the disputed Capital DSH issue in accordance with Medicare policy. . . . The MAC confirmed with the Group Representative that these 6 Providers, 'neither claimed the capital DSH cost at issue as an allowable cost nor protested it on their as-filed cost reports relevant to this appeal.'"[85]

vii. Case 24-1708G

FSS asserts the following eight (8) Providers did not make an appropriate claim for the Rural Capital DSH issue on their cost reports:

- Tucson Medical Center (Provider No. 03-0006, FYE 12/31/2020)
- Baptist Hospital (Provider No. 10-0093, FYE 9/30/2020)
- Owensboro Health Regional Hospital (Provider No. 18-0038, FYE 5/31/2010)
- Samaritan Medical Center (Provider No. 33-0157, FYE 12/31/2020)
- Hospital for Special Surgery (Provider No. 33-0270, FYE 12/31/2020)
- Cayuga Medical Center at Ithaca, Inc (Provider No. 33-0307, FYE 12/31/2020)
- Novant Health New Hanover Regional Medical Center (Provider No. 34-0141, FYE 9/30/2020)
- McLeod Regional Medical Center of Pee Dee Inc (Provider No. 42-0051, FYE 9/30/2020)

FSS argues that each Provider filed its relevant cost report identifying a specific amount in Part A Protested Amounts, as well as a Summary of Protested Amounts. These documents, however, did not establish a self-disallowed item for the Rural Capital DSH in the cost report, and therefore each provider failed to include an appropriate claim for the specific item sought as prescribed in 42 C.F.R. § 413.24(j).[86]

viii. "Non-Challenged Participants"

For all remaining participants in these seven (7) group cases (collectively "the Non-Challenged Participants"), since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an

[84] Case No. 24-1435G, Medicare Administrative Contractor Substantive Claim Challenge (Apr. 18, 2025).
[85] *Id.* at unnumbered pages 5-6.
[86] Case No. 24-1708G, Medicare Administrative Contractor Substantive Claim Challenge (Apr. 18, 2025).

appropriate claim was made,[87] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d) for the Non-Challenged Participants.

B. Providers' Responses

The Providers filed a consolidated response to the Substantive Claim Challenges.[88] For one Challenged Participant in Case 24-1435G (Michigan Health-West), the Provider claims it complied with the substantive claim criteria at 42 C.F.R. § 413.24(j)(1). They argue:

> The MAC made two adjustments related to the disallowance of Michigan Health-West's claimed capital DSH payment, although only one of these two adjustments is reflected in the Audit Adjustment Report. Specifically, on Worksheet S-2, Part I, line 45, Column 2, of its Fiscal Year Ending June 30, 2019 ("FYE 2019") as-filed cost report, Michigan Health-West responded affirmatively, with a "Y," that it qualified and received capital payment for Medicare DSH in accordance with 42 C.F.R. § 412.320. Exhibit P-B, at P0009. As a result, Michigan Health-West claimed a capital DSH adjustment of $106,475 on Worksheet L, Part I, Line 11 of its FYE 2019 as-filed cost report. *Id.* at P0010. Copies of the relevant portions of Michigan HealthWest's as-filed cost report Worksheets S-2 and L were filed with the initial appeal filing as supporting documentation for the MAC's adjustments. The MAC disallowed Michigan Health-West's selection that it qualified for and received capital payment for Medicare DSH on Worksheet S-2, Part I, line 45, Column 2, by changing Michigan Health-West's "Y" to an "N." Id. at P0011. Because of this disallowance, the MAC also disallowed the capital DSH adjustment amount Michigan Health-West claimed on Worksheet L, Part I, Line 11, such that this line reflects "0." Id. at P0012. Copies of the relevant portions of Michigan HealthWest's finalized cost report Worksheets S-2 and L were also filed with the initial appeal filing as supporting documentation for the MAC's adjustments. The Audit Adjustment Report, however, reflects only the revision made to Worksheet S-2 (at adjustment number 2) and not the adjustment the MAC made to Worksheet L. *Id.* at P0013-P0026.[89]

They further argue that the Board's "review requires only a determination of whether the provider included the cost in dispute on its as-filed cost report as an allowable cost or protested

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[87] 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."
[88] Providers' Response to FSS's Substantive Claim Challenges and Petition for Expedited Judicial Review of the Validity of 42 C.F.R. §§ 413.24(j) and 405.1873 (May 13, 2025) ("Response to Substantive Claim Challenges").
[89] *Id.* at 5-6.

amount." They conclude that, while it was not protested, "Michigan Health-West claimed capital DSH as an allowable cost on its FYE 2019 cost report."[90]

For the remaining Challenged Participants, the Providers argue that, "while they did not claim Capital DSH as an allowable cost or protested amount for the year at issue, each provider did self-disallow the issue based on the [Medicare Contractor] being bound by 42 C.F.R. § 412.320(a)(1)(iii)."[91] They also argue that the substantive claim requirements found in 42 C.F.R. §§ 413.320(j) and 405.1873 are unlawful and seek to challenge their validity.[92] The Providers claim that these regulatory provisions "contravene the Board's authority as set forth in 42 U.S.C. § 1395oo."[93] They cite *Bethesda Hosp. Ass'n v. Bowen*[94] and *Banner Heart Hospital v. Burwell*[95] in support of their position that these regulations are unlawful.[96]

The Providers request the Board grant EJR for all seven cases over the Capital DSH issue, as well as the substantive claim regulations for the Challenged Participants.

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

The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j) of this chapter)"[97] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

For the Non-Challenged Participants, the Board declines to make any findings of fact or conclusions of law with regard to whether an appropriate cost report claim was made since no party has raised the question.

The Challenged Participants generally do not dispute that they did not claim Capital DSH as an allowable cost or protested amount for the year at issue. They note that they did self-disallow the issue based on the Medicare Contractor being bound by 42 C.F.R. § 412.320(a)(1)(iii),[98] but they do not dispute FSS' assertion that there is insufficient support for the allegedly protested items.

The Providers argue that in Case 24-1435G, Michigan Health-West did comply with the substantive claim criteria at 42 C.F.R. § 413.24(j)(1). The Board disagrees. 42 C.F.R.

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[90] *Id.* at 15.
[91] *E.g.*, *id.* at 3.
[92] *Id.* at 10, 16.
[93] *Id.* at 16.
[94] 485 U.S. 399 (1988).
[95] 201 F.Supp.3d 131 (D.D.C. 2016)
[96] Response to Substantive Claim Challenges at 17-20.
[97] (Emphasis added.)
[98] *E.g.*, Response to Substantive Claim Challenges at 3.

§ 413.24(j) provides two ways for a provider to make an appropriate claim for a specific item. Section 413.24(j)(ii) notes an appropriate claim is made if the provider self-disallows the specific item on their cost report. Michigan Health-West concedes that it did not protest or self-disallow this item.[99] Instead, it argues that it "claimed capital DSH as an allowable cost on its FYE 2019 cost report."[100]

Section 413.24(j)(i) explains that an appropriate claim is made if a Provider claims full reimbursement on the cost report for the specific item ***in accordance with Medicare Policy.*** Current Medicare Policy does not allow Michigan Health-West to claim reimbursement for the specific item which it seeks – that is the basis of its appeal and Request for EJR. Nevertheless, it claimed it was entitled to the specific Capital DSH payment on its cost report. If the Provider ***believed*** it was entitled to the payment, it should have self-disallowed the item since current Medicare Policy dictates otherwise. Based on the foregoing, the Board finds this Provider did not make an appropriate claim for the Capital DSH payment in accordance with 42 C.F.R. § 413.24(j).

5. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that all of the participants in Cases 25-0090GC, 23-0427GC, 24-2037GC, 25-0503GC, 23-1513GC, 24-1435G, & 24-1708G are entitled to a hearing before the Board;

2) The review process in 42 C.F.R. § 405.1873(a)-(b) has been triggered for the Challenged Participants and the Board specifically finds that it is undisputed that these participants failed to include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1) ***except for*** that the sole Challenged Participant in Case 24-1435GC (University of Michigan Health-West, Provider No. 23-0236, FYE 06/30/2019);

3) The sole Challenged Participant in Case 24-1435GC (University of Michigan Health-West, Provider No. 23-0236, FYE 06/30/2019) ***did not*** include an appropriate claim for the specific item at issue in its appeal;

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

5) Based upon the participants' assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), there are no findings of fact for resolution by the Board;

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[99] Response to Substantive Claim Challenges at 15.
[100] *Id.* at 15.

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

7) It is without the authority to decide the legal questions of:

    a. Whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid; and
    b. For the Challenged Participants, whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid.[101]

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' EJR Request for the issue and the subject years in cases 25-0090GC, 23-0427GC, 24-2037GC, 25-0503GC, 23-1513GC, 24-1435G, and 24-1708G. The Board also finds that the question of the validity of the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Challenged Providers' requests for EJR for the issue and the subject years.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. The Board's jurisdictional determination is subject to review under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. § 405.1875 and 405.1877 upon final disposition of the appeal. Since this is the only issue under dispute in these cases, the Board hereby closes the cases and removes them from the Board's docket.

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

Board Members Participating:

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

FOR THE BOARD:

6/2/2025

X Kevin D. Smith, CPA

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

Enclosure: Schedules of Providers

cc: Pamela VanArsdale, National Government Services, Inc. (J-6)
Byron Lamprecht, WPS Government Health Administrators (J-8)
Judith Cummings, CGS Administrators (J-15)
Dean Wolfe, Noridian Healthcare Solutions, Inc. (J-F)
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-L)
Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Scott Berends, Esq., FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Baylor Scott & White Medical Center Carrollton, Prov. No. 45-0730, FYE 09/30/2015
Case No. 19-2112

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-2112. 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. 19-2112***

On **December 18, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2015.

On **June 17, 2019**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request included ten (10) issues:

1. SSI Percentage (Provider Specific)
2. SSI Percentage
3. SSI Fraction Medicare Managed Care Part C Days
4. SSI Fraction Dual Eligible Days
5. Medicaid Eligible Days
6. Medicaid Fraction Dual Eligible Days
7. Medicaid Fraction Medicare Managed Care Part C Days
8. 2 Midnight Census IPPS Payment Reduction
9. Uncompensated Care Distribution Pool
10. Standardized Payment Amount

As the Provider is commonly owned/controlled by Baylor Scott & White Health (hereinafter "BSWH"), 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 **January 23, 2020**, the Provider transferred Issues 2, 3, 4, 6, 7, 8, 9 and 10 to various BSWH CIRP groups.

On **June 25, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[1]

On **February 7, 2020**, the Provider timely filed its preliminary position paper. With respect to Issue 5, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2015 cost report does not reflect an accurate number of Medicaid eligible days." As a result, the Provider included, as an Exhibit, the original "estimated impact" for this issue of $18,684 based on an *estimated* 50 days.

On **May 21, 2020**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1 (SSI Provider Specific).

On **June 4, 2020**, the Medicare Contractor filed its preliminary position paper. With regard to Issue 5, the Medicare Contractor's position paper noted that the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position.

On **May 10, 2023**, QRS became the authorized representative in Case No. 19-2112.

On **August 12, 2024**, in response to the Medicare Contractor's May 21, 2020 jurisdictional challenge, the Board dismissed the SSI (Provider Specific) issue from Case No. 19-2112. On the same date the Board issued a Notice of Hearing scheduling the case for a hearing on **June 23, 2025** and requiring final position papers be filed by the Parties.

On **March 25, 2025** QRS timely filed its final position paper.

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[1] (Emphasis added.)

On **April 15, 2025**, Federal Specialized Services ("FSS") timely filed a final position paper on behalf of the Medicare Contractor. FSS noted that the Provider consolidated "Section 1115 waiver days" with their eligible days issue. However, because 1115 waiver days was not an issue in the appeal, the argument was not addressed in the final position paper. Additionally, FSS noted that only a redacted listing of Medicaid eligible days was submitted by the Provider as an exhibit to its final position paper. To date, the Medicare Contractor had not received an auditable listing. Consequently, the FSS requested the dismissal of the Medicaid Eligible Days issue.

On **April 21, 2025**, FSS filed a jurisdictional challenge on behalf of the Medicare Contractor over the Medicaid Eligible Days issue (#5).

On **May 7, 2025**, QRS filed a Redacted Medicaid Eligible Days listing in the Office of Hearings Case & Document Management System ("OH CDMS").[2]

On **May 8, 2025**, QRS responded to the Medicare Contractor's Jurisdictional Challenge.

MAC's Contentions

Issue 5 – 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 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 position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed in its entirety.
>
> Within its preliminary position paper, the Provider makes the broad allegation, ". . . the Provider contends that the total number of days reflected in its' [sic] 2015 cost report does not reflect an accurate number of Medicaid eligible days . . .". The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue.[3]

[2] The header refers to the listing as "Additional ME & 1115 Waiver Days."
[3] Jurisdictional Challenge at 8 (April 21, 2025).

Provider's Jurisdictional Response

On May 8, 2025 the Representative filed its jurisdictional response in which argued that the section 1115 waiver days issue was addressed in the June 17, 2019 appeal request based on the part of the issue statement which stated:

> 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.

QRS contends that the phrase "including but not limited to" makes it clear that all Medicaid eligible days, including section 1115 waiver days were appealed.

With regard to the Medicare Contractor's argument claiming the section 1115 waiver days issue was abandoned as it was not briefed in the preliminary position paper, QRS argues that ". . . section 1115 waiver days were addressed in the final position paper which identified the waiver program applicable to the Provider as the Texas Healthcare Transformation and Quality Improvement Program."[4]

In addition, QRS asserts that ". . . the Fifth Circuit ruled that the statute and CMS's own regulations require that CMS regard inpatient days attributable to an uncompensated care pool population as Medicaid eligible days. Forrest General Hospital v. Azar, 926 F.3d 221 (5th Cir. 2019)." Based on this Court case, QRS contends that the Medicare Contractor ". . . is required by specific command of CMS to accept and audit the Provider's section 1115 waiver days."[5]

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 last remaining issue.

A. DSH Payment – Medicaid Eligible Days

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

[4] Group's Jurisdictional Response at 3 (May 8, 2025).
[5] Id.

With regard to the filing of an individual appeal, Board Rule 7.3.2 (No Access to Data) (Aug. 2018) states:

> 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.[6]

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

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

[6] (Bold emphasis added.)

Rule 25 Preliminary Position Papers[7]

> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

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

25.1.1 The Provider's Position Paper

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

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

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

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

Moreover, in connection with Issue 5, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(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.[8]

[8] (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 February 7, 2020, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[9] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $18,684 based on an estimated 50 days). The Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar

[9] Provider's Preliminary Position Paper at 11 (Feb. 7, 2020).

> 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' 2015 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Jurisdictional Challenge, the Medicare Contractor asserts that the Provider was in violation of Board Rules 25.3 and 27.2 because 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 papers. In addition, 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.

On March 25, 2025, as an exhibit to the final position paper, QRS filed an "Additional ME & 1115 Waiver Days" listing. The listing was 15 pages showing 2859 Medicaid eligible days. QRS' filing did not explain why the listing of so many days was being submitted at this late date, ***almost 10 years after the fiscal year at issue had closed***. NOTE—the 2859 days included in this belated listing is *exponentially* larger than the original estimate of 50 days included with the appeal request. Regardless, this filing was more than ***5 years past the deadline for including it with its preliminary position paper*** since the position paper deadline was February 12, 2020.[10]

[10] On May 7, 2025, QRS uploaded a 13-page redacted copy of the additional Medicaid Eligible Days listing for the record, presumably in response to the Medicare Contractor's April 21, 2025 jurisdictional challenge.

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

The fact that a Listing of Medicaid Eligible Days was filed with the final position paper does not excuse the Provider for its failure to include the information with its preliminary position paper. Moreover, the Board rejects the Provider's attempt to include the March 25, 2020 and May 7, 2025 Eligible Days Listings as filings because:

1. The listings were filed ***more than 5 years*** *after the deadline* for that exhibit to be included with its preliminary position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)).

2. The Eligible Days listings fail to explain the following critical information: (a) *why* they were being filed so late (*i.e*., upon what basis or authority should the Board accept the late filings); (b) *why* the listing of the 2859 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 6 years after this appeal was filed and almost 10 years after the fiscal year at issue had closed).

3. Neither the Board Rules nor the June 25, 2019 Case Acknowledgment and Critical Due Dates permit the Provider to file a "Supplement" to its preliminary position paper (nor did the Provider allege in its filings that they do).

4. Given the fact that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the preliminary position paper filing, if the Board were to accept the listing as a supplement, it would need to either be a *refinement* of its preliminary position paper or a supplement of documents that were identified in the preliminary position paper as being unavailable consistent with Board Rule 25.2.2. However, neither the preliminary position paper nor the subsequent Eligible Days listings identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the listings cannot be considered a refinement of the position paper since no specific days or listing were included with the preliminary position paper (indeed the *tentative* 2859 days listed in the final position paper exhibit is, without explanation,

exponentially larger than the original estimated 50 days included with the appeal request).[11]

5. Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[12] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provider the § 412.106(b)(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. 1115 Waiver Days

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

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

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[13]

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

---

[11] *See, e.g.,* Board Rule 27.3 (Aug. 2018) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."
[12] (Emphasis added.)
[13] 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 (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). . .***[14]

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.[15]

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.

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

In this regard, the Board notes that Section 1115 waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[16] 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) (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 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.

[16] 65 FR 47054, 47087 (Aug. 1, 2000).

Regardless, even if the Provider had included in its appeal request (which it did not), the Provider failed to properly develop the issue in its position paper filings. First, the Provider's preliminary position paper does not even mention § 1115 waiver days (much less even identify the specific 1115 waiver day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (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* § 1115 waiver days sub-issue.

Finally, even in the Provider's final position paper, the Provider fails to identify what § 1115 waiver program(s) are involved and whether or not the § 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the final position paper is perfunctory in that it only makes perfunctory conclusions.[17] Again, the Provider failed to so develop its position paper notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Aug. 2018) as applied via Board Rule 27.2.

The Board's finding that neither the appeal request nor the final position paper met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[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

[17] For example, QRS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that "the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." However, QRS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is QRS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? QRS fails to brief the merits of its claims and fails to establish the Board's jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the final position paper references "uncompensated care pool."
[18] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[19] *Id*. at *11.
[20] *Id.*

which for the Board to dismiss the appeal.[21] 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 –DSH Medicaid Eligible Days (Issue 5). As no issues remain, the Board hereby closes Case No. 19-2112 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:

6/5/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[21] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Baylor Scott & White Medical Center Temple, Prov. No. 45-0054, FYE 08/31/2015
Case No. 20-0444

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 20-0444. 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. 20-0444***

On **May 29, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end August 31, 2015.

On **November 15, 2019**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request included ten (10) issues:

1. DSH - SSI Percentage (Provider Specific)
2. DSH - SSI Percentage (Systemic Errors)
3. DSH - SSI Fraction Part C Days
4. DSH - SSI Fraction Dual Eligible Days
5. DSH - Medicaid Eligible Days
6. DSH - Medicaid Fraction Part C Days
7. DSH - Medicaid Fraction Dual Eligible Days
8. Uncompensated Care Distribution Pool
9. 2 Midnight Census IPPS Payment Reduction
10. Standardized Payment Amount

As the Provider is commonly owned/controlled by Baylor Scott & White Health (hereinafter "BSWH"), the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **June 18, 2020**, the Provider transferred Issues 2, 3, 4, 6, 7, 9 and 10 to various BSWH CIRP groups.

On **December 4, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position

papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[1]

On **February 7, 2020**, the Provider timely filed its preliminary position paper. In the cover letter to the preliminary position paper, the Provider withdrew the Uncompensated Care ("UCC") Distribution Pool issue (#8). With respect to Issue #5, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2015 cost report does not reflect an accurate number of Medicaid eligible days." As a result, the Provider included, as an Exhibit, the original "estimated impact" for this issue of $93,240 based on an *estimated* 150 days.

The Provider also briefed the SSI Percentage (Provider Specific) issue (#1).[2]

On **October 20, 2020**, the Medicare Contractor filed its preliminary position paper. Regarding Issue #5, the Medicare Contractor's position paper noted that the Provider failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position. The Medicare Contractor also objected to the appeal of the SSI Percentage (Provider Specific) (#1) issue as it contends the issue was premature and duplicative of the issue pending in the SSI Percentage CIRP group, Case No. 18-1276GC.

On **May 10, 2023**, QRS became the authorized representative in Case No. 20-0444.

On **August 26, 2024**, the Board issued a Notice of Hearing scheduling a hearing date for July 1, 2025 and setting final position paper deadlines.

On **December 11, 2024**, QRS filed a Redacted Medicaid Eligible Days listing in the Office of Hearings Case & Document Management System ("OH CDMS").[3]

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[1] (Emphasis added.)
[2] The DSH SSI Percentage (Provider Specific) issue was withdrawn on April 24, 2025.
[3] The header refers to the listing as "Additional ME & 1115 Waiver Days."

On **February 3, 2025**, Federal Specialized Service ("FSS") filed a jurisdictional challenge[4] on behalf of the Medicare Contractor, in which it challenged the last two issues in the appeal: SSI Percentage (Provider Specific) (#1) and Medicaid Eligible Days (#5).[5]

On **April 2, 2025** QRS timely filed its final position paper.

On **April 16, 2025**, FSS timely filed a final position paper on behalf of the Medicare Contractor. FSS again noted the Provider's improper addition of the "Section 1115 waiver days" issue (*which was allegedly added with the submission of a redacted Medicaid Eligible Days and 1115 Waiver Days listing and when it was briefed with the eligible days issue in the final position paper*.) In addition, the Medicare Contractor advised that only a redacted listing of Medicaid eligible days had been submitted by the Provider. To date, the Medicare Contractor claimed it had not received an auditable listing. Consequently, the FSS requested the dismissal of the Medicaid Eligible Days issue.

On **April 24, 2025**, QRS filed a late response to the jurisdictional challenge.

MAC's Contentions

The MAC requested that the Board dismiss the Medicaid Eligible Days issue because the Provider was in violation of 42 C.F.R. § 405.1853(b)(2) and Board Rule 25 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 MAC argued that, in addition to the fact that the section 1115 waiver days is a separate and distinct issue from the eligible days issue, the Provider improperly and untimely added the issue to its appeal when it attempted to include it by filing a redacted listing on December 11, 2024, and as an exhibit to its final position paper dated April 2, 2025.[6]

Provider's Contentions

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[7] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a

[4] 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).

[5] As previously noted, the SSI Percentage (Provider Specific) issue was subsequently withdrawn on April 24, 2025.

[6] Jurisdictional Challenge at 16 (Feb. 3, 2025).

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

Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

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

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

A. DSH Payment – Medicaid Eligible Days

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

With regard to the filing of an individual appeal, Board Rule 7.3.2 (No Access to Data) (Aug. 2018) states:

> 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.[8]

[8] (Bold emphasis added.)

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

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

> **Rule 25 Preliminary Position Papers**[9]
>
> **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

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

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

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on December 4, 2019 included instructions on the content of the Provider's preliminary position paper consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 5, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(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.[10]

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

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

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

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

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

On July 2, 2020, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[11] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $93,240 based on an estimated 150 days). The Provider's complete briefing of this issue in its position paper is as follows:

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

[10] (Emphasis added.)
[11] Provider's Preliminary Position Paper at 11 (Feb. 7, 2020).

> 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' 2015 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Jurisdictional Challenge, the Medicare Contractor asserted that the Provider was in violation of 42 C.F.R. § 405.1853 and Board Rules 25.1, 25.2, and 25.3 because 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 papers. In addition, the Medicare Contractor argued that 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. Finally, the Medicare Contractor noted that the Provider had attempted to untimely and improperly add the section 1115 waiver days issue by including days of this type in the redacted listing provided on December 11, 2024.

The Board notes that QRS uploaded an eighty-two-page redacted Medicaid Eligible & 1115 Waiver Days listing in the Office of Hearing Case & Document Management System on December 11, 2024. Subsequently, QRS filed a ninety-two-page redacted listing which was included as an exhibit to the April 2, 2025 final position paper. The latter exhibit showed 13,603

Medicaid eligible days. QRS' filings did not, however, explain why the listing of so many days was being submitted so late, ***almost 10 years after the fiscal year at issue had closed***. NOTE—the 13,603 days included in this belated listing is *exponentially* larger than the original estimate of 150 days included with the appeal request. Regardless, this filing was almost ***5 years past the deadline for including it with its preliminary position paper*** since the position paper deadline was July 12, 2020.

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

The fact that QRS filed a Listing of Medicaid Eligible Days in December 2024, and again in April 2025 with its final position paper, does not excuse the Provider for its failure to include the information with its preliminary position paper. Moreover, the Board rejects the Provider's attempt to include these two Eligible Days Listings as filings because:

1. The listings were filed almost ***5 years*** *after the deadline* for that exhibit to be included with its preliminary position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)).

2. The Eligible Days listings failed to explain the following critical information: (a) *why* they were being filed so late (*i.e.*, upon what basis or authority should the Board accept the late filings); (b) *why* the listing of the 13,603 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 roughly 5 years after this appeal was filed and more than 9 years after the fiscal year at issue had closed).

3. Neither the Board Rules nor the December 4, 2019 Case Acknowledgment and Critical Due Dates permit the Provider to file a "Supplement" to its preliminary position paper (nor did the Provider allege in its filings 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 preliminary position paper filing, if the Board were to accept the listing as a supplement, it would need to either be a *refinement* of its preliminary position paper or a supplement of documents that were identified in the preliminary position paper as being unavailable consistent with Board Rule 25.2.2. However, neither the preliminary position paper nor the subsequent Eligible Days listings identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the

listings cannot be considered a refinement of the position paper since no specific days or listing were included with the preliminary position paper (indeed the *tentative* 13,603 days listed in the final position paper exhibit is, without explanation, *exponentially* larger than the original estimated 150 days included with the appeal request).[12]

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

B. 1115 Waiver Days

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

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

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[14]

---

[12] *See, e.g.,* Board Rule 27.3 (Aug. 2018) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."
[13] (Emphasis added.)
[14] 42 C.F.R. § 405.1835(b).

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

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

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

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

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

In this regard, the Board notes that section 1115 waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[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) (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 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

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

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 position paper filings. First, the Provider's preliminary position paper does not even mention section 1115 waiver days (much less even identify the specific 1115 waiver day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Aug. 2018). As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* section 1115 waiver days sub-issue.

Finally, even in the Provider's final position paper, the Provider fails to identify what section 1115 waiver program(s) are involved and whether or not the section 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(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.[18] Again, the Provider failed to so develop its position paper notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Aug. 2018) as applied via Board Rule 27.2.

The Board's finding that neither the appeal request nor the final position paper met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[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

[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 final position paper references "uncompensated care pool."
[19] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[20] *Id*. at *11.

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 –DSH Medicaid Eligible Days (Issue 5). As no issues remain, the Board hereby closes Case No. 20-0444 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:

6/12/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[21] *Id.*
[22] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Bayfront Health Brooksville, Prov. No. 10-0071, FYE 09/30/2016
Case No. 19-1835

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-1835. Set forth below is the decision of the Board to dismiss the sole remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for Medicaid Eligible Days issue.

Background

A. *Procedural History for Case No. 19-1835*

On **September 21, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2015.

On **March 20, 2019**, the Provider filed this individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

1. SSI Percentage (Provider Specific) – ***withdrawn on March 21, 2025***
2. SSI Percentage – ***transferred on October 22, 2019***
3. SSI Fraction Medicare Managed Care Part C Days – ***transferred on October 22, 2019***
4. SSI Fraction Dual Eligible Days – ***transferred on October 22, 2019***
5. Medicaid Eligible Days
6. Medicaid Fraction Medicare Managed Care Part C Days – ***transferred on October 22, 2019***
7. Medicaid Fraction Dual Eligible Days – ***transferred on October 22, 2019***
8. Uncompensated Care Distribution Pool– ***transferred on October 22, 2019***
9. 2 Midnight Census IPPS Payment Reduction – ***transferred on October 22, 2019***

On **May 3, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers.

This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[1]

On **November 1, 2019**, the Provider filed its Preliminary Position Paper.

On **June 28, 2019**, the Medicare Contractor filed a Jurisdictional Challenge over Issues 1, 3, 6, 8, and 9.

On **July 29, 2019**, the Provider filed a Response to the Jurisdictional Challenge.

On **October 22, 2019**, the Provider transferred Issues 2, 3, 4, 6, 7, 8, and 9 to group cases.

On **March 10, 2020**, the Medicare Contractor timely filed its Preliminary Position Paper.

On **July 26, 2021 and January 12, 2023**, the Medicare Contractor filed Requests for Documentation to substantiate the Medicaid Eligible Days issue.

On **August 14, 2024**, the Board issued the Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

> Provider's Final Position Paper – *For each remaining issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *also include* ***any exhibits*** *the Provider will use to support to support its position*. *See* Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.[2]

[1] (Emphasis added.)
[2] (Emphasis added.)

On **October 9, 2024**, the Medicare Contractor filed a second Jurisdictional Challenge over Issues 1 and 5, replacing its previously filed challenge.

On **March 21, 2025**, the Provider withdrew Issue 1.

On **March 25, 2025**, the Provider filed its Final Position Paper.

On **April 8, 2025**, the Medicare Contractor filed its Final Position Paper.

On **April1 15, 2025**, the Medicare Contractor filed a third Jurisdictional Challenge[3] with the Board over Issue 5, supplementing its second Jurisdictional Challenge and requesting that the Board dismiss the sole remaining issue.

On **May 7, 2025**, the Provider filed a Redacted Section 1115 and Medicaid Eligible Days Listing.

On **May 9, 2025**, the Provider filed a response to the Jurisdictional Challenge.

B. Description of Issue 5 in the Appeal Request – Medicaid Eligible Days

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

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.

[3] 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 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, 15, 16, s-d
>
> Estimated Reimbursement Amount: $49,000[4]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper[5] 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 5 – Medicaid Eligible Days

The MAC requests that the Board dismiss the DSH – Medicaid Eligible Days issue arguing this issue should be dismissed because the Provider failed to file a complete preliminary position paper including all supporting exhibits to document the merits of its argument in accordance with 42 C.F.R. §405.1853(b)(2) and Board Rule 25.3.[8]

The Medicare Contractor notes that position papers must include a fully developed narrative and all exhibits, but the preliminary position paper in this case did not contain a finalized eligibility day listing.[9] At the time of the second Jurisdictional Challenge, the Provider had not yet submitted complete, unredacted listing to the Medicare Contractor.[10]

Additionally, the MAC contends the Provider is attempting to add the Section 1115 Waiver days issue improperly and untimely. The Section 1115 Waiver days were not part of the initial appeal request and untimely added via its Final Position Paper.[11]

Provider's Jurisdictional Response

The Provider filed a Jurisdictional Response on May 9, 2025. The response only argues that the Section 1115 Waiver Days currently claimed were not untimely added. It claims the issue

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[4] Appeal Request at Issue 5.
[5] Copy at Medicare Administrative Contractor's Jurisdictional Challenge, Ex. C-2 (Oct. 9, 2024).
[6] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[7] Provider's Preliminary Position Paper at 7-8.
[8] Jurisdictional Challenge at 2-3, 13-14 (Oct. 9, 2024).
[9] *Id.* at 14.
[10] *Id.*
[11] Jurisdictional Challenge at 5-8 (Apr. 15, 2025).

statement in the appeal argued that the Medicare Contractor "failed to include all Medicaid eligible days, *including but not limited to* Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation."[12]

They also ***incorrectly*** cite to the 2015 version of the Board's Rules – arguing that this version was in effect at the time of the appeal. It claims that board Rule 8 discusses issues that have multiple components, but does not mention Section 1115 Waiver Days.

The Board notes that the instant appeal was filed on March 20, 2019. Thus, Board Rule 8 (v. 2.0), which was effective August 29, 2018, is applicable. Board Rule 8.1 ***specifically*** notes that Section 1115 waiver days is a separate issue:

> **8.1 General**
>
> Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7. Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: dual eligible Medicare Part A/Medicaid, dual eligible Medicare Part C/Medicaid, SSI data matching, state/program specific general assistance days, Section 1115 waiver days (program/waiver specific), and observation bed days.

The Jurisdictional Response does not address the failure to include an eligibility listing with its position papers, and merely notes "the Provider submitted a redacted listing on March 7, 2025, and an unredacted listing to the MAC."[13]

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), 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.

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[12] Jurisdictional Response at 1 (emphasis in original).
[13] *Id.* at 4.

A. DSH Payment – Medicaid Eligible Days

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

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

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

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

> (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 position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

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

---

[14] (Bold emphasis added.)

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.

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.

[15] (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 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on **May 3, 2019** included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 5, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(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 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 **November 1, 2019**, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[17] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $48,995 based on an estimated 150 days). The Provider's complete briefing of this issue in its position paper is as follows:

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

[16] (Emphasis added.)
[17] Provider's Preliminary Position Paper at 11 (Nov. 1, 2019).

> 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.

In its Jurisdictional Challenge, the Medicare Contractor asserts that the Provider has failed to submit a list of additional Medicaid eligible days and neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Medicare Contractor sent at least two (2) separate requests for the Provider's list of Medicaid Eligible days (and also discussed the lack of the listing in the Medicare Contractor's own position paper filing). The first notice was sent to the Provider on **July 26, 2021** and the second request was sent to the Provider on **January 12, 2023**, *more than six years after the end of the Provider's cost reporting period*.

Due to the non-responsiveness of the Provider, on **October 9, 2024**, the Medicare Contractor filed a Jurisdictional Challenge, requesting dismissal of DSH Medicaid Eligible Days because:

(1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish the list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2 (or when request by the Medicare Contractor 3 separate times after that). The Medicare Contractor thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the regulations and the Board Rules.[18]

The Provider's Jurisdictional Response filed on **May 9, 2025** does not address the failure to include an eligibility listing with its position papers, and merely notes "the Provider submitted a redacted listing on March 7, 2025, and an unredacted listing to the MAC."[19]

The Redacted Listing was 17 pages with hundreds of Medicaid eligible days. QRS' filing did not explain why the listing of so many days (compared to the estimated 150 days alleged in its position papers) was being submitted at this late date. The Board notes that the days included in this belated listing is *exponentially* larger than the original estimate of 150 days included with the position papers. Regardless, this filing was submitted ***more than five years past the deadline for including it with its preliminary position paper*** since the position paper deadline was November 15, 2019.

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

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[20] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less

[18] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.
[19] Jurisdictional Response at 4.
[20] (Emphasis added.)

provider the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[21]

A. 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 March of 2019 and the regulations required the following:

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

[21] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[22]

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

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

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

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[23]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[24]

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

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

[22] 42 C.F.R. § 405.1835(b).
[23] (Bold and italic emphasis added).
[24] *See* 73 Fed. Reg. 30190 (May 23, 2008).

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

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

In this regard, the Board notes that section 1115 Waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[25] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program and not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

[25] 65 FR 47054, 47087 (Aug. 1, 2000).

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

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

Regardless, even if the Provider had included in its appeal request (which it did not), the Provider failed to properly develop the issue in its position paper filings. First, the Provider's preliminary position paper does not even mention § 1115 waiver days (much less even identify the specific 1115 waiver day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (2018). As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* § 1115 waiver days sub-issue.

Finally, even in the Provider's final position paper, the Provider fails to identify what § 1115 waiver program(s) are involved and whether or not the § 1115 waive days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the final position paper is perfunctory in that it only makes perfunctory conclusions.[26] Again, the Provider failed to so develop its position paper notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (2023) as applied via Board Rule 27.2.

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

The Board's finding that neither the appeal request nor final position paper met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[27] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[28] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[29] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[30] Here, the Board makes the same finding based on similarly *overly generalized language.*

* * * * *

Based on the foregoing, the Board has dismissed the sole remaining issue in this case – (Issue 5). As no issues remain, the Board hereby closes Case No. 19-1835 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:

6/12/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[27] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[28] *Id*. at *11.
[29] *Id.*
[30] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Expedited Judicial Review Determination***
PRRB Cases 24-1468GC *et al*. - *FFY 2024 Unlawful Rural Floor and Rural Floor Budget Neutrality Factor Groups* (10 cases – *See* Appendix A)

Dear Mr. Robertson:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' consolidated Request for Expedited Judicial Review ("EJR") filed on May 20, 2025, in the ten (10) above-referenced group appeals. The Board's decision on jurisdiction and EJR for the ten (10) above-referenced group appeals are set forth below.

Issue:

The issue for which EJR has been requested is:

> [Whether each Providers'] Federal Fiscal Year 2024 ("FFY 2024") wage indexes and associated Medicare reimbursement were improperly calculated and are lower than required because the Secretary ("Secretary") of the United States Department of Health and Human Services' ("HHS") unlawful interpretation and application of the Rural Floor and the Rural Floor Budget Neutrality Factor ("RFBNF").[1]

Statutory and Regulatory Background:

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] 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").

[1] Request for Expedited Judicial Review at 1 (May 20, 2025).
[2] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).

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 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.[6]

A. Rural Floor; Rural Floor Budget Neutrality Factor

Though the general rule is that a hospital's payment rate is adjusted based on its geographical area, whether it be an "urban" or "rural" area,[7] Congress has made an exception to ensure that even hospitals in a low-wage urban area receive at least the wage index applicable to the rural hospitals in that state.[8] This minimum wage index is known as the "rural floor." To offset this increase in payment to urban hospitals, however, Congress also enacted a budget neutrality adjustment which decreased payments to other hospitals,[9] namely rural hospitals and high-wage

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[3] The standardized amount is based on per discharge averages from a base period and is 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. 27433, 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] *See* https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index (last visited June 12, 2025).
[7] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[8] *See* Balanced Budget Act of 1997 ("BBA 1997"), Pub. L. No. 105-33, § 4410(a), 111 Stat. 251, 402.
[9] BBA 1997, § 4410(b).

urban hospitals.[10] To implement this budget neutrality adjustment, the Secretary adopted an "iterative method."

First, the rural floor is applied to raise low-wage urban hospitals' wage indices to match the rural hospitals, which *raises* the overall Medicare payments for the CBSA. Second, to make these adjustments budget-neutral, the Secretary applies an overall downward adjustment to rural and high-wage urban hospitals. A downward adjustment to the rural hospitals lowers the rural floor, which allows the low-wage urban hospitals' wage indices to be decreased, which *lowers* the overall Medicare payments for the CBSA. To make these new adjustments budget neutral, the Secretary applies an overall upward adjustment to rural and high-wage urban hospitals, again altering the rural floor, requiring the low-wage urban hospitals' wage index to be increased again. The process repeats until the wage indices stabilize in a budget neutral manner.[11]

The Secretary has simplified the iterative method by "simply adjusting all area wage indices by a uniform percentage."[12] In this simplified method, low-wage urban hospitals' wage indices are raised to the rural floor, then a uniform percentage is applied to decrease the wage indices of all hospitals to achieve budget neutrality.[13] The process of applying the budget neutrality adjustment to all hospitals' wage indices continues to be applied in setting the current annual wage indices.[14]

Providers' Position:

The Providers filed a consolidated Request for EJR on May 20, 2025, arguing that the wage indices and associated Medicare reimbursement for FFY 2024 were improperly calculated and lower than required. They argue that the Secretary has unlawfully interpreted and applied the rural floor and rural floor budget neutrality factor.[15] The Providers recount how BBA 1997 § 4410 establishes a rural floor to increase low-wage urban hospitals' wage indices to at least equal the wage index of the rural areas in a particular area.[16] They also explain how other hospitals – the rural and high-wage urban hospitals – would have their wage indices reduced to achieve budget neutrality in light of those increases to low-wage urban hospitals.[17] They argue that the simplified "iterative method", wherein a uniform percentage is applied to decrease the wage indices of all hospitals to achieve budget neutrality, is unlawful. They posit that this uniform decrease lowers the wage indices of low-wage urban hospitals, which are supposed to be exempt from the budget neutrality adjustments.[18] The Providers claim that once the rural floor is set, low wage urban hospitals that receive the rural floor cannot have their wage indices reduced pursuant to BBA 1997 § 4410(b).[19]

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[10] 72 Fed. Reg. 47130, 47325 (Aug. 22, 2007).
[11] *See id.* at 47325-47329; *see also St. Mary Med. Ctr. v. Becerra*, 581 F.Supp.3d 119, 127 (D.D.C. 2022).
[12] 72 Fed. Reg. at 47325.
[13] *Id.*; *see also St. Mary Med Ctr. v. Becerra*, 581 F.Supp.3d at 138.
[14] *See* 89 Fed. Reg. 68986, 69299 (Aug. 28, 2025)
[15] Request for Expedited Judicial Review at 1.
[16] *Id.* at 3-4.
[17] *Id.* at 4.
[18] *Id.* at 4-5.
[19] *Id.* at 7.

The Providers ask the Board to grant EJR because it has jurisdiction over these appeals. The appeals were all filed withing 180 days of the publication of the FFY 2024 Final Rule and the Providers are dissatisfied with the calculation of their appliable wage indices as published therein. The reimbursement impact in each group case exceeds the $50,000 threshold to establish the Board's jurisdiction.[20] The Board, however, lacks the authority to grant the relief sought: to hold CMS' policy and calculation of the rural floor budget neutrality factor and the related decrease to their wage indices unlawful under the Medicare statute.[21]

Medicare Contractor's Position:

On May 28, 2025, the Medicare Contractor's Representative, Federal Specialized Services ("FSS"), filed a Response to the Request for EJR. The Response did not address the actual request but instead made a timely[22] certification that it would be filing Substantive Claim Challenges in eight (8) cases. Similarly, on May 21, 2025, National Government Services, the Medicare Contractor, filed a Response to the Request for EJR which did not address the request, but made a timely certification that it would be filing a Substantive Claim Challenge in an additional case (24-1567GC).

Decision of the Board:

The participants that comprise the group appeals within this EJR request have filed an appeal involving FFY 2024 based on their appeals from the FFY 2024 IPPS Final Rule.

A. Jurisdiction and Request for EJR

All of the participants in all of the group cases at issue appealed from the FFY 2024 IPPS Final Rule.[23] The Board has determined that (1) the participants' documentation in each of the group appeals shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal;[24] (2) the appeals were timely filed; and (3) Board review of the matter in these appeals is not precluded by statute or regulation. In finding that the groups meet the $50,000 amount in controversy, the Board recognizes that the Group Representative has explained that the amount in

[20] *Id.* at 10.
[21] *Id.* at 9-11.
[22] Board Rule 44.6 (2023) governs the timing of Substantive Claim Challenges in cases where a Request for EJR is filed less than sixty (60) days from the filing of a Final Schedule of Providers (or Board Rule 20 Certification filed in lieu of a Final SOP which certifies that the group is complete and fully populated in OH CDMS). In such instances, Board Rule 44.6 requires any party questioning the Board's jurisdiction or whether an appropriate cost report claim was made to file the challenge, or a certification that a challenge is forthcoming, within five (5) business days of the date the EJR Request was filed. The Request for EJR in these cases was filed on May 20, 2025, so any challenges (or certification that a challenge was forthcoming) were due no later than close of business May 28, 2025, noting that May 26, 2025 was a federal holiday and not a business day.
[23] The CMS Administrator confirmed that, consistent with the D.C. Circuit's decision in *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139 (D.C. Cir. 1986, a wage index notice published in the Federal Register is a final determination from which a provider may appeal to the Board within the meaning of 42 U.S.C. § 1395oo(a)(1)(A)(ii). *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993*), rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015); 42 C.F.R. § 405.1837.
[24] *See* 42 C.F.R. § 405.1837.

controversy ("AiC") calculation is simply based on the estimated IPPS payments for the period at issue if the rural floor budget neutrality factor were removed for the FFY and this AiC unmistakably demonstrates each of the groups more than clears the minimum $50,000 AiC hurdle. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractors for the actual final amounts in each case.

B. Application of 42 C.F.R. §§ 405.1873 and 413.24(j)

1. Regulatory Background

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

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

> **describing** how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[25]

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

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

[25] (Bold and underline emphasis added.)

> 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**.[26]

These regulations are applicable to the cost reporting periods in these group cases.

2. Appropriate Cost Report Claims: Findings of Fact and Conclusions of Law

As explained above, at issue in this appeal are cost reports beginning after January 1, 2016, which are subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[27] 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))"[28] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[29] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[30] In these ten (10) cases, no party has questioned whether there was an appropriate claim made.

However, the Board notes that, when the participants in a group have not filed their cost report, then § 405.1873(b) would not be triggered because the issue of whether the relevant participants' cost reports included an appropriate claim for the specific item under appeal would not yet be ripe.[31] Section 405.1873(b) sets forth the procedures for Board review of Substantive Claim Challenges:

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[26] (Bold and underline emphasis added.)
[27] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").
[28] (Emphasis added.)
[29] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[30] *See* 42 C.F.R. § 405.1873(a).
[31] The preamble to the final rule that adopted the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1973 responded to a comment about appeals from the Federal Register and confirmed that the substantive claim regulations applied to them. 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015). However, this preamble discussion does not address the manner in which they apply. Rather, the response concludes with the following directive in § 405.1873(a)-(b): "if a party to an appeal questions whether there was an appropriate cost report claim for a specific PPS item, the Board must take evidence and argument on that question; issue findings of fact and conclusions of law on such matter; and include those findings and conclusions in both the administrative record and certain types of overall Board decisions." *Id.* at 70570.

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

Significantly, the regulation simply directs the Board to give an adequate opportunity to take in evidence and argument and does not discuss staying appeals based on the Federal Register to allow future review and consideration of Substantive Claim Challenges. In this regard, the fact that a cost report has not been filed, it would not stop or delay the Board proceedings as set forth in § 405.1873(b). Accordingly, it is the Board's position that in these instances, any Substantive Claim Challenge would be premature.

That said, *if subsequent to the Federal Register appeal being filed*, one or more participants files its cost report, then any party may raise a Substantive Claim Challenge regarding those participants and submit argument and evidence supporting their position. Here, for the above-captioned appeals, no party has asserted that any of the participants in these Federal Register appeals later filed its cost report and failed to properly make a cost report substantive claim for the matter at issue.

Moreover, all of the participants in the above-referenced group cases are appealing the FFY 2024 Federal Register Notice and the cost reports impacted by such notice appear to have not yet been filed to trigger the general substantive payment requirement for cost reports under § 413.24(j).[32] Accordingly, the Board is not obligated under 42 C.F.R. § 405.1873 to include findings on substantive claim challenges in these cases for any of the participants.

C. Analysis Regarding Appealed Issue

The Board finds that the Secretary's determination to implement the rural floor budget neutrality adjustment was made through notice and comment in the form of an uncodified regulation[33] and that this policy continues to be applied in setting the current annual wage indices, including the FFY 2024 at issue in these appeals.[34] Therefore, the Board finds that this policy continues to be a binding, but uncodified, regulation for FFY 2024. 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 area wage indices, which incorporate this rural floor budget neutrality adjustment, and the Board does not have the authority to grant the relief sought by the Providers, namely to hold CMS' policy and calculation of the rural floor budget neutrality factor and the related decrease to their wage indices unlawful under the Medicare

[32] *See* 80 Fed. Reg. at 70556, 70569-70.
[33] *See* 72 Fed. Reg. 47130, 47325-47330 (Aug. 22, 2007) "III. Changes to the Hospital Wage Index, G. Computation of the FY 2008 Unadjusted Wage Index, 4. Application of Rural Floor Budget Neutrality."
[34] *See* 89 Fed. Reg. 68986, 69299 (Aug. 28, 2025)

statute.[35] As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in these cases.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the rural floor budget neutrality factor issue for the subject year in these cases and that the Providers in these group appeals are entitled to a hearing before the Board;

2) While the Providers appealed cost reporting periods beginning after January 1, 2016, no substantive claim challenges[36] have been filed pursuant to 42 C.F.R. § 405.1873(a) to trigger either Board review under § 405.1873(b) or reporting under § 405.1873(d)(2);

3) Based upon the Providers' assertions regarding the rural floor budget neutrality factor issue, there are no findings of fact for resolution by the Board;

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

5) It is without the authority to decide the legal question of whether the calculation and application of the rural floor budget neutrality factor and the related decrease to the Providers' wage indices is valid.

Accordingly, the Board finds that the question of the validity of the application of the rural floor budget neutrality factor and the related decrease to the Providers' wage indices properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject year.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes these cases.

[35] Request for Expedited Judicial Review at 9-11.
[36] As the Board explained in Board Rule 44.5, "[t]he Board adoption of the term "Substantive Claim Challenge' simply refers to any question raised by a party concerning whether *the cost report at issue* included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

Board Members Participating:

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

FOR THE BOARD:

6/12/2025

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

cc: Lorrain Frewert, Noridian Healthcare Solutions v/o Cahaba Safeguard Administrators (J-E)
Byron Lamprecht, WPS Government Health Administrators (J-5)
Cecile Huggins, Palmetto GBA (J-J)
Danelle Decker, National Government Services, Inc. (J-K)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)
Scott Berends, Esq., Federal Specialized Services

Appendix A
(Listing of 10 cases)

PRRB Case Number	PRRB Case: Case Name
24-1469GC	*CoxHealth FFY 2024 Unlawful Rural Floor & Rural Floor Budget Neutrality Factor CIRP Group*
24-1472GC	*Sharp Healthcare FFY 2024 Unlawful Rural Floor & Rural Floor Budget Neutrality Factor CIRP Group*
24-1468GC	*Cottage Health FFY 2024 Unlawful Rural Floor & Rural Floor Budget Neutrality Factor CIRP Group*
24-1647GC	*ScionHealth FFY 2024 Unlawful Rural Floor & Rural Floor Budget Neutrality Factor CIRP Group*
24-1643G	*Greenbaum, Rowe, Smith FFY 2024 Unlawful Rural Floor & Rural Floor Budget Neutrality Factor Group II*
24-1575GC	*Catholic Health FFY 2024 Unlawful Rural Floor & Rural Floor Budget Neutrality Factor CIRP Group*
24-1563GC	*Tufts Medicine FFY 2024 Unlawful Rural Floor & Rural Floor Budget Neutrality Factor CIRP Group*
24-1623GC	*Sarasota Mem Health FFY 2024 Unlawful Rural Floor & Rural Floor Budget Neutrality Factor CIRP Group*
24-1474GC	*Lee Memorial FFY 2024 Unlawful Rural Floor & Rural Floor Budget Neutrality Factor CIRP Group*
24-1604GC	*UNC Health FFY 2024 Unlawful Rural Floor & Rural Floor Budget Neutrality Factor CIRP Group*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

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

RE: ***Board Determination on Pending CIRP Group Without Participants***

Quorum Health CY 2021 DSH Unduly Narrow Definition of SSI Entitlement CIRP Group, Case Number: 25-4397GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("the Board") has reviewed the subject common issue related party ("CIRP") group appeal and notes that it was not properly filed. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

On **May 5, 2025**, Quality Reimbursement Services, Inc. ("QRS") filed the above referenced CIRP group on behalf of Quorum Health ("Quorum") for calendar year ("CY") 2021, appealing the DSH Unduly Narrow Definition of SSI Entitlement issue. The group appeal was formed in the Office of Hearings Case & Document Management System ("OH CDMS") without any participants.

On **May 7, 2025**, the Medicare Contractor filed its Rule 15.2 Review letter, in which it advised the Board that it did not note any impediments at the time but, if further review indicated impediments, it would so advise the Board.

On **June 5, 2025**, the Medicare Contractor filed a revised Rule 22 letter advising that the group was devoid of any participants and that more than thirty (30) days had passed with no additions or transfers. Therefore, the Medicare Contractor considered the appeal to have been abandoned.

Board Determination:

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

42 C.F.R. § 405.1837(b)(1) discusses the use of mandatory groups and states:

> (i)Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.
>
> *** * ***

42 C.F.R. § 405.1837(b)(3) provides the details for initiating a group appeal and indicates:

> With respect to group appeals brought under paragraph (b)(1) of this section, one or more commonly owned or operated providers must make a written request for a Board hearing as a group appeal in accordance with paragraph (c) of this section. Any group appeal filed by a single provider must be joined by related providers on common issues in accordance with paragraphs (b)(1) and (e) of this section….

Regarding the establishment of groups in OH CDMS, the commentary under Board Rule 12.1 indicates:

> . . . if a group is to be formed solely through transfers, it **may initially** be established in OH CDMS **with no participating providers. In such cases, the providers must be transferred i*mmediately* following the establishment of the group case** in order to fulfill the regulatory requirement for the minimum number of providers per Rule 12.6. **The Board will close all group cases that do not meet the minimum participant requirements**.[1,2]

Board Rule 12.6.1, goes on to state that "[a] CIRP group **may be initiated by a single provider under common ownership or control**, but at least two different providers must be in the group upon full formation. (See Rule 19.)"[3]

The Board finds that the subject group appeal, under Case No. 25-4397GC is a CIRP group that was formed without any providers. Further, there have been no additions or transfers to the group in more than thirty-eight ("38") days since its formation. Because the CIRP group was not filed in compliance with Board Rules or the regulations, the Board hereby dismisses

[1] Board Rules v, 3.2 (Dec. 15, 2023)
[2] Bold emphasis added.
[3] Bold emphasis added.

Case No. 25-4397GC.[4] 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.

Finally, the Board notes that QRS has filed many group appeals, both CIRP and optional, over the years. It is also noted that QRS is not new to using OH CDMS, which became mandatory for all filings in November, 2021. The improper formation of this "provider-less" CIRP group appears to be an attempt by QRS to create a "holding spot" for the future addition or transfer of related providers pursuing the DSH Unduly Narrow Definition of SSI Entitlement issue. Although the Commentary at Board Rule 12.1 does permit a "shell" to be formed in OH CDMS, it is only on a limited basis - for the sole purpose of allowing the ***transfer*** of issues from pending individual appeals. QRS' formation of this CIRP group, where there have been no transfers effectuated in over 38 days, violates the intent of the Board's rules and creates an unnecessary administrative burden on the Board and its staff (***i.e.***, having to formally dismiss the CIRP group.) The Board admonishes QRS for again failing to follow Board Rules governing the formation of a group.[5] The Representative is on notice that if this type of filing violation continues, the Board may prohibit the Representative from re-filing perfected CIRP groups for the same issue/CYs in future cases.

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

For the Board:

6/13/2025

X Kevin D. Smith, CPA

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

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

[4] Should QRS identify a Quorum Health participant appealing this issue for the referenced CY, it may form a new CIRP group by either effectuating a transfer or by including a CIRP provider when the group is formed if it is still within the filing deadline (i.e., Direct Add from receipt of the final determination).
[5] In January and March of this year, the Board dismissed other QRS' CIRP groups, under Case Nos. 25-1169GC, 25-1011GC, 25-2168GC and 25-2170GC, for the same reason.

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***
Baylor Scott & White Medical Center-College Station, Prov. No. 67-0088
FYE 05/31/2017, Case No. 20-0190

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 20-0190. 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. 20-0190*

On **April 8, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2017.

On **October 8, 2019**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request included ten (10) issues:

1. SSI Percentage (Provider Specific)
2. SSI Percentage
3. SSI Fraction Medicare Managed Care Part C Days
4. SSI Fraction Dual Eligible Days
5. Medicaid Eligible Days
6. Medicaid Fraction Medicare Managed Care Part C Days
7. Medicaid Fraction Dual Eligible Days
8. Uncompensated Care Distribution Pool
9. 2 Midnight Census IPPS Payment Reduction
10. Standardized Payment Amount

As the Provider is commonly owned/controlled by Baylor Scott & White Health (hereinafter "BSWH"), the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **May 26, 2020**, the Provider transferred Issues 2, 3, 4, 6, 7, 9 and 10 to various BSWH CIRP groups.

On **October 23, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[1]

On **June 2, 2020**, the Provider timely filed its preliminary position paper. With respect to Issue 5, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2017 cost report does not reflect an accurate number of Medicaid eligible days." As a result, the Provider included, as an Exhibit, the original "estimated impact" for this issue of $73,271 based on an *estimated* 100 days.

On **September 9, 2020**, Federal Specialized Services ("FSS") filed the preliminary position paper on behalf of the Medicare Administrative Contractor ("MAC" or "Medicare Contractor"). With regard to Issue 5, the Medicare Contractor's position paper noted that the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position.

On **April 13, 2021**, FSS filed a jurisdictional challenge over the SSI Provider Specific Issue (#1) and the Uncompensated Care ("UCC") Distribution Pool Issue (#8). The only other pending issue was the Medicaid Eligible Days Issue (#5) which was not challenged in this brief.

On **May 10, 2023**, QRS became the authorized representative in Case No. 20-0190.

On **August 20, 2024**, in response to the FSS' April 13, 2021 jurisdictional challenge, the Board dismissed the SSI (Provider Specific) and Uncompensated Care Distribution Pool issues from Case No. 20-0190.[2] **The Medicaid Eligible Days issue remained so the case remained open**.

[1] (Emphasis added.)
[2] Although the Board had dismissed the UCC issue (#8) from the appeal on 8/20/2024, the issue status remained open in OH CDMS. Consequently, on 12/12/2024, QRS filed a request to withdraw the issue in OH CDMS.

On **August 16, 2024**, the Board issued a Notice of Hearing scheduling the case for a hearing on **April 1, 2025** and requiring final position papers be filed by the Parties.[3]

On **December 20, 2024** QRS timely filed its final position paper.

On **January 13, 2025**, FSS timely filed a final position paper on behalf of the Medicare Contractor. FSS noted that in the final position paper, the Provider consolidated "Section 1115 waiver days" with their eligible days issue. However, because Section 1115 waiver days was not an issue in the appeal, the argument was not addressed in the Medicare Contractor's final position paper. Additionally, FSS noted that the Medicare Contractor had not received any listings of Medicaid eligible days as of the date of the final position paper. Consequently, FSS requested the dismissal of the Medicaid Eligible Days issue.

On **March 5, 2025**, FSS filed a jurisdictional challenge over the Medicaid Eligible Days issue (#5). FSS reiterated its arguments from the final position paper.

On **June 2, 2025**, QRS filed a Redacted Medicaid Eligible Days listing in the Office of Hearings Case & Document Management System ("OH CDMS").[4]

On **June 4, 2025**, QRS filed a late response to the Medicare Contractor's ("MAC") Jurisdictional Challenge.

MAC's Jurisdictional Challenge

Issue 3 – DSH Payment – Medicaid Eligible Days

The Medicare Contractor contends the Provider failed to file complete preliminary and final position papers 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 Rule 25 and 27. The Medicare Contractor maintains the Provider failed to submit a complete list of additional Medicaid eligible days or any other supporting documents or explanation for why it cannot produce those documents. As of the date of the Jurisdictional filing on March 5, 2025, almost five years after the listing was required in the preliminary position paper, no listing had been filed.

Section 1115 Waiver Days

Additionally, the Medicare Contractor contends the Provider is attempting to untimely add the section 1115 Waiver Days issue as a sub-issue via its final position paper filed on December 20, 2024.[5] The Provider originally characterized the Medicaid Eligible Days issue in its initial appeal request using the following language:

[3] On March 7, 2025, the Board rescheduled the hearing date in Case No. 20-0190 to July 1, 2025.
[4] The header refers to the listing as "Additional ME & 1115 Waiver Days."
[5] Medicare Contractor's March 5, 2025 Jurisdictional Challenge at 2.

> Specifically, the Provider contends that the MAC: …failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.

Neither the appeal request, nor the preliminary position paper, identified or mentioned the Section 1115 waiver days issue. It was not until the final position paper was filed that the Provider raised the issue – which was over five years after the regulatory deadline to add a new issue to the case. Therefore, the MAC contends that the Section 1115 waiver days issue should be dismissed on the grounds that it was untimely and improperly added to the case.

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[6] The Provider did not file a response to the Jurisdictional Challenge within the 30 days, instead filing it 90 days after the MAC's filing, with no explanation as to why its response was not timely filed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

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

As set forth below, the Board hereby dismisses the Provider's last 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 appeal in either the initial appeal or its position papers.

With regard to the filing of an individual appeal, Board Rule 7.3.2 (No Access to Data) (Aug. 2018) states:

> 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

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

> 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 (Aug. 2018) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

> **Rule 25 Preliminary Position Papers**[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.

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

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 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on October 23, 2019 included instructions on the content of the Provider's preliminary position paper consistent with the above-Board Rules and regulations, along with direction to the Provider to refer to Board Rule 25.

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

[9] (Emphasis added.)

procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On June 2, 2020, the Provider filed its preliminary position paper in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[10] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $73,271 based on an estimated 100 days). The Provider's complete briefing of this issue in its position paper is as follows:

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

[10] Provider's Preliminary Position Paper at 8 (June 2, 2020).

> 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.[11]

In its Jurisdictional Challenge, the Medicare Contractor asserts that the Provider was in violation of Board Rules 25.3 and 27.2 because 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 papers. In addition, 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.

On December 20, 2024, as an exhibit to the final position paper, QRS filed a statement indicating that "[a] listing of the additional Medicaid Eligible days being claimed will be submitted directly to the MAC. A redacted version of the list will be uploaded to the portal thereafter." More than five (5) months later, on June 2, 2025, QRS uploaded a 5-page redacted listing showing 724 Medicaid eligible days. QRS' filing did not explain why the listing of so many days was being submitted at this late date, ***almost 8 years after the fiscal year at issue had closed***. NOTE—the 724 days included in this belated listing is *exponentially* larger than the original estimate of 100 days included with the appeal request. Regardless, this filing was almost ***5 years past the deadline for including it with its preliminary position paper*** since the position paper deadline was June 4, 2020.

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

The fact that a Listing of Medicaid Eligible Days was filed more than 5 months after the final position paper filing does not excuse the Provider for its failure to include the information with its preliminary position paper. Moreover, the Board rejects the Provider's attempt to include the June 2, 2025 Eligible Days Listing as a filing because:

[11] Provider's preliminary position paper at 7-8 (June 2, 2020).

1. The listing was filed ***almost 5 years*** *after the deadline* for that exhibit to be included with its preliminary position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)).

2. The Eligible Days listing fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the 724 days was not previously available, *in whole or in part* (*i.e*., it is not clear why the Provider failed to identify a single day at issue until more than 5 years (*5 years, 7 months, 25 days*) after this appeal was filed and 8 years after the fiscal year at issue had closed).

3. Neither the Board Rules nor the October 23, 2019 Case Acknowledgment and Critical Due Dates permit the Provider to file a "Supplement" to its preliminary position paper (nor did the Provider allege in its filings 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 preliminary position paper filing, if the Board were to accept the listing as a supplement, it would need to either be a *refinement* of its preliminary position paper or a supplement of documents that were identified in the preliminary position paper as being unavailable consistent with Board Rule 25.2.2. However, the Eligible Day listing failed to identify any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the listing cannot be considered a refinement of the position paper since no specific days or listing was included with the preliminary position paper (indeed the *tentative* 724 days showing on the redacted listing filed on June 2, 2025 is, without explanation, *exponentially* larger than the original estimated 100 days included with the appeal request).[12]

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

---

[12] *See, e.g.,* Board Rule 27.3 (Aug. 2018) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."
[13] (Emphasis 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 October of 2019 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[14]

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

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

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

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**

[14] 42 C.F.R. § 405.1835(b).

> 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 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 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:

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

> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the Section 1115 waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The DSH Medicaid Eligible Days issue as stated in the original appeal request cannot be construed to include Section 1115 waiver days. Additionally, there is no indication that any 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 position paper filings. First, the Provider's preliminary position paper does not even mention Section 1115 waiver days (much less even identify the specific 1115 waiver day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Aug. 2018). As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 waiver days sub-issue.

Finally, even in the Provider's final position paper, the Provider fails to identify what Section 1115 waiver program(s) are involved and whether or not the Section 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(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 cursory conclusions.[18] Again, the Provider failed to so develop its position paper notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Aug. 2018) as applied via Board Rule 27.2.

The Board's finding that neither the appeal request nor the final position paper met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[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 –DSH Medicaid Eligible Days (Issue 5). As no issues remain, the Board hereby closes Case No. 20-0190 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:

6/13/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[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 final position paper 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.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Baylor Scott & White Medical Center Garland (45-0280)
FYE: 12/31/2010
Case No.: 17-2039

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 17-2039. 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. 17-2039*

On **February 24, 2017.** the Provider, Baylor Scott & White Medical Center Garland ("Baylor"), was issued a Notice of Program Reimbursement ("NPR") for the fiscal year ending December 31, 2010. The Provider is commonly owned by Baylor Health Care System ("BHCS").

On **August 16, 2017,** Baylor filed an Individual Appeal Request appealing the following (9) issues:

1. DSH Payment SSI Percentage ("Provider Specific")[1]
2. DSH SSI Percentage ("Systemic Errors")[2]
3. DSH Part C Days SSI Fraction[3]
4. DSH Dual Eligible Days SSI Fraction[4]
5. DSH Part C Days Medicaid/Medicare Fraction[5]
6. DSH Dual Eligible Days Medicaid Fraction[6]
7. DSH Medicaid Eligible Days
8. DSH Medicare Manage Part C Days[7]
9. DSH Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days, and No-Pay Part A)[8]

[1] On May 5, 2025, this issue was withdrawn.
[2] On April 26, 2018, this issue was transferred to Case No. 15-0360GC.
[3] On April 26, 2018, this issue was transferred to Case No. 15-0361GC.
[4] On April 26, 2018, this issue was transferred to Case No. 15-0358GC
[5] On April 26, 2018, this issue was transferred to Case No. 15-0364GC
[6] On April 26, 2018, this issue was transferred to Case No. 15-0356GC
[7] On April 26, 2018, this issue was transferred to Case No. 15-0364GC.
[8] On April 26, 2018, this issue was transferred to Case No. 15-0356GC.

As the Provider is commonly owned/controlled by BHCS, 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 **April 26, 2018**, the Provider transferred Issues 2,3,4,5,6,8,9 to BHCS CIRP groups.

After the transfers and withdraws, one issue remains in the appeal: Issue 7, DSH – Medicaid Eligible Days.[9]

On **August 16, 2017**, 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: "You are responsible for pursuing your appeal in accordance with the Board's Rules" and "See Board Rule 25 for Preliminary Position Paper requirements."[10]

On **April 10, 2018,** the Medicare Contractor filed a Jurisdictional Challenge[11] with the Board over Issue 1, DSH SSI Percentage ("Provider Specific"), Issue 8, DSH Medicare Manage Care Part C Days, and Issue 9, DSH Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days, and No-Pay Part A Days) requesting that the Board dismiss the issues.

On **April 27, 2018**, the Provider filed its preliminary position paper. With respect to Issue 7, Medicaid Eligible Days, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover (to be emailed separately). However, no such filing was made, and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the provided Listing of Medicaid Eligible days, the Provider contends that the total number of days reflected in its' 2010 cost report does not reflect an accurate number of Medicaid eligible days. . . ."[12] As a result, the Provider included as an exhibit the original "estimated impact" for this issue of $84,220 based on an *estimated* 150 days.

On **May 7, 2018**, the Provider filed a timely response to the Medicare Contractor's April 10, 2018 Jurisdictional Challenge.

On **August 23, 2018**, the Medicare Contractor filed its preliminary position paper.

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[9] Issue 1 was withdrawn on May 5, 2025.
[10] Board's August 16, 2017 Notice of Case Acknowledgement and Critical Due Dates at 2.
[11] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).
[12] Provider's April 27, 2018 Preliminary Position Paper at 8, Ex. 1. *See also* Medicare Contractor's November 8, 2024 Jurisdictional Challenge Ex. C-3.

On **May 9, 2023,** the Provider changed its designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **September 16, 2024**, the Provider filed its final position paper. With respect to Issue 7, DSH Medicaid Eligible Days, the Provider's final position paper, for the first time, mentions section 1115 Waiver Days.

On **October 15, 2024**, the Medicare Contractor filed its final position paper. Regarding Issue 7, DSH Medicaid Eligible Days, the Medicare Contractor's position paper noted that the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position. The Medicare Contractor also noted that the Provider is attempting to untimely add the "Section 1115 waiver days" issue through its final position paper. The Medicare Contractor noted that the Provider omits any mention of the 1115 waiver days issue in its appeal request and preliminary position paper. In its final position paper, the Provider subsequently added and briefed the "1115 waiver days" issue, which is a separate component of the DSH issue.[13]

On **November 8, 2024**, the Medicare Contractor filed a Jurisdictional Challenge with the Board over Issue 1, DSH SSI Percentage ("Provider Specific") and Issue 7, DSH Medicaid Eligible Days requesting that the Board dismiss the issues. Pursuant to Board Rule 44.4, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file a ***timely*** response within 30 days. The Provider filed its response 6 months after the deadline date.

On **November 21, 2024**, the Provider filed a document **entitled "1115 WAIVER DAYS WITHDRAWAL"** stating that it "will not be submitting a listing for the 1115 Waiver Days."[14]

On **April 28, 2025**, more than seven years after filing their preliminary position paper, QRS filed a "REDACTED MEDICAID ELIGIBLE DAYS LISTING SUBMISSION" and added the *caveat* that the "Listing [is] *pending finalization* upon receipt of State eligibility data."[15] The Listing was 28 pages with numerous Medicaid eligible days. QRS' filing did not explain why the listing was being submitted at this late date or why it was not final (*i.e.*, why it was "pending finalization") at this late date, ***more than 14 years after the fiscal year at issue had closed***.

On **May 8, 2025**, the Provider filed an ***untimely*** response to the Medicare Contractor's November 8, 2024 Jurisdictional Challenge.

B. Description of Issue 7 in the Appeal Request

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

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[13] Medicare Contractor's October 15, 2024 Final Position Paper at 18-19.
[14] Provider's November 21, 2024 1115 Waiver Days Withdrawal letter at 1. The Board will not address the waiver day jurisdictional challenge as the issue is no longer in the appeal.
[15] (Emphasis added.)

Statement of Issue

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

Statement of the Legal Basis

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

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

Audit Adjustment Number(s): 5,18, 19, 22, 38, 46, S-D

Estimated Reimbursement Amount: $84,000[16]

Regarding the Medicaid Eligible Days issue, the Provider argues in its Preliminary Position Paper that pursuant to the *Jewish Hospital* case[17] 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.[18]

Medicare Contractor's Contentions

Issue 7 – DSH Payment – Medicaid Eligible Days

The Medicare Contractor contends the Provider failed to file complete preliminary and final position papers 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 Rule 25.2, 25.3, and 27.2. The Medicare Contractor maintains the Provider failed to submit a complete list of additional Medicaid eligible days or any other supporting documents or explanation for why it cannot produce those documents. [19]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[20] The Provider has not

[16] Provider's August 16, 2017 Individual Appeal Request, Issue Statement, Issue 7.
[17] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[18] Provider's April 27, 2018 Preliminary Position Paper at 7.
[19] The Board will not be addressing the Medicare Contractor's 1115 waiver day jurisdictional arguments as the alleged late added issue was withdrawn on November 21, 2014.
[20] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2017), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

A. DSH Payment – Medicaid Eligible Days

The Provider's appeal request did not include a list of the specific additional Medicaid Eligible Days that are in dispute in this appeal in either the initial appeal or the preliminary position paper.

With regard to the filing of an individual appeal, Board Rule 7 (Issue Statement and Claim of Dissatisfaction) (Aug. 2017) 7.1(B) states:

> **No Access to Data**
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

42 C.F.R. § 405.1853(b)(2)-(3) (2017) 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.[21]

[21] (Bold emphasis added.)

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

Board Rule 25 (Aug. 2017) 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**[22]
>
> **COMMENTARY**:
>
> Under the Regulations effective August 21, 2008, all issues will have been identified well in advance of the due date for preliminary position papers. Unlike the prior practice, preliminary position papers now are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline. . . . [T]he 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 Intermediary and fifteen months for the Provider's response.
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the following sub-sections.
>
> **A. Provider's Preliminary Position Paper**
>
> 1. For each issue, state the material facts that support your claim.
>
> 2. Identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting your position.
>
> 3. Provider a conclusion applying the material facts to the controlling authorities.
>
> **25.2 Preliminary Documents**
>
> **A. General**
>
> With the preliminary position papers, the parties must exchange ***all*** available documentation as preliminary exhibits to fully support your position.

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

B. Unavailable and Omitted Preliminary 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. Once the documents become available, promptly forward them to the opposing party.

C. Preliminary Documentary List

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

25.3 Filing Requirements to the Board

Parties should file with the Board only (1) the cover page of the preliminary position paper, (2) the preliminary documentation list, and (3) a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. 405.1853. Do not file any other documents with the Board.

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on August 16, 2017, included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 7, Medicaid Eligible Days, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) (2017) 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.[23]

Along the same line, 42 C.F.R. § 405.1871(a)(3) (2017) makes clear that in connection with appeals to the Board, the provider carries 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:

[23] (Emphasis added.)

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

Finally, Board Rule 41.2 (2017) 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 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 April 27, 2018, the Provider filed its preliminary position paper in which it indicated that the eligibility listing was imminent by promising that the listing was to be emailed separately.[24] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $84,220 based on an estimated 150 days). The Provider's complete briefing of this issue in its preliminary position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *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:

[24] Provider's April 27, 2018 Preliminary Position Paper at Ex. 1.

> [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 provided Listing of Medicaid Eligible days, the Provider contends that the total number of days reflected in its' 2010 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.[25]

In its November 8, 2024 Jurisdictional Challenge, the Medicare Contractor asserts that the Provider has failed to submit a final list of additional Medicaid eligible days with its preliminary or final position papers or submit such list under separate cover to it. The Medicare Contractor maintains the Provider has neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with the regulations and Board Rules.[26]The Medicare Contractor contends the Provider placed a redacted list of additional Medicaid Eligible Days in OH CDMS on April 28, 2025, which was pending finalization, which was more than seven years after filing their preliminary position paper.

The Board finds the Provider's April 28, 2025 filing does not explain why the listing of additional days was being submitted at this late date *more than 14 years after the fiscal year at issue had closed*. NOTE—the days included in the April 28, 2025 belated listing is larger than the original estimate of 150 days included with the appeal request.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e*., the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid Eligible Days issue because the provider has failed to identify any specific Medicaid Eligible Days at issue (much less any supporting documentation for those days).

Pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[27] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single

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[25] *Id*. at 7-8.
[26] Medicare Contractor's November 8, 2024 Jurisdictional Challenge at 7-8.
[27] (Emphasis added).

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

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[28]

Based on the foregoing, the Board has dismissed the (1) remaining issue in this case – (Issue 7, Medicaid Eligible Days). As no issues remain, the Board hereby closes Case No. 17-2039 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:

6/13/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source
Wilson Leong, FSS

[28] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):
The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Navarro Regional Hospital (45-0447)
FYE: 12/31/2016
Case No.: 20-0334

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 20-0334. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days payment.

Background

A. *Procedural History for Case No. 20-0334*

On **May 2, 2019**, the Provider, Navarro Regional Hospital ("Navarro"), was issued a Notice of Program Reimbursement ("NPR") for the fiscal year ending December 31, 2016. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **October 28, 2019,** Navarro filed an Individual Appeal Request appealing the following (5) issues:

1. DSH Payment SSI Percentage ("Provider Specific")[1]
2. DSH SSI Percentage ("Systemic Errors")[2]
3. DSH Medicaid Eligible Days
4. Uncompensated Care Distribution Pool[3]
5. Two Midnight Census IPPS Payment Reduction[4]

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **May 27, 2020**, the Provider transferred Issues 2 and 5 to CHS CIRP groups.

After the transfers and withdraws, one issue remains: Issue 3, DSH – Medicaid Eligible Days.[5]

[1] On October 21, 2024, this issue was withdrawn.
[2] On Mary 27, 2020, this issue was transferred to Case No. 19-1409GC.
[3] On October 21, 2024, this issue was withdrawn.
[4] On May 27, 2020, this issue was transferred to Case No. 19-1410GC.
[5] Issue 1 and 4 were withdrawn on May 27, 2020.

On **November 15, 2019,** the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

On **June 22, 2020**, the Provider timely filed its preliminary position paper. With respect to Issue 3, Medicaid Eligible Days, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made, and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the 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. . . ."[7] As a result, the Provider included as an exhibit the original "estimated impact" for this issue of $33,484 based on an *estimated* 50 days.

On **September 2, 2020**, the Medicare Contractor filed a Jurisdictional Challenge[8] with the Board over Issue 1, DSH SSI Percentage ("Provider Specific") and Issue 4, Uncompensated Care Distribution Pool requesting that the Board dismiss the issues. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **September 25, 2020**, the Medicare Contractor filed its preliminary position paper. Regarding Issue 3, DSH Medicaid Eligible Days, the Medicare Contractor's position paper noted: (1) the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all

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[6] (Emphasis added).
[7] Provider's June 27, 2020 Preliminary Position Paper at 8.
[8] 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).

available documentation necessary to support its position; and (2) the Provider had failed to respond to any of the Medicare Contractor's requests for that Medicaid eligible days listing.[9]

On **January 18, 2023**, the Medicare Contractor filed its 3rd and Final Request for DSH Package in connection with Issue 3. In this filing, the Medicare Contractor noted that it had previously requested that the Provider send it a DSH package to resolve Issue 3 (on December 13, 2019 (1st request) and on June 19, 2020 (2nd request)). As no response was received, the Medicare Contractor formally filed the 3rd and Final Request for DSH Package to formally request that a listing of the Medicaid eligible days at issue plus supporting documentation be provided to the Medicare Contractor on or before February 18, 2023 (*i.e.*, within 30 days). Notwithstanding the formal request, the Provider failed to file any response to the Medicare Contractor.

On **November 13, 2023**, the Provider changed its designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **November 14, 2023**, almost 9 months after the deadline for responding to the Medicare Contractor's 3rd and Final Request for DSH Package and more than three years after filing their preliminary position paper, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the *caveat* that the "Listing [is] *pending finalization* upon receipt of State eligibility data."[10] The Listing was 5 pages with numerous Medicaid eligible days. QRS' filing did not explain why the listing was being submitted at this late date or why it was not final (*i.e.*, why it was "pending finalization") at this late date, ***more than 6 years after the fiscal year at issue had closed***.

On **November 29, 2023**, the Medicare Contractor requested Medicaid eligibility documentation for several patients on the Provider's Supplement to Position Paper/Redacted Medicaid Eligible Days Listing submission which was due within 15 days. The Provider did not submit the eligibility documentation.

On **March 11, 2025**, the Provider filed its final position paper. With respect to Issue 3, DSH Medicaid Eligible Days, the Provider's final position paper, for the first time, mentions section 1115 Waiver Days.

On **March 27, 2025**, the Medicare Contractor filed its final position paper. Regarding Issue 3, DSH Medicaid Eligible Days, The Medicare Contractor noted it will file a jurisdictional challenge because the Provider did not submit a final list of additional Medicaid eligible days with their appeal request and before or with their preliminary position paper. In addition, with its final position paper, the Provider attempts to add the Section 1115 Waiver Days issue.[11]

On **April 10, 2025**, the Medicare Contractor filed a Jurisdictional Challenge with the Board over Issues 3, DSH Medicaid Eligible Days including section 1115 waiver days, requesting that the Board dismiss the issue.

On **April 21, 2025**, the Provider filed a timely response to the Medicare Contractor's Jurisdictional Challenge.

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[9] Medicare Contractor's September 25, 2020 Preliminary Position Paper at 5-6.
[10] (Emphasis added.)
[11] Medicare Contractor's March 27, 2025 Final Position Paper at 3.

B. Description of Issue 3 in the Appeal Request

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

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 7, 20, 21 S-D
>
> Estimated Reimbursement Amount: $33,000[12]

Regarding the Medicaid Eligible Days issue, the Provider argues in its Preliminary Position Paper that pursuant to the *Jewish Hospital* case[13] 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.[14]

Medicare Contractor's Contentions

Issue 3 – DSH Payment – Medicaid Eligible Days

The Medicare Contractor contends the Provider failed to file complete preliminary and final position papers 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 Rule 25 and 27. The Medicare Contractor maintains the Provider failed to submit a complete list of additional Medicaid eligible days or any other supporting documents or explanation for why it cannot produce those documents.

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[12] Provider's October 28, 2019 Individual Appeal Request, Issue Statement, Issue 3.
[13] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[14] Provider's June 22, 2020 Preliminary Position Paper at 7.

Additionally, the Medicare Contractor contends the Provider is attempting to untimely add the section 1115 Waiver Days issue as a sub-issue via its final position paper filed on March 11, 2025.[15]

Provider's Jurisdictional Response

The Provider contends that it appealed all Medicaid Eligible Days in its Appeal Request, including section 1115 Waiver Days. The Provider asserts, by definition, section 1115 Waiver Days are Medicaid Eligible Days. The Provider maintains although the Medicare Contractor contends that it is attempting to untimely add the issue of section 1115 Waiver Days, there exists no such issue. The Provider argues section 1115 Waiver Days are part and parcel of Medicaid Eligible Days.

The Provider maintains the regulation at 42 C.F.R. § 405.1835 contains requirements for appealing an "issue" and a time limit on adding an "issue" – not on clarifying a "sub-issue" or "components" of an issue. The Provider argues both a June 25, 2004 proposed rule (69 Fed. Reg. 35716) and a May 23, 2008 final rule (73 Fed. Reg. 30190) indicate that an "issue" is encapsulated by a specific cost report adjustment. They do not slice and dice an "issue" into component parts, including the specific reason why Medicaid Eligible Days were not counted in the numerator of the Medicaid Fraction of the Disproportionate Payment Percentage.[16]

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

A. DSH Payment – Medicaid Eligible Days

The Provider's appeal request did not include a list of the specific additional Medicaid Eligible Days that are in dispute in this appeal in either the initial appeal or the preliminary position paper.

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

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

[15] Medicare Contractor's April 10, 2025 Jurisidictional Challenge at 2.
[16] Provider's April 21, 2025 Jurisdictional Response at 1-2.

> 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.[17]

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

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

> **Rule 25 Preliminary Position Papers**[18]
>
> **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.

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

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 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on November 15, 2019, included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicaid Eligible Days, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(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.[19]

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that in connection with appeals to the Board, "the provider carries 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.

[19] (Emphasis added.)

On June 22, 2020, the Provider filed its preliminary position paper in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[20] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $33,484 based on an estimated 50 days). The Provider's complete briefing of this issue in its preliminary position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[21]

[20] Provider's June 22, 2020 Preliminary Position Paper at 8.
[21] *Id*. at 7-8.

In its April 10, 2025 Jurisdictional Challenge, the Medicare Contractor asserts that the Provider has failed to submit a final list of additional Medicaid eligible days with its preliminary or final position papers or submit such list under separate cover to it. The Medicare Contractor maintains the Provider has neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with the regulations and Board Rules.[22]

Notably, the Medicare Contractor sent three (3) separate requests for the Provider's list of Medicaid Eligible days (and also discussed the lack of the listing in the Medicare Contractor's own position paper filing). The first notice was sent to the Provider on December 13, 2019, and the second request was sent to the Provider on June 19, 2020. The third, final request was filed formally with the Board in OH CMDS on January 18, 2023, six *years after the end of the Provider's cost reporting period*. The Medicare Contractor also informed the Provider in its final request for information that the deadline to respond was February 18, 2023. The Provider failed to file any response to the 3rd and final request. The Provider placed a redacted list of days in OH CDMS on November 14, 2023, which was pending finalization, which was more than three years after filing their preliminary position paper.

The Board finds the Provider's November 14, 2023 filing does not explain why the listing of additional days was being submitted at this late date *more than 6 years after the fiscal year at issue had closed*. NOTE—the days included in the November 14, 2023 belated listing is larger than the original estimate of 50 days included with the appeal request.

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

The fact that QRS filed a Listing of Medicaid Eligible Days in November 2023 (but then also failed to include a listing in its final position paper), does not excuse the Provider for its failure to include the information with its preliminary position paper. Moreover, the Board rejects the Provider's attempt to include the Listing as a filing because:

1. The listing was filed almost ***3 years*** *after the deadline* for that exhibit to be included with its preliminary position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)).

2. The Eligible Days listing failed to explain the following critical information: (a) *why* they were being filed so late (*i.e.*, upon what basis or authority should the Board accept the late filings); (b) *why* the four page listing was not previously available, *in whole or*

[22] Medicare Contractor's April 10, 2025 Jurisdictional Challenge at 7-8.

in part (*i.e.*, it is not clear why the Provider failed to identify a single day at issue until roughly 3 years after this appeal was filed and more than 7 years after the fiscal year at issue had closed).

3. Neither the Board Rules nor the November 15, 2019 Case Acknowledgment and Critical Due Dates permit the Provider to file a "Supplement" to its preliminary position paper (nor did the Provider allege in its filings 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 preliminary position paper filing, if the Board were to accept the listing as a supplement, it would need to either be a *refinement* of its preliminary position paper or a supplement of documents that were identified in the preliminary position paper as being unavailable consistent with Board Rule 25.2.2. However, neither the preliminary position paper nor the subsequent Eligible Days listings identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the listings cannot be considered a refinement of the position paper since no specific days or listing were included with the preliminary position paper (and the 4 page listing filed as supplement without explanation, is *exponentially* larger than the original estimate of $33,000 total impact (roughly 50days) included with the appeal request).[23]

5. Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[24] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provider the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[25]

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[23] *See, e.g.,* Board Rule 27.3 (Aug. 2018) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."

[24] (Emphasis added.)

[25] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an

A. 1115 Waiver Days

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

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

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[26]

Board Rule 7.2.1 (2019) 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 (2019) 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:

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appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

[26] 42 C.F.R. § 405.1835(b).

> 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). . .***[27]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[28]

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

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

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

In this regard, the Board notes that section 1115 Waiver Days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[29] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver Days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program and not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

[27] (Bold and italic emphasis added).
[28] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[29] 65 FR 47054, 47087 (Aug. 1, 2000).

> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

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

Regardless, even if the Provider had included in its appeal request (which it did not), the Provider failed to properly develop the issue in its position paper filings. First, the Provider's preliminary position paper does not even mention § 1115 Waiver Days (much less even identify the specific 1115 Waiver Day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25. As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* § 1115 Waiver Days sub-issue.

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

Rather, the final position paper is perfunctory in that it only makes perfunctory conclusions.[30] Again, the Provider failed to so develop its position paper notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Nov. 2021) as applied via Board Rule 27.2.

The Board's finding that neither the appeal request nor final position paper met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[31] 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 . . ."[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 has dismissed the (1) remaining issue in this case – (Issue 3, Medicaid Eligible Days). As no issues remain, the Board hereby closes Case No. 20-0334 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:

6/13/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Byron Lamprecht, WPS Government Health Adminstrators
Wilson Leong, FSS

[30] For example, QRS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that "the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." However, QRS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is QRS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? QRS fails to brief the merits of its claims and fails to establish the Board's jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the final position paper references "uncompensated care pool."
[31] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[32] *Id*. at *11.
[33] *Id.*
[34] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Stephanie Webster, Esq.
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RE: ***Expedited Judicial Review Determination***
Tampa General Hospital (Provider Number 10-0128)
FYE: 9/30/2006
Case Number: 25-2610

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's Petition for Expedited Judicial Review ("EJR") filed on May 21, 2025 in the above-referenced appeal. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

On February 13, 2025, the Board received a request for hearing for Tampa General Hospital. The Provider is appealing from a revised Notice of Program Reimbursement ("RNPR") dated August 20, 2024, which implements the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Provider's fiscal year ended ("FYE") 9/30/2006.

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

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] Appeal Request, Issue Statement at 1 (Feb. 13, 2025).

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[3] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4]

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[10]

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[11]

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[12]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[13]

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

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

In the September 4, 1990 Federal Register, the Secretary[14] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as

[11] 42 C.F.R. § 412.106(b)(2)-(3).
[12] (Emphasis added).
[13] 42 C.F.R. § 412.106(b)(4).
[14] of Health and Human Services.

> of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[15]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[16]

With the creation of Medicare Part C in 1997,[17] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C, and following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[18] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[19] The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[20]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.[21] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[22] In response to a comment regarding this change, the Secretary explained that:

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[15] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[16] *Id.*
[17] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[18] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[19] *Id.*
[20] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[21] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[22] 69 Fed Reg. 48916, 49099 (Aug. 11, 2004).

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[23]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[24] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[25] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[26]

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

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[23] *Id.* (emphasis added).
[24] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[25] *Id*. at 47411.
[26] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[27] In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[28] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[29] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[30] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[31] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.[32] A number of hospitals appealed this action.[33] In *Azar v. Allina Health Services* ("*Allina II*"),[34] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[35] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[36] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[37]

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[27] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[28] 746 F. 3d 1102 (D.C. Cir. 2014).
[29] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[30] *Id.* at 2011.
[31] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[32] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[33] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo****(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board,* ***pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[34] 139 S.Ct. 1804 (2019).
[35] *Id.* at 1817.
[36] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[37] 139 S.Ct. at 1814.

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[38] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[39]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[40] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[41]

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

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[38] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[39] CMS Ruling 1739-R at 1-2.
[40] 88 Fed. Reg. 37772 (June 9, 2023).
[41] 88 Fed. Reg. at 37788 (emphasis in original).

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports***. *In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[42]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[43]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically."[44]

4. "*When the Secretary's treatment of Part C days in this final action is reflected* ***in NPRs and revised NPRs****, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation* ***by appealing those NPRs and revised NPRs***. While some providers have already received reopening

[42] 88 Fed. Reg. at 37774-75 (emphasis added).
[43] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[44] *Id.* at 37788 (emphasis added).

> notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[45]

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

Provider's Position:

A. Provider's Appeal Request

The Provider's appeal request includes a "Statement of Jurisdiction" asserting that the Provider has met the applicable statutory conditions for appeal because it is dissatisfied with its revised NPR which applies the June 9, 2023 retroactive final rule related to Part C days. It cites language from that final rule which outlined Providers' ability to challenge this final rule once they were issued NPRs implementing the rule.[46]

The "Statement of Issue" included with the appeal request states that the issue concerns the proper treatment in the Medicare DSH calculation of days for Medicare Part C patients in the aftermath of the *Northeast Hospital* and *Allina II* litigation. The Provider contends that the Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.[47]

The Provider characterized the relevant background facts as follows:

1. In the FY 2005 IPPS Final Rule, CMS first announced a policy change to count Part C days in the SSI fraction and to exclude those days from the numerator of the Medicaid fraction.[48]

2. In *Allina I*, the D.C. Circuit vacated that policy change.[49]

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that "the Secretary's continued application of the same [Part C days policy] from the [FY 2005 IPPS Final Rule] in 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to engage in notice-and-comment rulemaking to adopt the 2004 standard. The Supreme Court's decision did not address the D.C. Circuit's alternate ruling that the readopted policy was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the policy could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[50]

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[45] *Id.* (emphasis added).
[46] Appeal Request, Statement of Jurisdiction (citations omitted).
[47] Appeal Request, Statement of Issue at 1.
[48] *Id.*
[49] *Id.*
[50] *Id.* (citing to 139 S. Ct. 1804 (2019) at 1810-1815, 1816).

4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.[51]

Based on the above, the Provider maintains that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule "is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[52]

B. Provider's Petition for EJR

The Provider has requested EJR over the "post-*Allina* retroactive Part C policy issue" because it believes it has met the requirements for a hearing before the Board, but the Board lacks the authority to decide the substantive and procedural validity of CMS' final rule published in the Federal Register on June 9, 2023.[53] It seeks a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.[54] The Provider states that it "contends that the new, post-*Allina* retroactive part C days rule, applied in the [NPR] appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[55] Since the Board is bound by this regulation,[56] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

On May 29, 2025, the Medicare Contractor's representative, Federal Specialized Services, filed a response to the Request for EJR simply advising that "a jurisdictional challenge will not be filed. A substantive claim challenge will not be filed. The MAC will not challenge Provider's request for expedited judicial review."

Decision of the Board:

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

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[51] *Id.*
[52] *Id.* at 2 (citing 5 U.S.C. § 706(2)).
[53] Provider's Petition for Expedited Judicial Review, 12-13 (May 21, 2025).
[54] *Id.* at 16.
[55] *Id.* at 1-2.
[56] 42 C.F.R. § 405.1867.

A. Jurisdiction

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

- It is dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination;[57] and
- The amount in controversy is $10,000 or more.[58]

For this individual appeal request, the provider appealed from a revised NPR which implements the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. The Provider appealed within 180 days of the issuance of its NPR and the amount in controversy exceeds $10,000.

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

B. Board's Decision Regarding the EJR Requests

The Board finds that:

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

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

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

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[57] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[58] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.

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

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

The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since no additional issues remain in this case, the Board will close the case and remove it from the Board's docket.

Board Members Participating:

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

FOR THE BOARD:

6/13/2025

X Kevin D. Smith, CPA

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

cc: Geoff Pike, First Coast Service Options Inc. c/o GuideWell Source (J-N)
Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Stephanie Webster, Esq.
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RE: ***Expedited Judicial Review Determination***
Maimonides Medical Center (Provider Number 33-0194)
FYE: 12/31/2012
Case Number: 25-3017

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's Petition for Expedited Judicial Review ("EJR") filed on May 21, 2025 in the above-referenced appeal. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

On February 19, 2025, the Board received a request for hearing for Maimonides Medical Center. The Provider is appealing from an original Notice of Program Reimbursement ("NPR") dated August 27, 2024, which implements the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Provider's fiscal year ended ("FYE") 12/31/2012.

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

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] Appeal Request, Issue Statement at 1 (Feb. 19, 2025).

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[3] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4]

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[10]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[11]

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

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[12]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[13]

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

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

In the September 4, 1990 Federal Register, the Secretary[14] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[15]

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

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[16]

With the creation of Medicare Part C in 1997,[17] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C, and following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[18] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[19] The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[20]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.[21] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[22] In response to a comment regarding this change, the Secretary explained that:

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

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

> *numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[23]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[24] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[25] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[26]

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

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[27]
In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[28] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[29] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[30] However, the Secretary has not acquiesced to that decision.

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

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[31] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.[32] A number of hospitals appealed this action.[33] In *Azar v. Allina Health Services* ("*Allina II*"),[34] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[35] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[36] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[37]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[38] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[39]

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[31] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[32] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[33] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo**(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board, **pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[34] 139 S.Ct. 1804 (2019).
[35] *Id.* at 1817.
[36] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[37] 139 S.Ct. at 1814.
[38] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[39] CMS Ruling 1739-R at 1-2.

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[40] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[41]

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

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports****. In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[42]

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

[40] 88 Fed. Reg. 37772 (June 9, 2023).
[41] 88 Fed. Reg. at 37788 (emphasis in original).
[42] 88 Fed. Reg. at 37774-75 (emphasis added).

> **adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[43]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically."[44]

4. "*When the Secretary's treatment of Part C days in this final action is reflected* ***in NPRs and revised NPRs****, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation* ***by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[45]

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

Provider's Position:

A. Provider's Appeal Request

The Provider's appeal requests include a "Statement of Jurisdiction" asserting that the Provider has met the applicable statutory conditions for appeal because it is dissatisfied with its original NPR which applies the June 9, 2023 retroactive final rule related to Part C days. It cites language from that final rule which outlined Providers' ability to challenge this final rule once they were issued NPRs implementing the rule.[46]

The "Statement of Issue" included with the appeal request states that the issue concerns the proper treatment in the Medicare DSH calculation of days for Medicare Part C patients in the aftermath of the *Allina II* litigation. The Provider contends that the Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of

[43] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[44] *Id.* at 37788 (emphasis added).
[45] *Id.* (emphasis added).
[46] Appeal Request, Statement of Jurisdiction (citations omitted).

the SSI fraction.[47]

The Provider characterized the relevant background facts as follows:

1. In the FY 2005 IPPS Final Rule, CMS first announced a policy change to count Part C days in the SSI fraction and to exclude those days from the numerator of the Medicaid fraction.[48]

2. In *Allina I*, the D.C. Circuit vacated that policy change.[49]

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that "the Secretary's continued application of the same [Part C days policy] from the [FY 2005 IPPS Final Rule] in 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to engage in notice-and-comment rulemaking to adopt the 2004 standard. The Supreme Court's decision did not address the D.C. Circuit's alternate ruling that the readopted policy was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the policy could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[50]

4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.[51]

Based on the above, the Provider maintains that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule "is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[52]

B. Provider's Petition for EJR

The Provider has requested EJR over the "post-*Allina* retroactive Part C policy issue" because it believes it has met the requirements for a hearing before the Board, but the Board lacks "the authority to decide the substantive and procedural validity of CMS' final rule published in the Federal Register on June 9, 2023."[53] It seeks a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.[54] "The Provider states that it "contends that the new, post-*Allina* retroactive part C days rule, applied in the original [NPR] appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by

[47] Appeal Request, Statement of Issue at 1.
[48] *Id.*
[49] *Id.*
[50] *Id.* (citing to 139 S. Ct. 1804 (2019) at 1810-1815, 1816).
[51] *Id.*
[52] *Id.* at 2 (citing 5 U.S.C. § 706(2)).
[53] Provider's Petition for Expedited Judicial Review at 13 (May 21, 2025).
[54] *Id.* at 15-16.

substantial evidence."[55] Since the Board is bound by this regulation,[56] it lacks the authority to provide the relief requested, and thus the Provider believes EJR is appropriate.

On May 29, 2025, the Medicare Contractor's representative, Federal Specialized Services, filed a response to the Request for EJR simply advising that "a jurisdictional challenge will not be filed. A substantive claim challenge will not be filed. The MAC will not challenge Provider's request for expedited judicial review."

Decision of the Board:

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

A. Jurisdiction

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

- It is dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination;[57] and
- The amount in controversy is $10,000 or more.[58]

For this individual appeal request, the provider appealed from an original NPR which implements the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. The Provider appealed within 180 days of the issuance of its NPR and the amount in controversy exceeds $10,000.

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

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[55] *Id.* at 1-2.
[56] 42 C.F.R. § 405.1867.
[57] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[58] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

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

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

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

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

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

The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since there are no additional issues under dispute in in this case, the Board will close the case and remove it from its docket.

Board Members Participating:

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

FOR THE BOARD:

6/13/2025

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Expedited Judicial Review Determination***
New York Presbyterian/Queens (Provider Number 33-0055)
FYE: 12/31/2005
Case Number: 25-3605

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's Petition for Expedited Judicial Review ("EJR") filed on May 21, 2025 in the above-referenced appeal. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

On March 10, 2025, the Board received a request for hearing for New York Presbyterian/Queens. The Provider is appealing from a revised Notice of Program Reimbursement ("RNPR") dated September 12, 2024, which implements the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Provider's fiscal year ended ("FYE") 12/31/2005.

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

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] Appeal Request, Issue Statement at 1 (Mar. 10, 2025).

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[3] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4]

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[10]

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[11]

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[12]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[13]

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

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

In the September 4, 1990 Federal Register, the Secretary[14] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as

[11] 42 C.F.R. § 412.106(b)(2)-(3).
[12] (Emphasis added).
[13] 42 C.F.R. § 412.106(b)(4).
[14] of Health and Human Services.

> of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[15]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[16]

With the creation of Medicare Part C in 1997,[17] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C, and following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[18] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[19] The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[20]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.[21] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[22] In response to a comment regarding this change, the Secretary explained that:

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[15] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[16] *Id.*
[17] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[18] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[19] *Id.*
[20] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[21] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[22] 69 Fed Reg. 48916, 49099 (Aug. 11, 2004).

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[23]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[24] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[25] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[26]

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

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[23] *Id.* (emphasis added).
[24] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[25] *Id*. at 47411.
[26] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[27] In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[28] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[29] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[30] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[31] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.[32] A number of hospitals appealed this action.[33] In *Azar v. Allina Health Services* ("*Allina II*"),[34] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[35] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[36] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[37]

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[27] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[28] 746 F. 3d 1102 (D.C. Cir. 2014).
[29] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[30] *Id.* at 2011.
[31] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[32] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[33] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo****(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board, **pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[34] 139 S.Ct. 1804 (2019).
[35] *Id.* at 1817.
[36] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[37] 139 S.Ct. at 1814.

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[38] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[39]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[40] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[41]

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

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[38] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[39] CMS Ruling 1739-R at 1-2.
[40] 88 Fed. Reg. 37772 (June 9, 2023).
[41] 88 Fed. Reg. at 37788 (emphasis in original).

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports***. *In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[42]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[43]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically."[44]

4. "*When the Secretary's treatment of Part C days in this final action is reflected* ***in NPRs and revised NPRs****, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation* ***by appealing those NPRs and revised NPRs***. While some providers have already received reopening

[42] 88 Fed. Reg. at 37774-75 (emphasis added).
[43] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[44] *Id.* at 37788 (emphasis added).

> notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[45]

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

Provider's Position:

A. Provider's Appeal Request

The Provider's appeal requests include a "Statement of Jurisdiction" asserting that the Provider has met the applicable statutory conditions for appeal because it is dissatisfied with its revised NPR which applies the June 9, 2023 retroactive final rule related to Part C days. It cites language from that final rule which outlined Providers' ability to challenge this final rule once they were issued NPRs implementing the rule.[46]

The "Statement of Issue" included with the appeal request states that the issue concerns the proper treatment in the Medicare DSH calculation of days for Medicare Part C patients in the aftermath of the *Northeast Hospital* and *Allina II* litigation. The Provider contends that the Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.[47]

The Provider characterized the relevant background facts as follows:

1. In the FY 2005 IPPS Final Rule, CMS first announced a policy change to count Part C days in the SSI fraction and to exclude those days from the numerator of the Medicaid fraction.[48]

2. In *Allina I*, the D.C. Circuit vacated that policy change.[49]

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that "the Secretary's continued application of the same [Part C days policy] from the [FY 2005 IPPS Final Rule] in 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to engage in notice-and-comment rulemaking to adopt the 2004 standard. The Supreme Court's decision did not address the D.C. Circuit's alternate ruling that the readopted policy was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the policy could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[50]

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[45] *Id.* (emphasis added).
[46] Appeal Request, Statement of Jurisdiction (citations omitted).
[47] Appeal Request, Statement of issue at 1.
[48] *Id.*
[49] *Id.*
[50] *Id.* (citing to 139 S. Ct. 1804 (2019) at 1810-1815, 1816).

4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.[51]

Based on the above, the Provider maintains that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule "is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[52]

B. Provider's Petition for EJR

The Provider has requested EJR over the "post-*Allina* retroactive Part C policy issue" because it believes it has met the requirements for a hearing before the Board, but the Board lacks the authority to decide the substantive and procedural validity of CMS' final rule published in the Federal Register on June 9, 2023.[53] It seeks a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.[54] The Provider states that it "contends that the new, post-*Allina* retroactive part C days rule, applied in the [NPR] appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[55] Since the Board is bound by this regulation,[56] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

On May 28, 2025, the Medicare Contractor's representative, Federal Specialized Services, filed a response to the Request for EJR simply advising that "a jurisdictional challenge will not be filed. A substantive claim challenge will not be filed. The MAC will not challenge Provider's request for expedited judicial review."

Decision of the Board:

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

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[51] *Id.*
[52] *Id.* (citing 4 U.S.C. § 706(2)).
[53] Provider's Petition for Expedited Judicial Review at 12 (May 21, 2025).
[54] *Id.* at 15.
[55] *Id.* at 1-2.
[56] 42 C.F.R. § 405.1867.

A. Jurisdiction

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

- It is dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination;[57] and
- The amount in controversy is $10,000 or more.[58]

For this individual appeal request, the provider appealed from a revised NPR which implements the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. The Provider appealed within 180 days of the issuance of its NPR and the amount in controversy exceeds $10,000.

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

B. Board's Decision Regarding the EJR Requests

The Board finds that:

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

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

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

[57] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[58] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.

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

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

The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since no additional issues remain in this case, the Board hereby closes the case and removes it from the Board's docket.

Board Members Participating:

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

FOR THE BOARD:

6/13/2025

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Expedited Judicial Review Determination***
Univ of Rochester CY 2012 Post-Allina II Medicare Part C Days CIRP Group
Case Number: 25-3845GC

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's Petition for Expedited Judicial Review ("EJR") filed on May 21, 2025 in the above-referenced group appeal. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

On March 17, 2025, the Board received a request to establish a group appeal and both of the participants were directly added the same day. The two Providers are appealing from original Notices of Program Reimbursement ("NPRs") dated September 19 and 23, 2024, which implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Providers' fiscal years ended ("FYE") 12/31/2012.

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

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] Appeal Request, Statement of Group Issue at 1 (Mar. 17, 2025).

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[3] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4]

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[10]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[11]

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

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not*** ***entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[12]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[13]

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

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

In the September 4, 1990 Federal Register, the Secretary[14] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[15]

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

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[16]

With the creation of Medicare Part C in 1997,[17] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C, and following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[18] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[19] The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[20]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.[21] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[22] In response to a comment regarding this change, the Secretary explained that:

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

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

> *associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[23]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[24] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[25] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[26]

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

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[27] In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[28] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005

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

IPPS rule.[29] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[30] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[31] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.[32] A number of hospitals appealed this action.[33] In *Azar v. Allina Health Services* ("*Allina II*"),[34] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[35] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[36] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[37]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[38] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding

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[29] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[30] *Id.* at 2011.
[31] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[32] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[33] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo****(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board,* ***pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[34] 139 S.Ct. 1804 (2019).
[35] *Id.* at 1817.
[36] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[37] 139 S.Ct. at 1814.
[38] 85 Fed. Reg. 47723 (Aug. 6, 2020).

> the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[39]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[40] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[41]

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

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

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

*fractions for **each** applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[42]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[43]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions **contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised **NPRs** will provide hospitals with a **vehicle to appeal** the new final action* even if the Medicare fraction or DSH payment does not change numerically."[44]

4. "*When the Secretary's treatment of Part C days in this final action is reflected **in NPRs and revised NPRs**, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation **by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[45]

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

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[42] 88 Fed. Reg. at 37774-75 (emphasis added).
[43] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[44] *Id.* at 37788 (emphasis added).
[45] *Id.* (emphasis added).

Providers' Position:

A. Providers' Appeal Request

The Providers' appeal requests include a "Statement of Jurisdiction" asserting that the Provider has met the applicable statutory conditions for appeal because it is dissatisfied with its NPR which applies the June 9, 2023 retroactive final rule related to Part C days. It cites language from that final rule which outlined Providers' ability to challenge this final rule once they were issued NPRs implementing the rule.[46]

The "Statement of Group Issue" included with the appeal request states that the issue concerns the proper treatment in the Medicare DSH calculation of days for Medicare Part C patients in the aftermath of the *Allina II* litigation. The Provider contends that the Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.[47]

The Provider characterized the relevant background facts as follows:

1. In the FY 2005 IPPS Final Rule, CMS first announced a policy change to count Part C days in the SSI fraction and to exclude those days from the numerator of the Medicaid fraction.[48]

2. In *Allina I*, the D.C. Circuit vacated that policy change.[49]

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that "the Secretary's continued application of the same [Part C days policy] from the [FY 2005 IPPS Final Rule] in 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to engage in notice-and-comment rulemaking to adopt the 2004 standard. The Supreme Court's decision did not address the D.C. Circuit's alternate ruling that the readopted policy was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the policy could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[50]

4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.[51]

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

[46] Appeal Request, Statement of Jurisdiction (citations omitted).
[47] Appeal Request, Statement of Group Issue at 1.
[48] *Id.*
[49] *Id.*
[50] *Id.* (citing to 139 S. Ct. 1804 (2019) at 1810-1815, 1816).
[51] *Id.*

agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[52]

B. Providers' Petition for EJR

The Providers have requested EJR over the "post-*Allina* retroactive Part C policy issue" because they believe they have met the requirements for a hearing before the Board, but the Board lacks the authority to decide the substantive and procedural validity of CMS' final rule published in the Federal Register on June 9, 2023.[53] They seek a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.[54] The Providers state that they "contend that the new, post-*Allina* retroactive part C days rule, applied in the original [NPRs] appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[55] Since the Board is bound by this regulation,[56] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

On May 29, 2025, the Medicare Contractor's representative, Federal Specialized Services, filed a response to the Request for EJR simply advising that "a jurisdictional challenge will not be filed. A substantive claim challenge will not be filed. The MAC will not challenge Provider's request for expedited judicial review."

Decision of the Board:

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

A. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;

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[52] *Id.* (citing 5 U.S.C. § 706(2)).
[53] Providers' Petition for Expedited Judicial Review at 13 (May 21, 2025).
[54] *Id.* at 16.
[55] *Id.* at 1-2.
[56] 42 C.F.R. § 405.1867.

- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [57]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[58]

Both Providers in this group appeal appealed from original NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. The Providers appealed within 180 days of the issuance of their NPRs and the amount in controversy exceeds $50,000.

The Board finds that the Providers have filed timely appeals from their original NPRs concerning the issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these NPRs. The Board also finds that the amount in controversy exceeds $50,000 as required by 42 C.F.R. § 405.1839(b)(1). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

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

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

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

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

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[57] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[58] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.

Accordingly, the Board finds that the question of the validity of the Part C Days policy issue, as adopted in the June 9, 2023 Final Rule, properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request 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 no additional issues remain in this case, the Board will close the case and remove it from the Board's docket.

Board Members Participating:

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

FOR THE BOARD:

6/13/2025

X Kevin D. Smith, CPA

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

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

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***
Easton Hospital, Prov. No. 39-0162, FYE 04/30/2017
Case No. 21-0225

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 21-0225. 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) issue.

Background:

A. ***Procedural History for Case No. 21-0225***

On **March 5, 2020**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end April 30, 2017. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **September 1, 2020**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained four (4) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – Medicaid Eligible Days[2]
4. 2 Midnight Census IPPS Payment Reduction[3]

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **March 23, 2021**, the Provider transferred Issue 2 to a CHS group (Case No. 20-0997GC).

As a result of the transfer, and after the withdrawal of Issues 3 and 4, there is one (1) remaining issue in this appeal: Issue 1 - DSH Payment/SSI Percentage (Provider Specific).

[1] On April 27, 2021, this issue was transferred to PRRB Case No. 20-0997GC.
[2] The Medicaid Eligible Days issue was withdrawn on January 30, 2024.
[3] The 2 Midnight Census issue was withdrawn on March 17, 2021.

On **November 18, 2020**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing the filing deadlines for the parties' preliminary position papers. On **April 22, 2021**, the Provider timely filed its preliminary position paper.

On **April 22, 2021**, the Provider filed its preliminary position paper.

On **June 18, 2021**, the Medicare Administrative Contractor ("MAC") filed a jurisdictional challenge, requesting the dismissal of Issue 1. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **August 6, 2021**, the MAC timely filed its preliminary position paper.

On **November 13, 2023**, the Representative for Case No. 21-0225 was changed to Quality Reimbursement Services, Inc. ("QRS").

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20-0997GC

In their Individual Appeal Request, the Provider summarizes the legal basis for its Issue 1: DSH Payment/SSI Percentage (Provider Specific), in part, as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[4]

Here it is important to note that the amount in controversy listed for both Issues 1 (Provider Specific) and Issue 2 (Systemic Errors) in the Provider's individual appeal request is $47,000. Additionally, the audit adjustment numbers and the tab references are also identical.

The DSH/SSI Systemic Errors Group Issue Statement in Case No. 20-0997GC, to which the Provider transferred Issue No. 2 reads, in part:

[4] Issue Statement at 1 (Sept. 18, 2020).

Statement of the Issue:

Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

Statement of the Legal Basis

The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

The Providers challenge their SSI percentages based on the following reasons:

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.[5]

On April 22, 2021, the Provider filed its Preliminary Position Paper ("PPP"). The following is the entirety of Provider's position on Issue 1 set forth therein:

Provider Specific

The Provider contends that its' [sic] SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (April 30).

[5] Group Issue Statement, Case No. 20-0997GC.

> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[6]

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. The MAC states that Provider's Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2. Further, the MAC argues that the portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[7]

Provider's Jurisdictional Response

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the MAC'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 June 18, 2021. The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed.

[6] Provider's Preliminary Position Paper at 8-9 (April 22, 2021).
[7] Medicare Contractor's Jurisdictional Challenge at 2, 6-7 (Jun. 18, 2021).

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 MAC, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider's disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in Case No. 20-0997GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[8] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the MAC "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[9] The Provider argues that "its'[sic] SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [MAC]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[10]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-0997GC also alleges that the MAC and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to several factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F).

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to a single provider.[11] Rather, it applies to all SSI calculations. To this end,

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[8] Issue Statement at 1.
[9] *Id.*
[10] *Id.*
[11] 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).

the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, Provider's PPP does not explain how this argument is ***specific to this provider***. Instead, the PPP refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Furthermore, the Provider cites *Loma Linda Community Hospital* and alleges that "SSI entitlement of individuals can be ascertained from State records."[12] But the Provider fails to explain its alleged similarities to *Loma Linda Community Hospital* or how it can ascertain SSI entitlement from the state records.

In accordance with 42 C.F.R. § 405.1853(b), the commentary to Rule 23.3 (Aug. 29, 2018) explains that preliminary position papers must "be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." The commentary to Rule 25 also explicitly states, "preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline." Moreover, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[13]

In its PPP (filed on April 22, 2021), the Provider only cites to the 2000 Federal Register as the source for the MEDPAR data it claims it has yet to receive. 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*

[12] It is also not clear whether this is a systemic issue for CHS providers in the same state subject to the CIRP rules or something that is provider specific because, if it was a common systemic issue, it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

[13] (Italics and underline emphasis added.)

> *fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year.

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[14]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[15] The Provider's appeal is relative to FYE 2017.

Based on the foregoing, the Board finds that the Provider's *Preliminary Position Paper* failed to comply with Board Rules 23 and 25 (November 1, 2021) governing the content of position papers. The Board also finds that the Provider's *Preliminary Position Paper* failed to comply with Board Rule 25.2.2 by not addressing why the MEDPAR data for FYE 2017 was allegedly unavailable. Thus, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue No. 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 20-0997GC.

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 20-0997GC are the same issue.[16] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

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[14] Last accessed September 10, 2024.
[15] Emphasis added.
[16] 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).

Pursuant to 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[.]" In this case, there is nothing in the record to indicate that a proper written realignment request was made by the Provider and that the MAC made a final determination regarding DSH SSI Percentage realignment from which the Provider can appeal. Moreover, an appeal before the Board may not be used a conduit for the MAC (the intermediary) nor for CMS. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

Based on the foregoing, the Board has dismissed the remaining issue in this case – (Issue 1: Provider Specific). As no issues remain, the Board hereby closes Case No. 21-0225 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:

6/13/2025

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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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***
AllianceHealth Midwest, Prov. No. 37-0094, FYE 06/30/2018
Case No. 21-1442

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 21-1442. Set forth below is the decision of the Board to dismiss the 2 remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) and Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 21-1442*

On **January 11, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2018. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **July 1, 2021**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained seven (7) issues:

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

[1] On January 7, 2022, this issue was transferred to Case No. 21-1206GC.
[2] On January 7, 2022, this issue was transferred to Case No. 20-2149GC.
[3] On January 7, 2022, this issue was transferred to Case No. 21-0066GC.
[4] On January 7, 2022, this issue was transferred to Case No. 20-2149GC.
[5] On January 7, 2022, this issue was transferred to Case No. 21-0066GC.

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **January 7, 2022**, the Provider transferred Issues 2, 3, 4, 6 and 7 to CHS CIRP groups.

As a result of the case transfers, there are two (2) remaining issues in this appeal: Issue 1 (the DSH – SSI Percentage Provider Specific) and Issue 5 (the DSH – Medicaid Eligible Days).

On **July 15, 2021**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

On **February 8, 2022**, the Provider timely filed its preliminary position paper. With respect to Issue 5, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2018 cost report does not reflect an accurate number of Medicaid eligible days." As a result, the Provider included, as an Exhibit, the original "estimated impact" for this issue of $55,817 based on an *estimated* 100 days.

On **May 13, 2022**, the Medicare Contractor timely filed a Jurisdictional Challenge[7] with the Board over Issue 1 requesting that the Board dismiss these issues. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

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[6] (Emphasis added.)

[7] 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).

On **June 3, 2022**, the Medicare Contractor filed its preliminary position paper. With regard to Issue 5, the Medicare Contractor's position paper noted that: (1) the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position; and (2) the Provider had failed to respond to any of the Medicare Contractor's requests for that Medicaid eligible days listing.

On **January 6, 2023**, the Medicare Contractor filed its 3rd and Final Request for DSH Package in connection with Issue 5. In this filing, the Medicare Contractor noted that, on July 15, 2021 (1st request) and on March 25, 2022 (2nd request), it had previously requested that the Provider send it a DSH package to resolve Issue 5. As no response was received, the Medicare Contractor formally filed the 3rd and Final Request for DSH Package to formally request that a listing of the Medicaid eligible days at issue plus supporting documentation be provided to the Medicare Contractor on or before February 5, 2023 (*i.e.*, within 30 days). Notwithstanding the formal request, the Provider failed to file any response to the Medicare Contractor.

As no response was received from the Provider, on **August 18, 2023**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to furnish documentation in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); (2) the Provider failed to furnish the Medicaid eligible days listing with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2; and (3) the Provider has effectively abandoned Issue 5. Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** timely respond to that Motion.

On **November 8, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **November 9, 2023**, almost 3 months after the deadline for responding to the Motion to Dismiss Issue 5, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the *caveat* that the "Listing [is] *pending finalization* upon receipt of State eligibility data."[8] The Listing was 19 pages with roughly 3,360 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 3,360 days) was being submitted at this late date or why it was not final (*i.e.*, why it was "pending finalization") at this late date, ***more than 5 years after the fiscal year at issue had closed***. NOTE—the roughly 3,360 included in this belated listing is *exponentially* larger than the original *estimated* impact of 100 days included with the appeal request.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 21-1206GC - CHS CY 2018 DSH SSI Percentage CIRP Group

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

[8] (Emphasis added.)

> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).[9]

The Group issue Statement in Case No. 21-1206GC, to which the Provider transferred Issue No. 2, reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and

[9] Issue Statement at 1 (Jul. 1, 2021).

6. Failure to adhere to required notice and comment rulemaking procedures.[10]

On February 8, 2022, the Board received the Provider's preliminary position paper in 21-1442. 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 based on the Provider's Fiscal Year End (June 30).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services,* No. CV-94-0055 (C.D. Cal June 2, 1995), the SSI entitlement of individuals can be ascertained from [s]tate records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the completed MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008).[11]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $47,000.

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2. The portion

[10] Group Appeal Issue Statement in Case No. 21-1206GC.
[11] Provider's Preliminary Position Paper at 8-9 (Feb. 8, 2022).

related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[12]

Finally, the MAC asserts that the Provider did not file a complete preliminary position paper and therefore violated Board Rule 25 and 42 C.F.R. § 405.1853.

Issue 5 – DSH Payment – Medicaid Eligible Days

The MAC contends that the Provider failed to properly develop its arguments within its preliminary position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25. The MAC argues the Provider has not submitted a Medicaid eligible days listing and therefore, requests the Board dismiss the issue.

Provider's Jurisdictional Response

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

Similarly, the Provider's response to the Motion to Dismiss was due within 30 days but the Provider failed to timely file a response. In this regard, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Decision of the Board

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

As set forth below, the Board hereby ***dismisses*** the Provider's two (2) remaining issues.

A. DSH Payment/SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine

[12] Medicare Contractor's Jurisdictional Challenge at 6-7 (May 13, 2022).
[13] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

the DSH percentage; and (2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Case No. 21-1206GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[14] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[15] The Provider argues in its issue statement, which was included in the appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[16]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 21-1206GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 21-1442 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 21-1206GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[17], the Board dismisses this aspect of the 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.[18] Accordingly, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged

[14] Issue Statement at 1.
[15] *Id.*
[16] *Id.*
[17] PRRB Rules v. 2.0 (Aug. 2018).
[18] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

"systemic" issues argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 21-1206GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 21-1206GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records" but fails to explain how it can, explain how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2.[19] Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (Nov. 1, 2021) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Nov. 1, 2021), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents (Nov. 1, 2021)**
>
> If documents necessary to support your position are still unavailable, then provide the following information in the position papers:
>
> 1. *Identify* the missing documents;
> 2. *Explain why* the documents remain unavailable;
> 3. *State the efforts* made to obtain the documents; *and*
> 4. *Explain when* the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[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 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*

[19] It is also not clear whether this is a systemic issue for CHS providers in the same state subject to the CIRP rules or something that is provider specific because, if it was a common systemic issue, it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

[20] (Italics and underline emphasis added.)

for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[21]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[22]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 21-1206GC.

Accordingly, *based on the record before it*,[23] the Board finds that the SSI Provider Specific issue in Case No. 21-1442 and the group issue from the CHS CIRP group under Case No. 21-1206GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

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

[21] Last accessed Oct. 15, 2024.
[22] (Emphasis added).
[23] Again, the Board notes that the Provider failed to respond to the Jurisdictional Challenge and the Board must make its determination based on the record before it.

Percentage realignment. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

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

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

> The provider must support the determination being appealed and the basis for its dissatisfaction for ***each*** issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

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

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

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

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

[24] (Bold emphasis added.)

Rule 25 Preliminary Position Papers[25]

> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

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

25.1.1 The Provider's Position Paper

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

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

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

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on July 15, 2021 included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 5, 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.[26]

[26] (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 February 8, 2022, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[27] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $55,877 based on an estimated 100 days). The Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits:

[27] Provider's Preliminary Position Paper at 8.

> *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2018 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Motion to Dismiss, the Medicare Contractor asserts that the Provider has failed to submit a list of additional Medicaid eligible days and neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Medicare Contractor sent three (3) separate requests for the Provider's list of Medicaid Eligible days (and also discussed the lack of the listing in the Medicare Contractor's own position paper filing). The first notice was sent to the Provider on July 15, 2021 and the second request was sent to the Provider on March 25, 2022. The third, final request was filed formally with the Board in OH CMDS on January 6, 2023, *over four years after the end of the Provider's cost reporting period*. The Medicare Contractor also informed the Provider in its final request for information that the deadline to respond was February 5, 2023. The Provider failed to file any response to the 3rd and final request.

Due to the non-responsiveness of the Provider, on **August 18, 2023**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish the list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2 (or when requested by the Medicare Contractor 3 separate times after that). The Medicare Contractor thus asserts that the Provider has essentially abandoned the

issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the regulations and the Board Rules.[28]

Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** timely respond to that Motion by the September 17, 2023 filing deadline (*i.e.*, 30 days after August 18, 2023).

However, on November 9, 2023 (more than 2 months after the deadline to respond to the Motion), QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the caveat that the "Listing [is] pending finalization upon receipt of State eligibility data." The Listing was 19 pages with roughly 3,360 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 3,360 days) was being submitted at this late date or why it was not final (*i.e.*, why it was "pending finalization") at this late date, ***more than 5 years after the fiscal year at issue had closed***. NOTE—the roughly 3,360 included in this belated listing is *exponentially* larger than the original estimate of 100 days included with the appeal request. Regardless, this filing was more than 2 months past the deadline for responding to the Motion to Dismiss *and, more importantly,* ***was more than 1½ years past the deadline for including it with its preliminary position paper*** since the position paper deadline was February 26, 2022.

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

The fact that the Listing was filed merely 1 day after the Provider changed its designated representative to QRS does not excuse the Provider for its failure to include the information with its preliminary position paper or its failure to timely respond to the Motion to Dismiss. Board Rule 5.2 makes clear that "the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings." Moreover, the Board rejects the Provider's attempt to label the November 13, 2023 filing as a "Supplement to Position Paper" and does not accept that filing because:

1. The alleged "Supplement" was filed ***more than 1½ years*** *after the deadline* for that exhibit to be included with its preliminary position paper filing consistent with Board

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

Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)). Indeed, the Provider failed to timely reply to the Medicare Contractor's Motion to Dismiss Issue 5 and the alleged "Supplement" was filed ***more than 2 months*** *after the deadline* for filing a response to the Motion to Dismiss Issue 5.

2. The alleged "Supplement" fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the roughly 3,360 days was not previously available, *in whole or in part* (*i.e*., it is not clear why the Provider failed to identify a single day at issue until more than 2 years after this appeal was filed and more than 5 years after the fiscal year at issue had closed); and (c) why the listing still was ***not*** a "*final*" listing at this late date.

3. Neither the Board Rules nor the July 15, 2021 Case Acknowledgment and Critical Due Dates permit the Provider to file a "Supplement" to its preliminary position paper (nor did the Provider allege in the "Supplement" filing that they do).

4. Given the fact that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the position paper filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its preliminary position paper or a supplement of documents that were identified in the preliminary position paper as being unavailable consistent with Board Rule 25.2.2. However, neither the preliminary position paper nor the alleged "Supplement" identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the alleged "Supplement" cannot be considered a refinement of the position paper since no specific days or listing were included with the preliminary position paper (indeed the *tentative* 3,360 days listed in the alleged "Supplement" is, without explanation, *exponentially* larger than the original estimated 100 days included with the appeal request).[29]

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[30] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provider the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary

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[29] *See, e.g.,* Board Rule 27.3 (Aug. 2018) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."
[30] (Emphasis added.)

evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[31]

* * * * *

Based on the foregoing, the Board has dismissed the two (2) remaining issues in this case – (Issues 1 and 5). As no issues remain, the Board hereby closes Case No. 21-1442 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:

6/13/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[31] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):
The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision* – DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**
Vista Medical Center East (Provider No. 14-0084)
FYE 11/30/2017
Case No. 22-0778

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. 22-0778*

On **August 19, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end November 30, 2017.

On **February 14, 2022**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained three (3) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – Medicaid Eligible Days

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, on **September 7, 2022**, the Provider transferred Issue 2 to Quorum Health groups. As a result, there are two (2) remaining issues in this appeal: Issue 1 (DSH Payment/SSI Percentage (Provider Specific)) and Issue 3 (DSH Payment – Medicaid Eligible Days).

On **February 14, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

[1] On September 7, 2022, this issue was transferred to PRRB Case No. 20-1339GC.

> 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 **October 11, 2022**, the Provider timely filed its preliminary position paper.

On **December 5, 2022**, the Medicare Administrative Contractor ("MAC") requested from the Provider all documentation necessary to resolve Issue 3 (DSH Payment – Medicaid Eligible Days).

On **January 23, 2023**, the MAC filed a Jurisdictional Challenge, requesting the dismissal of Issues 1 and 3. The Provider filed a Jurisdictional Response on **March 8, 2023,** after the 30-day deadline).

On **January 27, 2023**, the MAC timely filed its preliminary position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20-1339GC

In their Individual Appeal Request, the Provider summarizes the legal basis for its Issue 1: DSH Payment/SSI Percentage (Provider Specific), in part, as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[3]

Here it is important to note that the amount in controversy listed for both Issues 1 (Provider Specific) and Issue 2 (Systemic Errors) in the Provider's individual appeal request is $60,542. Additionally, the audit adjustment numbers and the tab references are also identical.

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[2] (Emphasis added).
[3] Issue Statement at 1 (Feb. 14, 2022).

The DSH/SSI Systemic Errors Group Issue Statement in Case No. 20-1339GC, Quorum Health CY 2017 DSH SSI Percentage CIRP Group, to which the Provider transferred Issue 2 (Systemic Errors), reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[4]

On October 11, 2022, the Provider filed its Preliminary Position Paper ("PPP"). The following is the entirety of Provider's position on Issue 1 set forth therein

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

[4] Group Issue Statement, Case No. 20-1339GC.

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

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

Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[5]

C. Description of Issue 3 in the Appeal Request

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

Statement of Issue

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

Statement of the Legal Basis

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

[5] Provider's Preliminary Position Paper at 8-9 (Oct. 11, 2022).

> unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 6,8,19,S-D
>
> Estimated Reimbursement Amount: $51,919[6]

In its Preliminary Position Paper, regarding the Medicaid eligible days issue, 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 1 – DSH Payment/SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. The MAC states that Provider's Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2. Further, the MAC argues that the portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[9]

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC contends that the Provider failed to properly develop its arguments within its preliminary position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25. The MAC argues the Provider has not submitted a Medicaid eligible days listing and therefore, requests the Board dismiss the issue.

Provider's Jurisdictional Response

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the MAC'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 January 23, 2023. The Provider filed a response on March 8, 2023, after the February 22, 2023 deadline. As a result of the late filing, the Board will not consider the Provider's Jurisdictional Response.

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[6] Appeal Request at Issue 3.
[7] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[8] Provider's Preliminary Position Paper at 7-8.
[9] MAC's Jurisdictional Challenge at 6-7 (Jan. 23, 2023).

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 MAC, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider's disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 20-1339GC.

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."[10] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the MAC "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[11] The Provider argues that "its'[sic] SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [MAC]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[12]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-1339GC also alleges that the MAC 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).

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to a single provider.[13] Rather, it applies to all SSI calculations. To this end,

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[10] Issue Statement at 1.
[11] *Id.*
[12] *Id.*
[13] 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).

the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, Provider's PPP does not explain how this argument is ***specific to this provider***. Instead, the PPP refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Furthermore, the Provider cites *Loma Linda Community Hospital* and alleges that "SSI entitlement of individuals can be ascertained from State records."[14] But the Provider fails to explain its alleged similarities to *Loma Linda Community Hospital* or how it can ascertain SSI entitlement from the state records.

In accordance with 42 C.F.R. § 405.1853(b), the commentary to Rule 23.3 (Aug. 29, 2018) explains that preliminary position papers must "be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." The commentary to Rule 25 also explicitly states, "preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline." Moreover, 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.[15]

In its PPP (filed on October 11, 2022), the Provider only cites to the 2000 Federal Register as the source for the MEDPAR data it claims it has yet to receive. 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*

[14] It is also not clear whether this is a systemic issue for CHS providers in the same state subject to the CIRP rules or something that is provider specific because, if it was a common systemic issue, it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

[15] (Emphasis added).

> *information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year.

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[16]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[17] The Provider's appeal is relative to FYE 2017.

Based on the foregoing, the Board finds that the Provider's *Preliminary Position Paper* failed to comply with Board Rules 23 and 25 (November 1, 2021) governing the content of position papers. The Board also finds that the Provider's *Preliminary Position Paper* failed to comply with Board Rule 25.2.2 by not addressing why the MEDPAR data for FYE 2017 was allegedly unavailable. Thus, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue No. 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 20-1339GC

Accordingly, *based on the record before it*, the Board finds that the SSI Provider Specific issue in the instant appeal and the group issue from Group Case 20-1339GC are the same issue.[18] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

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

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.

Pursuant to 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[.]" In this case, there is nothing in the record to indicate that a proper written realignment request was made by the Provider and that the MAC made a final determination regarding DSH SSI Percentage realignment from which the Provider can appeal. Moreover, an appeal before the Board may not be used a conduit for the MAC (the intermediary) nor for CMS. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

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

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[19]

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:

[19] Individual Appeal Request, Issue 3.

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

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

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

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

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[20]

[20] (Emphasis added).

Similarly, with regard to position papers,[21] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[22] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

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

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 February 14, 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.[24] ***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

[21] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[22] (Emphasis added).
[23] (Emphasis added).
[24] Provider's Preliminary Position Paper at 8.

those documents, as required by the regulations and the Board Rules.[25] Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 20-1339GC and because the purported realignment portion of the issue is premature in absence of a properly submitted written realignment request subject to a final determination from which the Provider can appeal. The Board also dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for submitting fully developed and complete position papers in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 22-0778 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:

6/13/2025

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Heather Mogden
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Milwaukee, WI 53202

RE: **Notice of Dismissal**
Hall Render DSH SSI Data Match RNPR CIRP and Optional Groups
Case Numbers: 25-0786GC *et al.* (7 Cases – *See* **Appendix A**)

Dear Ms. Mogden:

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the Common Interest Related Party ("CIRP") and Optional Group cases listed in **Appendix A**. The groups are appealing an SSI Data Matching issue from Revised Notices of Program Reimbursement ("RNPRs"). The decision of the Board to ***dismiss*** the appeals is set forth below.

Procedural history:

The Providers in these groups are appealing from RNPRs. The Providers acknowledge the RNPRs were "issued as a result of the June 9, 2023 Final Rule (88 Fed. Reg. 37772) and Change Request 13294 (Feb. 21, 2024).[1]

The Group Issue in these cases is related to "DSH SSI Data Match" and is described as follows:

> The failure of the Fiscal Intermediary and the Centers for Medicare and Medicaid Services (CMS) to properly determine the ratio of patient days for patients entitled to Medicare Part A and Supplemental Security Income (SSI) benefits (excluding any State supplementation) to patient days for patients entitled to Medicare Part A (Medicare Proxy or Fraction) for the Provider in its Disproportionate Share Hospital (DSH) eligibility determination and payment calculation, including any related impact on capital DSH. The Provider asserts that the Medicare Proxy is improperly understated due to a number of factors, including CMS's inaccurate and improper matching or use of data along with policy changes to determine both the number of Medicare Part A SSI patient days in the numerator of the fraction and the total Medicare Part A patient days in the denominator,

[1] *See, e.g.*, Case 25-0768GC, Provider Number 11-0129, Provider's Memorandum Regarding Notice of Reopening.

> as utilized in the calculation of the Medicare percentage of low income patients for purposes of DSH.[2]

The Providers note that the Board issued a decision in *Baystate* which identified flaws in the compilation of Medicare SSI days, and that this decision was upheld by the District Court for the District of Columbia in 2008. The Providers also explain that, in 2010, CMS issued Ruling 1498-R in response to the *Baystate* decision which sets forth a revised data match process, but that they believe errors still exist in this process, such as the failure to include all Dual Eligible patient days in the Medicare fraction numerator.[3]

Relevant Law:

A. RNPR Appeals

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2023), which provides in relevant part:

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

Additionally, 42 C.F.R. § 405.1889 (2023)[4] explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

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[2] *E.g.*, Case 25-0768GC, Issue Description for DSH SSI Data Match Issue.
[3] *Id.*
[4] *See also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

As outlined above, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[5]

B. Retroactive Part C Rule, Resulting RNPRs, and Associated Appeal Rights

i. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[6] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[7]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[8] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[9]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[10] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[11] The DPP is defined as the sum of two fractions expressed as percentages.[12] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

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

---

[5] 42 C.F.R. § 405.1889(b)(1).
[6] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[7] *Id.*
[8] *See* 42 U.S.C. § 1395ww(d)(5).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[12] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).

> denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[13]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[14]

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[15]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[16]

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

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

In the September 4, 1990 Federal Register, the Secretary[17] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it

[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(2)-(3).
[15] (Emphasis added.)
[16] 42 C.F.R. § 412.106(b)(4).
[17] of Health and Human Services.

> is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that are associated with Medicare patients. Therefore, since that time we have been including HMO days in SSI/Medicare percentage [of the DSH adjustment].[18]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[19]

With the creation of Medicare Part C in 1997,[20] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C, and following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[21] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[22] The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[23]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that

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[18] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[19] *Id.*
[20] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization has a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[21] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[22] *Id.*
[23] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).

proposal in the FY 2005 IPPS final rule.[24] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[25] In response to a comment regarding this change, the Secretary explained that:

> *. . . we do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[26]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[27] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[28] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[29]

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[24] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[25] 69 Fed Reg. 48916, 49099 (Aug. 11, 2004).
[26] *Id.* (emphasis added).
[27] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[28] *Id*. at 47411.
[29] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and

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

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[30] In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[31] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[32] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[33] However, the Secretary has not acquiesced to that decision.

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

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§ 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

[30] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).

[31] 746 F. 3d 1102 (D.C. Cir. 2014).

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

[33] *Id.* at 2011.

[34] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).

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

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

[37] 139 S. Ct. 1804 (2019).

[38] *Id.* at 1817.

proceedings consistent with [its] opinion."[39] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[40]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[41] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[42]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[43] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

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

[39] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[40] 139 S. Ct. at 1814.
[41] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[42] CMS Ruling 1739-R at 1-2.
[43] 88 Fed. Reg. 37772 (June 9, 2023).

> the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[44]

Finally, the following excerpts from the June 9, 2023 Final Rule discuss a hospital's right to challenge the Part C days policy adopted therein:

1. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[45]

2. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and ***will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary will likewise receive NPRs or revised NPRs reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and **the new or revised NPRs will provide hospitals with a vehicle to appeal the new final action *even if the Medicare fraction or DSH payment does not change numerically***."[46]

3. "When the Secretary's treatment of Part C days in this final action is reflected in NPRs and revised NPRs, providers, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], **will be able to challenge the agency's interpretation by appealing those NPRs and revised NPRs.** While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, **the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings.**"[47]

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

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

Decision of the Board:

42 C.F.R. § 405.1889 governs the scope of appeals once a contractor determination is "reopened as provided in § 405.1885[.]" In this circumstance, Providers have *limited* appeal rights and are only able to appeal issues or matters that were "specifically revised" in the RNPRs.

The appeal rights detailed in the June 9, 2023 Final Rule specifically limit a provider's appeal rights to specific matters related to the actual RNPR (*i.e.*, the Part C Days policy). First, the Secretary made clear that the Part C Days rule could be appealed following the issuance of a new NPR or RNPR "***even if the Medicare fraction or DSH payment does not change numerically.***"[48] Thus, the new rule could be appealed even if the treatment of Part C Days was not "specifically revised."

The appeal rights, however, are strictly limited to the policy related to the treatment of Part C days. Following the issuance of a RNPR, the Secretary stated that Providers "***will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions contained in the NPRs or revised NPRs***[,]" "**will be able to challenge the agency's interpretation** [of the treatment of Part C days in this final action] by appealing those NPRs and revised NPRs[,]" and further stated that they "**can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[49]

Conclusion:

The issue being appealed in the seven (7) cases listed in **Appendix A** is related to the data matching process used in calculating the Medicare Fraction. The appeals were taken from an RNPRs that were issued ***specifically*** to reflect and implement the treatment of Part C days as set forth in the June 23, 2023 Final Rule, but the Providers have not briefed any Part C Days issues. The RNPRs make no changes at all to the Provider's payment or cost report related to Dual Eligible Days in the Medicare Fraction. The Board finds that (1) the RNPRs did not "specifically revise" their SSI Fractions with regard to the data matching issue or any alleged failure to include Dual Eligible days and thus, pursuant to 42 C.F.R. § 405.1889(b)(1), that issue is beyond the scope of any appeal from the RNPRs, and (2) the only appeal rights afforded from the RNPRs as set forth in the June 23, 2023 Final Rule are to challenge the treatment of Part C Days in the RNPRs. Based on the foregoing, the Board hereby ***dismisses*** the seven (7) CIRP and optional group appeals listed in **Appendix A** and removes them from the Board's docket.

[48] *Id.* (emphasis added).
[49] *Id.* at 37787-88 (emphasis added).

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

Board Members:

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

For the Board:

6/16/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq. Federal Specialized Services
Cecile Huggins, Palmetto GBA (J-J)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Pamela VanArsdale, National Government Services, Inc. (J-6)

Appendix A
(7 Cases)

Case No.	Case Name
25-0768GC	Scion Health CY 2009 DSH SSI Data Match RNPR CIRP Group
25-1047GC	LifePoint Health CY 2013 DSH SSI Data Match RNPR CIRP Group
25-1050GC	Ascension Health CY 2012 DSH SSI Data Match RNPR CIRP Group
25-1074GC	LifePoint Health CY 2009 DSH SSI Data Match RNPR CIRP Group
25-1077GC	Ascension Health CY 2014 DSH SSI Data Match RNPR CIRP Group
25-1092G	Hall Render CY 2012 DSH SSI Data Match RNPR Group
25-1176G	Hall Render CY 2009 DSH SSI Data Match RNPR Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Heather Mogden
Hall, Render, Killian, Heath & Lyman, P.C.
330 E. Kilbourn Ave.
Suite 1250
Milwaukee, WI 53202

RE: **Notice of Dismissal**
Hall Render DSH Dual Eligible Days RNPR CIRP and Optional Groups
Case Numbers: 25-1319GC *et al.* (24 Cases – *See* **Appendix A**)

Dear Ms. Mogden:

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the Common Interest Related Party ("CIRP") and Optional Group cases listed in **Appendix A**. The groups are appealing a Dual Eligible Days issue from Revised Notices of Program Reimbursement ("RNPRs"). The decision of the Board to ***dismiss*** the appeals is set forth below.

Procedural history:

The Providers in these groups are appealing from RNPRs. The Providers acknowledge the RNPRs were "issued as a result of the June 9, 2023 Final Rule (88 Fed. Reg. 37772) and Change Request 13294 (Feb. 21, 2024).[1]

The Group Issue in these cases is related to "DSH SSI Ratio Dual Eligible Days" and is described as follows:

> Providers assert their Medicare Disproportionate Share Hospital (DSH) calculation was understated in the RNPRs because, in implementing the Final Rule described above, the Centers for Medicare & Medicaid Services (CMS) and the Medicare Administrative Contractor (MAC) failed to include, in the numerator of the Medicare Fraction, all days for patients who were eligible for and enrolled in the Supplemental Security Income (SSI) program but did not receive an SSI stipend for the month in which they received services from the Provider(s) ("SSI Eligible Days), as required by 42 U.S.C. § 1395ww(d)(5)(F).[2]

The Providers cite to the Supreme Court's decision in *Becerra v. Empire Health Foundation,* 597 U.S. 424 (2022). The Provider argues that "CMS and the MAC are required to count all SSI

[1] *See, e.g.*, Case 25-1319GC, Provider Number 52-0136, Provider's Memorandum Regarding Notice of Reopening.
[2] *E.g.*, Case 25-1319GC, Issue Description for DSH Dual Eligible Days Issue.

enrollees who meet basic SSI program eligibility requirements regardless of whether they received a monthly SSI stipend."[3] The Provider then quotes *Empire*, which states "individuals 'entitled to [Medicare Part A] benefits' are all those qualifying for the program, regardless of whether they are receiving Medicare payments for part or all of a hospital stay") and ("the stoppage of payment for any given service cannot be thought to affect the broader statutory entitlement…."). The Providers also "contend the same holds true with respect to entitlement to SSI benefits, and SSI Eligible Days should be included in the Medicare Fraction numerator."[4]

Relevant Law:

A. RNPR Appeals

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2023), which provides in relevant part:

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

Additionally, 42 C.F.R. § 405.1889 (2023)[5] explains the effect of a cost report revision:

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

[3] *Id.* at 3.
[4] *Id.*
[5] *See also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

As outlined above, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[6]

B. Retroactive Part C Rule, Resulting RNPRs, and Associated Appeal Rights

i. Medicare DSH Payment

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

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[9] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[10]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[11] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[12] The DPP is defined as the sum of two fractions expressed as percentages.[13] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

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

[6] 42 C.F.R. § 405.1889(b)(1).
[7] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[8] *Id.*
[9] *See* 42 U.S.C. § 1395ww(d)(5).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[12] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[13] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).

> days) were ***entitled to benefits under part A*** of this subchapter . . . .[14]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[15]

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[16]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[17]

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

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

In the September 4, 1990 Federal Register, the Secretary[18] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a

[14] (Emphasis added.)
[15] 42 C.F.R. § 412.106(b)(2)-(3).
[16] (Emphasis added.)
[17] 42 C.F.R. § 412.106(b)(4).
[18] of Health and Human Services.

> qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that are associated with Medicare patients. Therefore, since that time we have been including HMO days in SSI/Medicare percentage [of the DSH adjustment].[19]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[20]

With the creation of Medicare Part C in 1997,[21] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C, and following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[22] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[23] The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[24]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.[25] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42

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[19] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[20] *Id.*
[21] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization has a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[22] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[23] *Id.*
[24] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[25] 69 Fed. Reg. 28196, 28286 (May 18, 2004).

C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[26] In response to a comment regarding this change, the Secretary explained that:

> *. . . we do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[27]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[28] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[29] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[30]

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[26] 69 Fed Reg. 48916, 49099 (Aug. 11, 2004).
[27] *Id.* (emphasis added).
[28] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[29] *Id*. at 47411.
[30] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

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

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[31] In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[32] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[33] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[34] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[35] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.[36] A number of hospitals appealed this action.[37] In *Azar v. Allina Health Services* ("*Allina II*"),[38] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[39] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[40] The Supreme Court did not reach the question of

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[31] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[32] 746 F. 3d 1102 (D.C. Cir. 2014).
[33] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[34] *Id.* at 2011.
[35] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[36] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[37] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo**(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board, **pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[38] 139 S. Ct. 1804 (2019).
[39] *Id.* at 1817.
[40] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.

whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[41]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[42] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[43]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[44] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> ***The Ruling was not intended to cut off appeal rights and will not operate to do so***. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[45]

[41] 139 S. Ct. at 1814.
[42] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[43] CMS Ruling 1739-R at 1-2.
[44] 88 Fed. Reg. 37772 (June 9, 2023).
[45] 88 Fed. Reg. at 37788 (bold emphasis added).

Finally, the following excerpts from the June 9, 2023 Final Rule discuss a hospital's right to challenge the Part C days policy adopted therein:

1. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[46]

2. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and ***will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary will likewise receive NPRs or revised NPRs reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and **the new or revised NPRs will provide hospitals with a vehicle to appeal the new final action *even if the Medicare fraction or DSH payment does not change numerically***."[47]

3. "When the Secretary's treatment of Part C days in this final action is reflected in NPRs and revised NPRs, providers, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], **will be able to challenge the agency's interpretation by appealing those NPRs and revised NPRs.** While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, **the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings.**"[48]

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

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[46] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[47] *Id.* at 37788 (emphasis added).
[48] *Id.* (emphasis added).

Decision of the Board:

42 C.F.R. § 405.1889 governs the scope of appeals once a contractor determination is "reopened as provided in § 405.1885[.]" In this circumstance, Providers have *limited* appeal rights and are only able to appeal issues or matters that were "specifically revised" in the RNPRs.

The appeal rights detailed in the June 9, 2023 Final Rule specifically limit a provider's appeal rights to specific matters related to the actual RNPR (*i.e.*, the Part C Days policy). First, the Secretary made clear that the Part C Days rule could be appealed following the issuance of a new NPR or RNPR "***even if the Medicare fraction or DSH payment does not change numerically.***"[49] Thus, the new rule could be appealed even if the treatment of Part C Days was not "specifically revised."

The appeal rights, however, are strictly limited to the policy related to the treatment of Part C days. Following the issuance of a RNPR, the Secretary stated that Providers "***will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions contained in the NPRs or revised NPRs***[,]" "**will be able to challenge the agency's interpretation** [of the treatment of Part C days in this final action] by appealing those NPRs and revised NPRs[,]" and further stated that they "**can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[50]

Conclusion:

The issue being appealed in the twenty-four (24) cases listed in **Appendix A** is related to Dual Eligible Days in the Medicare Fraction. The appeals were taken from RNPRs that were issued specifically to reflect and implement the treatment of Part C days as set forth in the June 23, 2023 Final Rule, but the Providers have not briefed any Part C Days issues. The RNPRs make no changes at all to the Provider's payment or cost report related to Dual Eligible Days in the Medicare Fraction. The Board finds that (1) the RNPRs did not "specifically revise" Dual Eligible Days and thus, pursuant to 42 C.F.R. § 405.1889(b)(1), that issue is beyond the scope of any appeal from the RNPRs, and (2) the only appeal rights afforded from the RNPRs as set forth in the June 23, 2023 Final Rule are to challenge the treatment of Part C Days in the RNPRs. Based on the foregoing, the Board hereby ***dismisses*** the twenty-four (24) CIRP and optional group appeals listed in **Appendix A** and removes them 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.

[49] *Id.* (emphasis added).
[50] *Id.* at 37787-88 (emphasis added).

Board Members:

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

For the Board:

6/16/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq. Federal Specialized Services
Cecile Huggins, Palmetto GBA (J-J)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Judith Cummings, CGS Administrators (J-15)
Pamela VanArsdale, National Government Services, Inc. (J-6)

Appendix A
(24 Cases)

Case No.	Case Name
25-1319GC	Ascension Health CY 2011 DSH Dual Eligible Days RNPR CIRP Group
25-1680GC	St. Elizabeth Healthcare CY 2010 DSH Dual Eligible Days RNPR CIRP Group
25-1682GC	LifePoint Health CY 2014 DSH Dual Eligible Days RNPR CIRP Group
25-1133GC	Valley Health CY 2013 DSH Dual Eligible Days RNPR CIRP Group
25-1175G	Hall Render CY 2009 DSH Dual Eligible Days RNPR Group
25-0767GC	Scion Health CY 2009 DSH Dual Eligible Days RNPR CIRP Group
25-1048GC	LifePoint Health CY 2013 DSH Dual Eligible Days RNPR CIRP Group
25-1049GC	Ascension Health CY 2012 DSH Dual Eligible Days RNPR CIRP Group
25-1073GC	LifePoint Health CY 2009 DSH Dual Eligible Days RNPR CIRP Group
25-1076GC	Ascension Health CY 2014 DSH Dual Eligible Days RNPR CIRP Group
25-1081G	Hall Render CY 2012 DSH Dual Eligible Days RNPR Group
25-1262GC	LifePoint Health CY 2010 DSH Dual Eligible Days RNPR CIRP Group
25-1277GC	St. Elizabeth Healthcare CY 2013 DSH Dual Eligible Days RNPR CIRP Group
25-1279GC	Premier Health Partners CY 2012 DSH Dual Eligible Days RNPR CIRP Group
25-1280GC	Premier Health Partners CY 2010 DSH Dual Eligible Days RNPR CIRP Group
25-1314GC	Premier Health Partners CY 2009 DSH Dual Eligible Days RNPR CIRP Group
25-1315GC	St. Elizabeth Healthcare CY 2008 DSH Dual Eligible Days RNPR CIRP Group
25-1317GC	Premier Health Partners CY 2011 DSH Dual Eligible Days RNPR CIRP Group
25-1415GC	St. Elizabeth Healthcare CY 2009 DSH Dual Eligible Days RNPR CIRP Group
25-1498GC	Aultman Health CY 2011 DSH Dual Eligible Days RNPR CIRP Group
25-1500GC	Aultman Health CY 2012 DSH Dual Eligible Days RNPR CIRP Group
25-1507GC	LifePoint Health CY 2011 DSH Dual Eligible Days RNPR CIRP Group
25-1508GC	LifePoint Health CY 2012 DSH Dual Eligible Days RNPR CIRP Group
25-1674GC	Ascension Health CY 2010 DSH Dual Eligible Days RNPR CIRP Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Expedited Judicial Review Determination***
Univ of Rochester CY 2013 Post-Allina II Medicare Part C Days CIRP Group
Case Number: 25-3902GC

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's Petition for Expedited Judicial Review ("EJR") filed on May 23, 2025 in the above-referenced group appeal. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

On March 19, 2025, the Board received a request to establish a group appeal and both of the participants were directly added the same day. The two Providers are appealing from original Notices of Program Reimbursement ("NPRs") dated September 24 and 25, 2024, which implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Providers' fiscal years ended ("FYE") 12/31/2013.

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

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] Appeal Request, Statement of Group Issue at 1 (Mar. 19, 2025).

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[3] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4]

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[10]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[11]

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

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not*** ***entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[12]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[13]

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

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

In the September 4, 1990 Federal Register, the Secretary[14] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[15]

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

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[16]

With the creation of Medicare Part C in 1997,[17] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C, and following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[18] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[19] The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[20]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.[21] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[22] In response to a comment regarding this change, the Secretary explained that:

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

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

> *associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[23]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[24] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[25] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[26]

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

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[27] In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[28] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005

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

IPPS rule.[29] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[30] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[31] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.[32] A number of hospitals appealed this action.[33] In *Azar v. Allina Health Services* ("*Allina II*"),[34] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[35] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[36] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[37]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[38] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding

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[29] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[30] *Id.* at 2011.
[31] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[32] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[33] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo****(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board,* ***pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[34] 139 S.Ct. 1804 (2019).
[35] *Id.* at 1817.
[36] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[37] 139 S.Ct. at 1814.
[38] 85 Fed. Reg. 47723 (Aug. 6, 2020).

> the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[39]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[40] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[41]

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

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

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

*fractions for **each** applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[42]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[43]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions **contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised **NPRs** will provide hospitals with a **vehicle to appeal** the new final action* even if the Medicare fraction or DSH payment does not change numerically."[44]

4. "*When the Secretary's treatment of Part C days in this final action is reflected **in NPRs and revised NPRs**, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation **by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[45]

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

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[42] 88 Fed. Reg. at 37774-75 (emphasis added).
[43] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[44] *Id.* at 37788 (emphasis added).
[45] *Id.* (emphasis added).

Providers' Position:

A. Providers' Appeal Request

The Providers' appeal requests include a "Statement of Jurisdiction" asserting that the Provider has met the applicable statutory conditions for appeal because it is dissatisfied with its NPR which applies the June 9, 2023 retroactive final rule related to Part C days. It cites language from that final rule which outlined Providers' ability to challenge this final rule once they were issued NPRs implementing the rule.[46]

The "Statement of Group Issue" included with the appeal request states that the issue concerns the proper treatment in the Medicare DSH calculation of days for Medicare Part C patients in the aftermath of the *Allina II* litigation. The Provider contends that the Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.[47]

The Provider characterized the relevant background facts as follows:

1. In the FY 2005 IPPS Final Rule, CMS first announced a policy change to count Part C days in the SSI fraction and to exclude those days from the numerator of the Medicaid fraction.[48]

2. In *Allina I*, the D.C. Circuit vacated that policy change.[49]

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that "the Secretary's continued application of the same [Part C days policy] from the [FY 2005 IPPS Final Rule] in 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to engage in notice-and-comment rulemaking to adopt the 2004 standard. The Supreme Court's decision did not address the D.C. Circuit's alternate ruling that the readopted policy was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the policy could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[50]

4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.[51]

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

[46] Appeal Request, Statement of Jurisdiction (citations omitted).
[47] Appeal Request, Statement of Group Issue at 1.
[48] *Id.*
[49] *Id.*
[50] *Id.* (citing to 139 S. Ct. 1804 (2019) at 1810-1815, 1816).
[51] *Id.*

agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[52]

B. Providers' Petition for EJR

The Providers have requested EJR over the "post-*Allina* retroactive Part C policy issue" because they believe they have met the requirements for a hearing before the Board, but the Board lacks the authority to decide the substantive and procedural validity of CMS' final rule published in the Federal Register on June 9, 2023.[53] They seek a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.[54] The Providers state that they "contend that the new, post-*Allina* retroactive part C days rule, applied in the original [NPRs] appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[55] Since the Board is bound by this regulation,[56] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

On May 28, 2025, the Medicare Contractor's representative, Federal Specialized Services, filed a response to the Request for EJR simply advising that "a jurisdictional challenge will not be filed. A substantive claim challenge will not be filed. The MAC will not challenge Provider's request for expedited judicial review."

Decision of the Board:

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

A. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;

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[52] *Id.* (citing 5 U.S.C. § 706(2)).
[53] Providers' Petition for Expedited Judicial Review at 13 (May 23, 2025).
[54] *Id.* at 16.
[55] *Id.* at 1-2.
[56] 42 C.F.R. § 405.1867.

- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [57]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[58]

Both Providers in this group appeal appealed from original NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. The Providers appealed within 180 days of the issuance of their NPRs and the amount in controversy exceeds $50,000.

The Board finds that the Providers have filed timely appeals from their original NPRs concerning the issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these NPRs. The Board also finds that the amount in controversy exceeds $50,000 as required by 42 C.F.R. § 405.1839(b)(1). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

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

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

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

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

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[57] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[58] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.

Accordingly, the Board finds that the question of the validity of the Part C Days policy issue, as adopted in the June 9, 2023 Final Rule, properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request 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 no additional issues remain in this case, the Board will close the case and remove it from the Board's docket.

Board Members Participating:

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

FOR THE BOARD:

6/16/2025

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Nathan Summar
Community Health Systems, Inc.
4000 Meridian Boulevard
Franklin, TN 37067

Byron Lamprecht
WPS Government Health Administrators
1000 N 90th Street, Suite 302
Omaha, NE 68114

RE: ***Board Decision*** **– DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**
Laredo Medical Center (Provider No. 45-0029)
FYE 09/30/2016
Case No. 21-0279

Dear Mr. Summar 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. 21-0279***

On **April 1, 2020**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2016.

On **September 28, 2020**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained four (4) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – Medicaid Eligible Days
4. 2 Midnight Census IPPS Payment Reduction[2]

The Provider is commonly owned/controlled by Community Health Systems, Inc. (hereinafter "CHS") and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **April 27, 2021**, the Provider transferred Issue 2 to Community Health groups. After the withdrawal of Issue 4, there are two (2) remaining issues in this appeal: Issue 1 (DSH Payment/SSI Percentage (Provider Specific)) and Issue 3 (DSH Payment – Medicaid Eligible Days).

[1] On April 27, 2021, this issue was transferred to PRRB Case No. 19-1409GC.
[2] This issue was withdrawn on May 10, 2021.

On **November 24, 2020**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[3]

On **May 10, 2021**, the Provider timely filed its preliminary position paper.

On **August 25, 2021**, the Medicare Administrative Contractor ("MAC") filed a jurisdictional challenge, requesting the dismissal of Issue 1. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **September 8, 2021**, the MAC timely filed its preliminary position paper.

On **January 5, 2023**, the MAC filed its 3rd and Final Request for DSH Package in connection with Issue 3. In this filing, the MAC noted that, on February 3, 2021 (1st request) and April 23, 2021 (2nd request), it had previously requested that the Provider send it a DSH package to resolve Issue 3. As no response was received, the MAC formally filed the 3rd and Final Request for DSH Package to formally request that a listing of the Medicaid eligible days at issue plus supporting documentation be provided to the MAC on or before February 4, 2023 (*i.e.*, within 30 days). Notwithstanding the formal request, the Provider failed to file any response to the MAC.

As no response was received from the Provider, on **August 17, 2023**, the MAC filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to furnish documentation in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); (2) the Provider failed to furnish the Medicaid eligible days listing with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2; and (3) the Provider has effectively abandoned Issue 3. Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** timely respond to that Motion.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-1409GC

[3] (Emphasis added).

In their Individual Appeal Request, the Provider summarizes the legal basis for its Issue 1: DSH Payment/SSI Percentage (Provider Specific), in part, as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[4]

Here it is important to note that the amount in controversy listed for both Issues 1 (Provider Specific) and Issue 2 (Systemic Errors) in the Provider's individual appeal request is $75,000. Additionally, the audit adjustment numbers, and the tab references are also identical.

The DSH/SSI Systemic Errors Group Issue Statement in Case No. 19-1409GC, CHS CY 2016 DSH SSI Percentage CIRP Group, to which the Provider transferred Issue 2 (Systemic Errors), reads, in part:

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

[4] Issue Statement at 1 (Sept. 28, 2020).

> their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[5]

On May 10, 2021, the Provider filed its Preliminary Position Paper ("PPP"). The following is the entirety of Provider's position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Texas and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Texas and has learned that similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, 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. *See* 65 Fed. Reg. 50,548 (2000). 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.[6]

[5] Group Issue Statement, Case No. 19-1409GC.
[6] Provider's Preliminary Position Paper at 8-9 (May 10, 2021).

C. Description of Issue 3 in the Appeal Request

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

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the 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): 10,21,22,S-D
>
> Estimated Reimbursement Amount: $19,000[7]

Regarding the Medicaid eligible days issue, in its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[8] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[9]

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue for three reasons. First, the MAC argues that the SSI realignment portion of the issue has been abandoned by the Provider because it failed to brief the issue in its PPP. Second, the MAC questions the Provider's preservation realignment rights when the Provider's cost

[7] Appeal Request at Issue 3.
[8] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[9] Provider's Preliminary Position Paper at 7-8.

reporting year end is identical to the federal fiscal year end.[10] Third, notwithstanding the foregoing, the MAC argues the realignment sub-issue is premature because the hospital has yet to formally request realignment of its SSI percentage, and such an election is not a final intermediary determination ripe for appeal.[11]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[12]

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC contends that the Provider failed to properly develop its arguments within its preliminary position paper in accordance with Board Rules 7, 25.2.1 and 25.2.2. The MAC argues the Provider has not submitted a Medicaid eligible days listing and therefore, requests the Board dismiss the issue.

Provider's Response

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the MAC'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] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed.

Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party." [14] The Provider failed to timely file a response.

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 MAC, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

A. DSH Payment/SSI Percentage (Provider Specific)

[10] Jurisdictional Challenge at 6 (June 7, 2023).
[11] *Id*. at 6-7.
[12] *Id*. at 4-6.
[13] Board Rule 44.4.3, v. 2.0 (Aug. 2018).
[14] Board Rules, v. 3.1 (Nov. 2021).

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider's disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 19-1409GC.

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."[15] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the MAC "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[16] The Provider argues that "its'[sic] SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [MAC]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[17]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 19-1409GC also alleges that the MAC and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F).

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to a single provider.[18] Rather, it applies to all SSI calculations. To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, Provider's PPP does not explain how this argument is ***specific to this provider***. Instead, the PPP refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Furthermore, the Provider cites *Loma Linda Community Hospital* and alleges that "SSI entitlement of individuals can be ascertained from State records."[19] But the Provider fails to explain its alleged similarities to *Loma Linda Community Hospital* or how it can ascertain SSI entitlement from the state records.

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[15] Issue Statement at 1.
[16] *Id.*
[17] *Id.*
[18] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[19] It is also not clear whether this is a systemic issue for CHS providers in the same state subject to the CIRP rules or something that is provider specific because, if it was a common systemic issue, it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

In accordance with 42 C.F.R. § 405.1853(b), the commentary to Rule 23.3 (Aug. 29, 2018) explains that preliminary position papers must "be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." The commentary to Rule 25 also explicitly states, "preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline." Moreover, Board Rule 25.2.2 specifies:

> **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.[20]

In its PPP (filed on May 10, 2021), the Provider only cites to the 2000 Federal Register as the source for the MEDPAR data it claims it has yet to receive. But additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have since occurred. For example, as noted in the FY 2006 IPPS Final Rule:

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

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

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[20] (Emphasis added).

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[21]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[22] The Provider's appeal is relative to FYE 2016.

Based on the foregoing, the Board finds that the Provider's *Preliminary Position Paper* failed to comply with Board Rules 23 and 25 (November 1, 2021) governing the content of position papers. The Board also finds that the Provider's *Preliminary Position Paper* failed to comply with Board Rule 25.2.2 by not addressing why the MEDPAR data for FYE 2017 was allegedly unavailable. Thus, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue No. 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 19-1409GC.

Accordingly, *based on the record before it*, the Board finds that the SSI Provider Specific issue in the instant appeal and the group issue from Group Case 19-1409GC are the same issue.[23] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

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.

Pursuant to 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[.]" In this case, there is nothing in the record indicating that a proper written realignment request was made by the Provider and that the MAC made a final determination regarding DSH SSI Percentage realignment from which the Provider can appeal. Moreover, an appeal before the Board may not be used a conduit for the MAC (the intermediary) nor for CMS. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

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

B. DSH Payment – Medicaid Eligible Days

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

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[24]

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

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

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

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

[24] Individual Appeal Request, Issue 3.

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

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[25]

Similarly, with regard to position papers,[26] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[27] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 (August 29, 2018) provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> If documents necessary to support your position are still unavailable, *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.[28]

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

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

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

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

This appeal was initiated on September 28, 2020 (nearly 5 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.[29] ***To-date, no listing has been provided—even after the MAC requested the listing on three (3) occasions***. Accordingly, the Provider has abandoned the issue by failing to properly develop its arguments and provide supporting documents, and by failing to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[30] Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board takes administrative notice that it has made similar dismissal in other cases involving CHS providers.[31]

****

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. 19-1409GC and because the purported realignment portion of the issue is premature in absence of a properly submitted written realignment request subject to a final determination from which the Provider can appeal. The Board also dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to

[29] Provider's Preliminary Position Paper at 8.
[30] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.
[31] An example of a CHS individual provider case in which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

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. 21-0279 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

6/16/2025

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision* – Medicaid Eligible Days Issue**
Tennova Healthcare – Cleveland (Provider No. 44-0185)
FYE 08/31/2017
Case No. 21-0404

Dear Mr. Ravindran and Mr. Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed and GRANTS the *Motion to Dismiss* filed on May 4, 2025, in the above referenced appeal. The decision of the Board is set forth below.

Background:

A. *Procedural History for Case No. 21-0404*

On **June 24, 2020**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end August 31, 2017.

On **December 11, 2020**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained three (3) issues:

1. DSH Payment/SSI Percentage (Provider Specific)[1]
2. DSH/SSI Percentage (Systemic Errors)[2]
3. DSH Payment – Medicaid Eligible Days

The Provider is commonly owned/controlled by Community Health Systems, Inc. (hereinafter "CHS") and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **July 26, 2021**, the Provider transferred Issue 2 to a Community Health group. After the dismissal of Issue 1, there is one (1) remaining issue in this appeal: Issue 3 (DSH Payment – Medicaid Eligible Days).

[1] On April 25, 2025, this issue was dismissed by the Board.
[2] On July 26, 2021, this issue was transferred to PRRB Case No. 20-0997GC.

On **December 22, 2020**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[3]

On **July 26, 2021**, the Medicare Administrative Contractor ("MAC") requested from the Provider all documentation necessary to resolve Issue 3 (DSH Payment – Medicaid Eligible Days).

On **September 1, 2021**, the Provider timely filed its preliminary position paper.

On **November 19, 2021**, the MAC timely filed its preliminary position paper.

On **January 12, 2023**, the MAC requested for the second and final time from the Provider all documentation necessary to resolve Issue 3 (DSH Payment – Medicaid Eligible Days).

On **January 31, 2025**, the Board issued the Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

> Provider's Final Position Paper – *For each remaining issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *also include* ***any exhibits*** *the Provider will use to support to support its position*. *See* Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.[4]

On **March 7, 2025**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **May 4, 2025**, the MAC filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to furnish documentation in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); (2) the

[3] (Emphasis added).
[4] (Emphasis added.)

Provider failed to furnish the Medicaid eligible days listing with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2; and (3) the Provider has effectively abandoned Issue 3. Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** timely respond to that Motion.

B. Description of Issue 3 in the Appeal Request

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

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 5,17,18,S-D
>
> Estimated Reimbursement Amount: $46,000[5]

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

MAC's Contentions

Issue 3 – DSH Payment – Medicaid Eligible Days

[5] Appeal Request at Issue 3.
[6] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[7] Provider's Preliminary Position Paper at 7-8 (Sept. 1, 2021).

In its *Motion to Dismiss*, the MAC requests that the Board find the Provider abandoned the DSH – Medicaid Eligible Days issue because: 1) the Provider's PPP failed to specify the number of additional Medicaid Eligible Days that were excluded by the MAC; and 2) the Provider has failed to respond to the MAC's prior requests for documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable.

Provider's Response

Board Rule 44.3 specifies: "Unless the Board imposes a different deadline, an opposing party may file a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party." To date, the Provider has failed to respond to the *Motion to Dismiss* and the time for doing so has elapsed.

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the MAC, 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.

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

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after

> the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[8]

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) 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) provides:

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

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

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Furthermore, 42 C.F.R. § 405.1853(b) addresses position papers and states 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

[8] Individual Appeal Request, Issue 3.

> accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[9]

Similarly, with regard to position papers,[10] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[11] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, ***promptly*** forward them to the Board and the opposing party.[12]

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

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

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

This appeal was initiated on December 11, 2020 (over 4 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expect to be included in their

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

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.[13] ***To-date, no listing has been provided—even after the MAC requested the listing on two (2) occasions***. Accordingly, the Provider has abandoned the issue by failing to properly develop its arguments and provide supporting documents, and by failing to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[14] Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board takes administrative notice that it has made similar dismissal in other cases involving CHS providers.[15]

****

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. 21-0404 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:

6/16/2025

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

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

[13] Provider's Preliminary Position Paper at 8.
[14] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.
[15] An example of a CHS individual provider case in which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Tennova Healthcare - Clarksville, Prov. No. 44-0035, FYE 09/30/2015
Case No. 19-2248

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-2248. 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. 19-2248*

On **January 29, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2015.

On **July 12, 2019**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. DSH – SSI Income Percentage (Provider Specific)
2. DSH – SSI Income Percentage
3. DSH - Medicaid Eligible Days
4. Uncompensated Care ("UCC") Distribution Pool
5. 2 Midnight Census IPPS Payment Reduction

The Provider is commonly owned/controlled by Community Health Systems, Inc. (hereinafter "CHS") and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **February 24, 2020**, the Provider transferred Issues 2, 4 and 5 to various CHS CIRP groups.

On **July 17, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[1]

On **March 5, 2020**, the Provider timely filed its preliminary position paper.

On **June 30, 2020**, the Medicare Contractor filed its preliminary position paper. Regarding Issue #3, the Medicare Contractor's position paper noted that the Provider failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position. *The Medicare Contractor also briefed the SSI (Provider Specific) (#1) issue- which was subsequently withdrawn on February 5, 2025*.

On **June 3, 2024**, the Board issued a Notice of Hearing scheduling a hearing date for February 17, 2025, and setting final position paper deadlines. (***On February 10, 2025, the hearing was rescheduled to April 16, 2025. On April 11, 2025, the hearing was again rescheduled – and is currently set for July 9, 2025.)***

On **November 19, 2024**, CHS timely filed its final position paper, briefing the last two remaining issues: SSI Provider Specific and Medicaid Eligible days.

On **December 2, 2024,** QRS became the authorized Representative in Case No. 19-2248. *On the same date, QRS filed a redacted copy of the additional Medicaid Eligible Days listing in the Office of Hearings Case & Document Management System ("OH CDMS") showing 1652 days.*

On **December 12, 2024**, FSS timely filed a final position paper on behalf of the Medicare Contractor. FSS argued that the Provider improperly added the "Section 1115 waiver days" issue by briefing it with the eligible days issue in the final position paper. In addition, the MAC noted that only a redacted listing of Medicaid eligible days pending finalization was submitted by the Provider as an exhibit to its final position paper. The Medicare Contractor claimed that, to date, it had not received an auditable listing. Consequently, FSS requested the dismissal of the Medicaid Eligible Days issue.

On **December 13, 2024**, Federal Specialized Service ("FSS") filed a formal jurisdictional challenge on behalf of the Medicare Contractor, in which it challenged the last two issues in the appeal: SSI Income Percentage (Provider Specific) and Medicaid Eligible Days.[2]

---

[1] (Emphasis added.)
[2] SSI Income Percentage (Provider Specific) issue (#1) was subsequently withdrawn by QRS on February 5, 2025.

On **December 23, 2024**, QRS filed a response to the jurisdictional challenge.

On **February 5, 2025**, QRS withdrew Issue 1 – SSI Percentage (Provider Specific) leaving ME days as the final remaining issue.

MAC's Contentions:

Issue 3 – DSH Payment – Medicaid Eligible Days[3]

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 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 position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.
>
> Within its preliminary position paper, the Provider makes the broad allegation, ". . . the Provider contends that the total number of days reflected in its' [sic] 2015 cost report does not reflect an accurate number of Medicaid eligible days . . .". The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue.[4]

Section 1115 Waiver Days

Additionally, the Medicare Contractor contends the Provider is attempting to untimely add the section 1115 Waiver Days issue as a sub-issue via its final position paper filed on November 19, 2024.[5] The Provider originally characterized the Medicaid Eligible Days issue in its initial appeal request using the following language:

> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after

[3] Since the SSI Provider Specific issue was withdrawn, only the Medicaid Eligible Days issue will be addressed.
[4] Jurisdictional Challenge at 13-14 (Dec. 13, 2024).
[5] Medicare Contractor's Jurisdictional Challenge at 15-19 (dated Dec. 13, 2024 but uploaded into OH CDMS on Dec. 23, 2024).

> the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.

Neither the appeal request, nor the preliminary position paper, identified or mentioned the Section 1115 waiver days issue. It was not until the final position paper was filed that the Provider raised the issue – which was more than four and a half years after the regulatory deadline to add a new issue to the case. Therefore, the MAC contends that the Section 1115 waiver days issue should be dismissed on the grounds that it was untimely and improperly added to the case.

Provider's Jurisdictional Response

The Representative argued that based on the Rules in effect at the time of this appeal (version 2.0 (8/29/2018), ". . . a Final Position Paper is required for appeals filed prior to the effective date of Version 2.0." Therefore, it was the Provider's understanding that the deadline for the Medicaid Eligible Days listing was the Final Position Paper deadline.

With regard to the MAC's claim regarding the untimely addition of the section 1115 waiver days issue, QRS contends that this issue was addressed in the Provider's July 12, 2019 appeal request based on the part of the issue statement which stated:

> 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.

QRS contends that the phrase "including but not limited to" makes it clear that all Medicaid eligible days, including section 1115 waiver days were appealed.

With regard to the Medicare Contractor's argument claiming the section 1115 waiver days issue was abandoned as it was not briefed in the preliminary position paper, QRS argues that the ". . . the Fifth Circuit ruled that the statute and CMS's own regulations require that CMS regard inpatient days attributable to an uncompensated care pool population as Medicaid eligible days. *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019)." Based on this Court case, QRS contends that the Medicare Contractor ". . . is required by specific command of CMS to accept and audit the Provider's section 1115 waiver days."[6]

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is

[6] Jurisdictional Responsive Brief at 5 (Dec. 23, 2024).

$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 appeal in either the initial appeal or the preliminary position papers.

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

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

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

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

[7] (Bold emphasis added.)

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

Rule 25 Preliminary Position Papers[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.

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

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 17, 2019 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's preliminary position paper consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

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

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this

> paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[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 March 5, 2020, the Provider filed its preliminary position paper in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[10] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $24,930 based on an estimated 50 days). The Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir.

[9] (Emphasis added.)
[10] Provider's Preliminary Position Paper at 8.

> 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' 2015 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its December 13, 2024 Jurisdictional Challenge, the Medicare Contractor requested dismissal of the Medicaid Eligible Days issue because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish an unredacted, auditable list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2. The Medicare Contractor thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the Board Rules.[11]

[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.

In addition, the Medicare Contractor argued the Provider was attempting to untimely and improperly add the Section 1115 waiver days issue by including it in its final position paper submission.

On November 19, 2024 (over four years after the preliminary position paper deadline), as an exhibit to its final position paper, CHS filed a Redacted Medicaid Eligible Days Listing. The 14-page exhibit, showing 1658 Medicaid eligible days, included the caveat that the "Listing [is] pending finalization upon receipt of State eligibility data."

On December 2, 2024, after being appointed the group representative in Case No. 19-2248, QRS uploaded another copy of a Redacted Medicaid Eligible Days listing. QRS' 12-page version did not include the caveat and showed 1652 Medicaid Eligible Days. Neither the CHS, nor the QRS, listings explained why so many days (*over 1650*) were being submitted at this late date or why, in the case of CHS, it was not final (*i.e.*, why it was "pending finalization"), even though it was being filed ***more than 9 years after the fiscal year at issue had closed***. NOTE—the *1650+* days included in these belated listings are *significantly* larger than the original estimate of 50 days included with the appeal request. Regardless, these filings ***were more than 4 years past the deadline for including it with the Provider's preliminary position paper*** for which the deadline was March 8, 2020.

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

The Board rejects the Provider's attempts to include the Eligible days listing submitted as an exhibit to its November 19, 2024 final position paper and the subsequent upload to OH CDMS on December 2, 2024 because:

1. The exhibit and subsequent upload were filed ***over 4 years*** *after the deadline* for the exhibits to be included with the preliminary position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)).

2. The position paper exhibit (and subsequent uploaded exhibit) fail to explain the following critical information: (a) *why* they were being filed so late (*i.e.*, upon what basis or authority should the Board accept the late filing); (b) *why* the listings of the roughly 1650+ days were not previously available, *in whole or in part* (*i.e.*, it is not clear why the Provider failed to identify a single day at issue until nearly 5 years after this appeal was

filed and more than 9 years after the fiscal year at issue had closed); and (c) why the CHS listing still was ***not*** a "*final*" listing at this late date.

3. Neither the Board Rules nor the July 17, 2019 Case Acknowledgment and Critical Due Dates notice permit the Provider to file a "Supplement" to its preliminary position paper (nor did the Provider allege in the exhibit to the final position paper, or the subsequent 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 preliminary position paper filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its preliminary position paper or a supplement of documents that were identified in the preliminary position paper as being unavailable consistent with Board Rule 25.2.2. However, neither the preliminary position paper, the final position paper exhibit, nor the subsequent listing uploaded by QRS, identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the final position paper exhibit (and additional QRS upload) cannot be considered a refinement of the preliminary position paper since no specific days or listing were included with the preliminary position paper (indeed the *tentative* 1652 - 1658 days listed in the late exhibits are, without explanation, *significantly* larger than the original estimated 50 days included with the appeal request).[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 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. 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 July of 2019 and the regulations required the following:

---

[12] *See, e.g.,* Board Rule 27.3 (Aug. 2018) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."
[13] (Emphasis added.)

> (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 (2018) elaborated on this regulatory requirement, instructing providers:

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

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

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

Effective August 21, 2008, following the appropriate notice and comment period, new Board

[14] 42 C.F.R. § 405.1835(b).
[15] (Bold and italic emphasis added).

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 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 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.

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

> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.**
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the Section 1115 waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The DSH Medicaid Eligible Days issue as stated in the original appeal request cannot be construed to include Section 1115 waiver days. Additionally, there is no indication that any 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 preliminary position paper filing. First, the Provider's preliminary position paper does not even mention Section 1115 waiver days (much less identify the specific 1115 waiver day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Aug. 2018). As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 waiver days sub-issue.

Finally, even in the Provider's final position paper, the Provider fails to identify what Section 1115 waiver program(s) are involved and whether or not the Section 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(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 cursory conclusions.[18] Again, the Provider failed to so develop its position paper notwithstanding 42

[18] For example, CHS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that "the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." However, CHS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is

C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Aug. 2018) as applied via Board Rule 27.2.

The Board's finding that neither the appeal request nor the final 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*.[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 3). As no issues remain, the Board hereby closes Case No. 19-2248 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:

6/17/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Cecile Huggins, Palmetto GBA (J-J)
Wilson Leong, FSS

CHS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that in *Forrest General Hosp.*? CHS fails to brief the merits of its claims and fails to establish the Board's jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the final position paper 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.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

John Traverso
Hartford HealthCare
181 Patricia M. Genova Drive
Newington, CT 06111-1500

RE: ***Notice of Dismissal***
The Hospital of Central Connecticut (Provider Number 07-0035)
FYE: 9/30/2016
Case Number: 21-0079

Dear Mr. Traverso:

The Provider Reimbursement Review Board ("Board" or "PRRB") received The Hospital of Central Connecticut's ("Provider") Individual Appeal Request on **April 17, 2020**, appealing from a Notice of Program Reimbursement ("NPR") dated **October 24, 2019**. The appeal request contained eleven (11) issues:

1. DSH/SSI Percentage (Provider Specific)
2. DSH/SSI – ***transferred on December 3, 2020***
3. DSH/SSI Fraction Medicare Managed Care Part C Days – ***transferred on December 3, 2020***
4. DSH/SSI Fraction Dual Eligible Days – ***transferred on December 3, 2020***
5. DSH/Medicaid Eligible Days
6. DSH/Medicaid Fraction Medicare Managed Care Part C Days – ***transferred on December 3, 2020***
7. DSH/Medicaid Fraction Dual Eligible Days – ***transferred on December 3, 2020***
8. Medicaid Eligibility Patient Days - CT State Admin Gen Asst – ***withdrawn April 1, 2021***
9. Uncompensated Care ("UCC") Distribution Pool – ***withdrawn December 9, 2020***
10. 2 Midnight Census IPPS Payment Reduction – ***transferred on December 3, 2020***
11. Standardized Payment Amount – ***transferred on December 3, 2020***

The Board received the Provider's Preliminary Position Paper ("PPP") on **February 9, 2021**, and the Medicare Contractor's PPP on **May 28, 2021**. A notice of Hearing was issued on **December 6, 2024**, which set a hearing date for **June 26, 2025**.

On **May 21, 2025**, the Board Advisor assigned to this case reached out to the parties to inquire whether the two remaining issues may resolve or if they anticipated moving forward with the June 26 hearing. The Board Advisor also noted:

> Please note that Mr. Traverso's email address appears to be inactive so I am copying Quality Reimbursement Services as a one-time courtesy since I see that they are the designated representative for other Hospital of Central Connecticut cases. Any future communications will be with the official designated representative listed in OH CDMS.

The Board Advisor received no response from either the designated representative or from Quality Reimbursement Services.

On **June 11, 2025**, the Board issued a Notice of Potential Dismissal. Based on the failure of the Provider's Representative to respond to the Board's direct inquiries and the lack of any contact with the Board since withdrawing an issue in April, 2021, the Board ordered the Provider's Representative to respond within five (5) days of that Notice to advise whether the Provider is still pursuing this appeal. The Board specifically stated that "[f]ailure of the Provider to respond by the above filing deadline will result in the dismissal of this case." The Provider's Representative filed no response nor did they otherwise reply to any of the Board's communications about the upcoming hearing or status of the case.

Board Rule 5.2 sets forth some of the responsibilities of a designated case representative:

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

Board Rule 5.3 also explicitly notes that "[t]he Board's communications will be sent to the case representative via email to the case representative's email address on file with the Board (*see* Rule 5.2). The Board will address notices only to the official case representative."

Board Rule 41.2 (2023) permits dismissal or closure of a case on the Board's own motion:

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

Failure to comply with the Board's requirements or orders can be found at 42 C.F.R. § 405.1868:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—
> (1) Dismiss the appeal with prejudice;
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
> (3) Take any other remedial action it considers appropriate.

Based on the failure of the Provider's Representative to respond to the Board's direct inquiries, the lack of any contact with the Board since withdrawing an issue in April, 2021, and the failure to respond to the Board's Notice of Potential Dismissal, the Board is exercising its discretion pursuant to 42 C.F.R. § 405.1868(b)(1) to dismiss Case 21-0079 with prejudice and hereby removes it from its docket.

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

Board Members:

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

For the Board:

6/18/2025

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Bayfront Health Port Charlotte, Prov. No. 10-0077, FYE 12/31/2016, Case No. 19-0935

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-0935. 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. 19-0935***

On **July 26, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2016.

On **January 3, 2019**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request included nine (9) issues:

1. DSH - SSI (Provider Specific)
2. DSH - SSI
3. DSH - SSI Fraction/Medicare Managed Care Part C Days
4. SSI Fraction/Dual Eligible Days
5. DSH - Medicaid Eligible Days
6. DSH - Medicaid Fraction/Medicare Managed Care Part C Days
7. DSH - Medicaid Fraction/Dual Eligible Days
8. Uncompensated Care ("UCC") Distribution Pool
9. 2 Midnight Census IPPS Payment Reduction

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 **July 22, 2019**, the Provider transferred Issues 2, 3, 4, 6, 7, 8 and 9 to various CHS CIRP groups.

On **February 4, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position

papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[1]

On **August 20, 2019**, the Provider timely filed its preliminary position paper. With respect to Issue 5, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and there was no explanation as to why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days." As a result, the Provider included, as an Exhibit, the original "estimated impact" for this issue of $84,681 based on an *estimated* 150 days. The Provider also briefed Issue 1, SSI Percentage (Provider Specific).[2] The Provider contends the percentage was incorrectly computed because it didn't include all patients entitled to SSI benefits in the calculation based on the Provider's fiscal year end (Dec. 31).

On **November 7, 2019**, the Medicare Contractor filed its preliminary position paper. Regarding Issue 5, the Medicare Contractor's position paper noted that the Provider failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position. The Medicare Contractor also briefed Issue 1, SSI (Provider Specific), which was subsequently withdrawn.

On **November 13, 2019**, the Medicare Contractor filed a Substantive claim challenge over the Medicaid eligible days issue.[3]

On **November 20, 2019**, the Medicare Contractor filed a jurisdictional challenge over the SSI Provider Specific issue. *This issue was subsequently withdrawn on May 12, 2025*.

On **December 12, 2019,** CHS responded to the Medicare Contractor's substantive claim challenge, although it was filed in the Office of Hearings Case & Document Management

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[1] (Emphasis added.)
[2] The SSI Percentage (Provider Specific) issue was withdrawn on May 12, 2025.
[3] The Medicare Contractor submitted the substantive claim challenge using "Other Case Correspondence" rather than the "Substantive Claim Challenge" case action.

System ("OH CDMS") as a response to the Medicare Contractor's jurisdictional challenge.[4] The Provider contends that it does have a substantive claim over the eligible days issue.

On **August 23, 2024**, the Board issued a Notice of Hearing scheduling a hearing date for July 14, 2025 and setting final position paper deadlines.

On **April 14, 2025,** QRS timely filed its final position paper.

On **May 9, 2025**, FSS timely filed a final position paper on behalf of the Medicare Contractor. FSS noted that the Provider improperly added the "Section 1115 waiver days" issue by briefing it with the eligible days issue in the final position paper. In addition, the MAC noted that only a redacted listing of Medicaid eligible days pending finalization was submitted by the Provider as an exhibit to its final position paper. To date, the Medicare Contractor had not received an auditable listing. Consequently, FSS requested the dismissal of the Medicaid Eligible Days issue.

On **May 15, 2025**, Federal Specialized Service ("FSS") filed an updated jurisdictional challenge on behalf of the Medicare Contractor, challenging the last issue in the appeal: Medicaid eligible days (#5).

On **June 4, 2025**, QRS filed a response to the jurisdictional challenge over Eligible days.

MAC's Jurisdictional Challenge

Issue 5 – DSH Payment – Medicaid Eligible Days

The Medicare Contractor contends the Provider failed to file complete preliminary and final position papers 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 Rule 25 and 27. The Medicare Contractor maintains the Provider failed to submit a complete list of additional Medicaid eligible days or any other supporting documents or explanation for why it cannot produce those documents. As of the date of the Jurisdictional filing on May 15, 2025, almost six years after the listing was required in the preliminary position paper, no auditable listing had been filed.

Section 1115 Waiver Days

Additionally, the Medicare Contractor contends the Provider is attempting to untimely add the section 1115 Waiver Days issue as a sub-issue via its final position paper filed on April 14, 2025.[5] The Provider originally characterized the Medicaid Eligible Days issue in its initial appeal request using the following language:

[4] Because it was filed in response to the Jurisdictional challenge, the brief is labeled "Jurisdictional Challenge Response" in OH CDMS.
[5] Medicare Contractor's May 15, 2025 Jurisdictional Challenge at 11-12.

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

Neither the appeal request, nor the preliminary position paper, identified or mentioned the Section 1115 waiver days issue. It was not until the final position paper was filed that the Provider raised the issue – which was over six years after the regulatory deadline to add a new issue to the case. Therefore, the MAC contends that the Section 1115 waiver days issue should be dismissed on the grounds that it was untimely and improperly added to the case.

Provider's Jurisdictional Response

In jurisdictional response filed by QRS, it argued that the section 1115 waiver days issue was addressed in the January 3, 2019 appeal request based on the part of the issue statement which stated:

> 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.

QRS contends that the phrase "including but not limited to" makes it clear that all Medicaid eligible days, including section 1115 waiver days were appealed.

In addition, with regard to the MAC's argument that the issue was abandoned because it was not briefed in the preliminary position paper, QRS argued that ". . . the Fifth Circuit ruled that the statute and CMS's own regulations require that CMS regard inpatient days attributable to an uncompensated care pool population as Medicaid eligible days. Forrest General Hospital v. Azar, 926 F.3d 221 (5th Cir. 2019)." Based on this Court case, QRS maintained that the Medicare Contractor ". . . is required by specific command of CMS to accept and audit the Provider's section 1115 waiver days."[6]

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.

[6] Representative's Responsive Jurisdictional Brief at 3 (June 4, 2025).

As set forth below, the Board hereby dismisses the Provider's last 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 appeal in either the initial appeal or its preliminary position papers.

With regard to the filing of an individual appeal, Board Rule 7.3.2 (No Access to Data) (Aug. 2018) states:

> 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 (Aug. 2018) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

[7] (Bold emphasis added.)

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.

25.2.2 Unavailable and Omitted Documents

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

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

The Notice of Case Acknowledgement and Critical Due Dates, issued to the Provider on February 4, 2019, included instructions on the content of the Provider's preliminary position paper consistent with the above-Board Rules and regulations, along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 5, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(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 August 20, 2019, the Provider filed its preliminary position paper in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[10] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $84,681 based on an estimated 150 days). The Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar

[10] Provider's Preliminary Position Paper at 8 (August 20, 2019).

> 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.[11]

In its Jurisdictional Challenge, the Medicare Contractor asserts that the Provider was in violation of Board Rules 25.3 and 27.2 because 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 papers. In addition, 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.

On April 15, 2025, as an exhibit to the final position paper, QRS filed a statement indicating that "[a] listing of the additional Medicaid Eligible days being claimed is being submitted directly to the MAC." A redacted version of the listing was included, however, QRS added the caveat that the "Listing [is] pending finalization upon receipt of State eligibility data." The Listing was 12 pages showing 1750 Medicaid eligible days. QRS' filing did not explain why the listing of so many days was being submitted at this late date, ***more than 8 years after the fiscal year at issue had closed***. NOTE—the 1750 days included in this belated listing is *exponentially* larger than the original estimate of 150 days included with the appeal request. Regardless, this filing was ***more than 5 years past the deadline for including it with its preliminary position paper*** since the position paper deadline was August 31, 2019.

[11] Provider's preliminary position paper at 7-8 (Aug. 20, 2019).

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

Moreover, the Board rejects the Provider's attempt to include the April 15, 2025 Eligible Days Listing as a filing because:

1. The listing was submitted as an exhibit to the final position paper, which was filed ***more than 5 years*** *after the deadline* for that exhibit to be included with its preliminary position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)).

2. The Eligible Days listing failed to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the 1750 days was not previously available, *in whole or in part* (*i.e*., it is not clear why the Provider failed to identify a single day at issue until more than 6 years (6 *years, 3 months, 11 days*) 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 February 4, 2019 Case Acknowledgment and Critical Due Dates notice, permit the Provider to file a "Supplement" to its preliminary position paper (nor did the Provider allege in its filings 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 preliminary position paper filing, if the Board were to accept the listing as a supplement, it would need to either be a *refinement* of its preliminary position paper or a supplement of documents that were identified in the preliminary position paper as being unavailable consistent with Board Rule 25.2.2. However, the Eligible Day listing failed to identify any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the listing cannot be considered a refinement of the position paper since no specific days or listing was included with the preliminary position paper (indeed, the *tentative* 1750 days showing on the redacted listing included as an exhibit to the April 14, 2025 final position paper is, without explanation, *exponentially* larger than the original estimated 150 days included with the appeal request).[12]

[12] *See, e.g.,* Board Rule 27.3 (Aug. 2018) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."

5. Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[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)(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. 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 January of 2019 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[14]

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

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:

[13] (Emphasis added.)
[14] 42 C.F.R. § 405.1835(b).

- the adjustment, including the adjustment number,
- the controlling authority,
- why the adjustment is incorrect,
- how the payment should be determined differently,
- the reimbursement effect, and
- the basis for jurisdiction before the [Board].

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

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

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

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 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 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 preliminary position paper filing. First, the Provider's preliminary position paper does not even mention Section 1115 waiver days (much less identify the specific 1115 waiver day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Aug.

2018). As noted above, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 waiver days sub-issue.

Finally, even in the Provider's final position paper, the Provider fails to identify what Section 1115 waiver program(s) are involved and whether or not the Section 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(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 cursory conclusions.[18] Again, the Provider failed to so develop its position paper notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Aug. 2018) as applied via Board Rule 27.2.

The Board's finding that neither the appeal request nor the final position paper met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[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 –DSH Medicaid Eligible Days (Issue 5). As no issues remain, the Board hereby closes Case No. 19-0935 and

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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 final position paper 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.*

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:

6/24/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
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RE: ***Notice of Dismissal***
Houston Methodist Clear Lake Hospital (*formerly, Houston Methodist St. John Hospital*), Prov. No. 45-0709, FYE 12/31/2015, Case No. 19-2632

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-2632. Set forth below is the decision of the Board to dismiss the one remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Payment for Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 19-2632*

On **March 20, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2015.

On **September 11, 2019**, the Board received the Provider's individual appeal request. The Individual Appeal Request contained eight (8) issues:

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

[1] On March 28, 2025, the SSI Percentage (Provider Specific) issue was withdrawn from the appeal.
[2] On May 4, 2020, this issue was transferred to PRRB Case No. 20-0068GC.
[3] On May 4, 2020, this issue was transferred to PRRB Case No. 20-0069GC.
[4] On May 4, 2020, this issue was transferred to PRRB Case No. 20-0070GC.
[5] On May 4, 2020, this issue was transferred to PRRB Case No. 20-0071GC.
[6] On May 4, 2020, this issue was transferred to PRRB Case No. 20-0072GC.
[7] On May 4, 2020, this issue was transferred to PRRB Case No. 20-0073GC.

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

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

The Provider is commonly owned/controlled by Houston Methodist Hospital System (hereinafter "HMHS") and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **May 4, 2020**, the Provider transferred Issues 2, 3, 4, 6, 7 and to HMHS CIRP groups.

On **May 8, 2020**, the Provider filed its preliminary position paper. The following are excerpts from the Provider's position on Issue 5 set forth therein:

> 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.
>
> HMSTJH is seeking reimbursement for an additional 126 Medicaid Eligible days. The Provider, in this appeal, contends that the documentation necessary to pursue DSH was not available from the State of Texas in time to include all DSH/Medicaid Eligible Days on the cost report.[9]

On **August 25, 2020**, the Medicare Contractor filed its preliminary position paper.

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[8] (Emphasis added).
[9] Provider's Preliminary Position Paper at 5-6 (May 8, 2020).

On **January 13, 2021**, the Medicare Contractor filed a jurisdictional challenge over Issue 1 in the appeal, to which the Representative responded on **January 28, 2021**. ***The SSI Provider Specific issue was subsequently withdrawn from the appeal on March 28, 2025***.

On **May 10, 2024**, the Provider changed the Representative to Quality Reimbursement Services, Inc. ("QRS").

On **August 23, 2024**, 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*. *See* Board Rule 27 for more specific content requirements.[10]

On **November 23, 2024**, QRS filed a Redacted Medicaid Eligible Days listing in OH CDMS. The thirteen (13) page listing included 1833 "Additional ME & 1115 Waiver Days."

On **January 21, 2025**, the Provider timely filed its final position paper. The following is the Provider's ***complete*** position on Issue 5 set forth therein:

> Specifically, the Provider disagrees with the MAC's calculation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp., Inc. v. Secretary of Health and Human Servs.* 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits…
>
> CMS acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or

[10] (Emphasis added).

> 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 the authority of section 1115 of the Social Security Act and regarded 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 directly to the MAC, including section 1115 waiver days (redacted copy was previously uploaded to the portal on November 32, 2024), the Provider contends that the total number of days reflected in its 2015 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal court decisions.
>
> With respect to section 1115 waiver days, the courts have firmly rejected CMS's interpretation of its regulations, holding instead that the plain language of the statute and the regulations require inclusion in the Medicaid Fraction of the days belonging to individuals who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool. *See Forrest General Hospital*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. 2018); *Bethesda Health Inc., v. Azar*, 389 F. Supp. 3d 32, (D.D.C. 2019), *aff'd,* 980 F.3d 121 (D.C. Cir. 2020). CMS has acquiesced in *Bethesda* and is now following the statute and the plain meaning of its own regulations (which regulations represent the official policy of CMS all along) and properly accounting for 1115 Waiver days as Medicaid Eligible days. *See* CMS Manual Instructions System, Change Request 12669, Transmittal No. 11912 (March 16, 2023) ("Transmittal 11912"), attached as Exhibit P-3.[11]

On **February 18, 2025**, the Medicare Contractor timely filed its final position paper.

On **March 21, 2025**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 5.[12]

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[11] Provider's Final Position Paper at 8-10 (Mar. 13, 2025) (emphasis added).

[12] The Jurisdiction Challenge also supplemented the previous challenge over Issue #1 (SSI Provider Specific) but that issue was subsequently withdrawn.

On **March 26, 2025**, QRS filed a response to the Medicare Contractor's jurisdictional challenge.

MAC's Jurisdictional Challenge

Issue 5 – DSH Payment – Medicaid Eligible Days

The Medicare Contractor contends that this issue should be dismissed because the Provider failed to complete preliminary or final position papers including all supporting exhibits to document the merits of its argument in accordance with 42 C.F.R. §405.1853(b)(2) and Board Rule 25 and 27.[13]

The Medicare Contractor contends that 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 papers. 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. The Provider has not included a complete, unredacted list of additional Medicaid eligible days with its preliminary or final position papers or submitted such list under separate cover to the Medicare Contractor. The unredacted and finalized eligibility days listing was not included as an exhibit with either the preliminary or final position paper. As of the date of the Medicare Contractor's challenge, a complete, unredacted listing had not yet been supplied to it. The first redacted Medicaid Eligible Days listing, which included Section 1115 waiver days, was the submission QRS uploaded to the portal on November 23, 2024.[14]

Additionally, the Medicare Contractor argues the Provider is attempting to untimely and improperly add the issue of Section 1115 waiver days as a sub-issue via its submission of the redacted day listing filed on November 23, 2024. The Medicare Contractor issued the Provider's NPR on March 20, 2019. In accordance with 42 C.F.R. § 415.1835(e), the deadline for adding issues to the appeal was November 20, 2019. The issue was informally added through a letter uploaded to OH CDMS on November 23, 2024, five years after the filing deadline to add an issue.[15]

The Medicare Contactor contends that the Section 1115 waiver days issue is one component of the DSH issue that must be appealed as a separate issue. The Medicare Contractor notes that Board Rule 8 explains that one issue can have multiple components. Within Board Rule 8, some of the disproportionate share hospital (DSH) components are identified. Specifically, the Board identifies Section 1115 waiver days as a distinct DSH component that the Provider must appeal separately. [16]

Provider's Jurisdictional Response

Issue 5 – DSH Payment – Medicaid Eligible Days

[13] Medicare Contractor's jurisdictional challenge at 7 (March 21, 2025).
[14] Medicare Contractor's jurisdictional challenge at 9 and 11 (March 21, 2025).
[15] Medicare Contractor's jurisdictional challenge at 10-11. (March 21, 2025).
[16] Medicare Contractor's jurisdictional challenge at 13 (March 21, 2025).

In its jurisdictional response, the Provider only responds to the Medicare Contractor's challenge over the Section 1115 waiver days issue. The Provider argues that the phrasing of its issue statement with respect to the Medicaid Eligible Days issue makes clear that the Provider appealed all Medicaid eligible days, including Section 1115 waiver days. By definition, Section 1115 waiver days are Medicaid eligible days. Whereas the Medicare Contractor states that the Section 1115 waiver days issue is one component of the DSH issue, the regulations at 42 C.F.R. § 405.1835 contain requirements for appealing an "issue" and a time limit on adding an "issue" – not on clarifying "sub-issues" or "components" of an issue. Both a June 25, 2004 proposed rule (69 *Fed. Reg.* 35716) and a May 23, 2008 final rule (73 *Fed. Reg.* 30190) indicate that an "issue" is encapsulated by a specific cost report adjustment. They do not slice and dice an "issue" into component parts, including the specific reason why Medicaid eligible days were not counted in the numerator of the Medicaid Fraction of the Disproportionate Payment Percentage. There is no dispute that the same cost report adjustment that affects other types of Medicaid eligible days also affects Section 1115 waiver days.[17]

The Provider goes on to assert that the version of Board Rule 8 (July 1, 2015) that was effective when the Provider filed its appeal, makes no mention of "section 115 waiver days" nor even "Medicaid eligible days." Therefore, even if Rule 8's extension to "components of issues" were valid (and the Provider contends it is not), the Provider had no notice that it was required to specify Section 1115 waiver days in its appeal request, and it would be a denial of due process for the PRRB to dismiss the Section 1115 waiver days component of its appeal of Medicaid eligible
days. [18]

Finally, the Provider contends that, subsequent to the Provider's Preliminary Position Paper, the Fifth Circuit ruled that the statute and CMS's own regulations require that CMS regard inpatient days attributable to an uncompensated care pool population as Medicaid eligible days, *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019). The Medicare Contractor is required by specific command of CMS to accept and audit the Provider's section 1115 waiver days in providers' Medicaid Fractions. Following a string of litigation defeats, including those in *Forrest General Hospital* and *Bethesda Health, Inc. v. Azar*, 980 F.3d 121 (D.C. Cir.2020), CMS issued Change Request 12669, Transmittal No. 11912 (March 16, 2023). The Provider asserts that under this Transmittal, the Medicare Contractor has the duty to accept the Provider's listing of Section 1115 waiver days and audit them. The Provider states that it submitted a redacted listing to the Board with their Supplement to position paper/redacted Medicaid Eligible Days Listing Submission on September 19, 2024, and an unredacted listing to the Medicare Contractor.[19]

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

[17] Provider's jurisdictional response at 1-2 (March 26, 2025).
[18] Provider's jurisdictional response at 2-3 (March 26, 2025).
[19] Provider's jurisdictional response at 3-4 (March 26, 2025). **NOTE**: OH CDMS does not reflect a submission of the alleged September 19, 2024 Supplement. The only redacted listing in OH CDMS was the one submitted on November 23, 2024.

$10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the sole remaining issue in the appeal.

DSH Payment – Medicaid Eligible Days

1. *Medicaid Eligible Days*

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

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

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

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

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[20]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal. Board Rule 25 (Aug. 2018) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

[20] (Bold emphasis added.)

Rule 25 Preliminary Position Papers[21]

> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will issue a notice setting deadlines for the first position paper generally at eight months after filing the appeal request for the provider, and twelve months for the Medicare contractor…Therefore, the Board requires preliminary position papers to present the ***fully*** developed positions of the parties and expects that parties will be diligent in planning and conducting any required investigation, discovery, and analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

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

25.1.1 Provider's Position Paper

The provider's preliminary position paper must:

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

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation 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.

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

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

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[22]

[22] (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 May 8, 2020, the Provider filed its preliminary position paper. Significantly, the position paper indicates it is seeking reimbursement for 126 Medicaid eligible days and continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $9,500).[23]

On January 21, 2025, the Provider filed its final position paper. Attached as Exhibit P-1 was a statement as follows: "A listing of the additional Medicaid Eligible days being claimed will be submitted directly to the MAC. A redacted version of this same list is being included with this position paper." A copy of the November 13, 2024 redacted listing titled "Additional ME & 1115 Waiver Days" was also included. There is no indication that an unredacted listing was sent to the Medicare Contractor. The 13 page listing, showed 1,833 days. The Provider did not explain why the listing of days was being submitted at this late date, ***almost 9 years after the fiscal year at issue had closed***. NOTE—the 1,833 days included in this belated listing is *exponentially* larger than the original estimate of 126 days included with the appeal request. Regardless, this filing, *importantly,* ***was more than 4 years past the deadline for including it with its preliminary position paper*** since the position paper deadline was May 8, 2020.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the

[23] Provider's Preliminary Position Paper at 6. (May 8, 2020).

requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[24] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to submit a finalized listing of Medicaid eligible days, notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[25]

2. *Section 1115 Waiver Days*

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

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

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing…must

[24] (Emphasis added.)

[25] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

> 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…[26]

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

> The following information and supporting document must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>   - the adjustment, including the adjustment number,
>   - the controlling authority,
>   - why the adjustment is incorrect,
>   - how the payment should be determined differently,
>   - the reimbursement effect, and
>   - the basis for jurisdiction before the Board.[27]

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

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include:…***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:

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

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

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

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

Specifically, § 412.106(b)(4) (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**

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

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

Because the Provider did not raise the Section 1115 waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The DSH Medicaid eligible days issue as stated in the original appeal request cannot be construed to include Section 1115 waiver days. Additionally, there is no indication that any 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 position paper filings. First, the Provider's preliminary position paper does not even mention Section 1115 waiver days (much less even identify the specific 1115 waiver day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (2018). Pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 waiver days sub-issue.

Finally, even in the Provider's final position paper, the Provider fails to identify what Section 1115 waiver program(s) are involved and whether or not the Section 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(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.[31] Again, the Provider failed to so develop its position paper notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (2023) as applied via Board Rule 27.2.

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

The Board's finding that neither the appeal request nor the final position paper met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[32] 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 . . ."[33] 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."[34] The Court found that this description of the issue was a violation of Board rules and a proper basis for the Board to dismiss the appeal.[35] Here, the Board makes the same finding based on similar *overly generalized language*.

Based on the above, the Board finds that the appeal did not include the *alleged* Section 1115 waiver days sub-issue consistent with 42 C.F.R. §§ 405.1835(b)(2)-(3), 412.106(b)(4)(iii), and 405.1871(a)(3) and Board Rules 7.1, 8, 25, and 27.2.[36] In the alternative, the Board finds that, even if it had been included as part of the appeal, the issue was not properly developed in the position paper process.

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Based on the foregoing, the Board dismisses the sole remaining issue in this case – (Issue 5- DSH Payment – Medicaid Eligible Days. As no issues remain, the Board hereby closes Case No. 19-2632 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:

6/25/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[32] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[33] *Id*. at *11.
[34] *Id.*
[35] *Id.*
[36] If Section 1115 waiver days were found to be part of the appeal request and had been properly briefed, the Board would still need to address an additional jurisdictional issue – review whether it had jurisdiction over the Section 1115 waiver days. For example, the Board has found that when a class of days (*e.g*., 1115 waiver days) is excluded due to choice, error, and/or advertence from the as-filed cost report, then that class of days is an unclaimed cost for which the Board would lack jurisdiction under 42 U.S.C. § 1395oo(a). *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 061852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days from the appeal because no days were claimed with the as-filed cost report due to choice, error and/or inadvertence and, as such, the practical impediment standard or futility concept in the *Norwalk* and *Danbury* Board decisions is not applicable).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Baylor Scott & White Medical Center Garland, Prov. No. 45-0280, FYE 12/31/2012
Case No. 18-1674

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 18-1674. 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. 18-1674***

On **February 27, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2012.

On **August 30, 2018**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request included seven (7) issues:

1. DSH SSI Percentage (Provider Specific)
2. DSH SSI Percentage
3. DSH SSI Fraction Medicare Managed Care Part C Days
4. DSH SSI Fraction Dual Eligible Days
5. DSH Medicaid Eligible Days
6. DSH Medicaid Fraction Medicare Managed Care Part C Days
7. DSH Medicaid Fraction Dual Eligible Days

The Provider is commonly owned/controlled by Baylor Scott & White Health (hereinafter "BSWH)" and, thereby, is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **March 26, 2019**, the Provider transferred Issue #s 2, 3, 4, 6, and 7 to various BSWH CIRP groups.

On **September 14, 2018**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[1]

On **December 21, 2018**, Federal Specialized Services ("FSS") filed a jurisdictional challenge over Issue #1, SSI Provider Specific, on behalf of the Medicare Contractor, to which BSWH filed it responsive brief on **January 22, 2019**.

On **April 12, 2019**, BSWH timely filed the Provider's preliminary position paper briefing the two remaining issues: SSI Provider Specific and Medicaid Eligible Days. With respect to Issue #5, BSWH suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the preliminary position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and, instead, asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2012 cost report does not reflect an accurate number of Medicaid eligible days." The Exhibit BSWH included was the original "estimated impact" for this issue of $92,467 based on an *estimated* 150 days.

On **August 20, 2019**, FSS filed the Medicare Contractor's preliminary position paper on the last two issues. The Medicare Contractor indicated the SSI Provider Specific issue (#1) should be dismissed (*formal challenge previously filed*). With regard to the Eligible Days issue (#5), the Medicare Contractor's position paper indicates that the Provider had not supplied all required documentation pursuant to 42 C.F.R. § 413.24(2)(c).

On **July 28, 2022**, the Board issued a jurisdictional determination dismissing the SSI Provider Specific issue (#1).

On **May 10, 2023**, QRS became the authorized representative in Case No. 18-1674.

On **February 20, 2024**, the Board scheduled the case for a hearing on December 9, 2024 and set final position paper deadlines for the Parties.

On **September 9, 2024,** QRS timely filed the Provider's final position paper, in which it QRS advised that a Medicaid Eligible days listing was being sent under separate cover (with a redacted copy to follow).

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[1] (Emphasis added.)

On **October 8, 2024**, FSS timely filed the Medicare Contractor's final position paper. FSS again noted that the Provider had not supplied all required documentation, nor had it filed complete preliminary or final position papers. In addition, FSS noted that the Provider attempted to untimely add the "Section 1115 waiver days" issue through its final position paper. However, 1115 waiver days was not an issue in the appeal or in the preliminary position paper.

On **November 4, 2024**, FSS filed a jurisdictional challenge on behalf of the Medicare Contractor, over the Medicaid Eligible Days issue (#5). FSS argued that:

1. the Provider failed to file complete preliminary and final position papers including all supporting exhibits to document the merits of its arguments in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rules 25 and 27. By failing to file a complete position paper with all exhibits, it essentially abandoned the Medicaid Eligible Days issue; and

2. the Provider was attempting to untimely and improperly add the Section 1115 Waiver Days issue as a sub-issue in its September 9, 2024 final position paper.

On **November 11, 2024**, QRS filed a copy of an Administrative Resolution Package it had filed with the Medicare Contractor. The package indicates there are four exhibits included which show:

1. Medicaid DSH days of 8,157;
2. Medicaid Eligible days of 37;
3. 4,614 Section 1115 Waiver days; and
4. Electronic listings of the first three exhibits with the Texas Medicaid Eligibility responses.

**The exhibits were not included with the copy uploaded in the Office of Hearings Case & Document Management System ("OH CDMS")*.

The following week, **on November 19, 2024** (and a corrected version filed on **November 20, 2024** reflecting the MAC's concurrence), QRS requested a postponement of the hearing date. On **November 25, 2024**, the Board rescheduled the hearing date for **March 19, 2025**. Subsequently, on February 27, 2025, the hearing date was again rescheduled – this time for **July 16, 2025**.

On **November 21, 2024**, QRS filed a responsive jurisdictional brief addressing the Medicare Contractor's challenge over the untimely addition of the Section 115 waiver days and its contention that the Provider had abandoned the issue.

Medicare Contractor's Contentions:

Issue #5 – 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 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 position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.
>
> Within its preliminary position paper, the Provider makes the broad allegation, ". . . the Provider contends that the total number of days reflected in its' [sic] 2012 cost report does not reflect an accurate number of Medicaid eligible days . . .". The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue.[2]

Section 1115 Waiver Days

Additionally, the Medicare Contractor contends the Provider is attempting to untimely add the section 1115 Waiver Days issue as a sub-issue via its final position paper filed on September 9, 2024.[3] The Provider originally characterized the Medicaid Eligible Days issue in its initial appeal request using the following language:

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

Neither the appeal request, nor the preliminary position paper, identified or mentioned the Section 1115 waiver days issue. It was not until the final position paper was filed that the Provider raised the issue – which was over five years after the regulatory deadline to add a new issue to the case. Therefore, the MAC contends that the Section 1115 waiver days issue should be dismissed on the grounds that it was untimely and improperly added to the case.[4]

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[2] Jurisdictional Challenge at 7 (Nov. 4, 2024).
[3] Id at 9-12.
[4] Id. at 11.

Provider's Jurisdictional Response:

In its jurisdictional response, the Provider only responds to the Medicare Contractor's challenge over the Section 1115 waiver days issue. The Provider argues that the phrasing of its issue statement with respect to the Medicaid Eligible Days issue makes clear that the Provider appealed all Medicaid eligible days, including Section 1115 waiver days. By definition, Section 1115 waiver days are Medicaid eligible days. Whereas the Medicare Contractor states that the Section 1115 waiver days issue is one component of the DSH issue, the regulations at 42 C.F.R. § 405.1835 contain requirements for appealing an "issue" and a time limit on adding an "issue" – not on clarifying "sub-issues" or "components" of an issue. Both a June 25, 2004 proposed rule (69 *Fed. Reg.* 35716) and a May 23, 2008 final rule (73 *Fed. Reg.* 30190) indicate that an "issue" is encapsulated by a specific cost report adjustment. They do not slice and dice an "issue" into component parts, including the specific reason why Medicaid eligible days were not counted in the numerator of the Medicaid Fraction of the Disproportionate Payment Percentage. There is no dispute that the same cost report adjustment that affects other types of Medicaid eligible days also affects Section 1115 waiver days. [5]

The Provider goes on to contend that the version of Board Rule 8 (July 1, 2015) that was effective when the Provider filed its appeal, makes no mention of "section 115 waiver days" nor even "Medicaid eligible days." Thus, even if Rule 8's extension to "components of issues" were valid (and the Provider contends it is not), the Provider had no notice that it was required to specify Section 1115 waiver days in its appeal request, and it would be a denial of due process for the PRRB to dismiss the Section 1115 waiver days component of its appeal of Medicaid eligible days. [6]

Finally, the Provider contends that, subsequent to the Provider's Preliminary Position Paper, the Fifth Circuit ruled that the statute and CMS's own regulations require that CMS regard inpatient days attributable to an uncompensated care pool population as Medicaid eligible days, *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019). The Medicare Contractor is required by specific command of CMS to accept and audit the Provider's section 1115 waiver days in providers' Medicaid Fractions. Following a string of litigation defeats, including those in *Forrest General Hospital* and *Bethesda Health, Inc. v. Azar*, 980 F.3d 121 (D.C. Cir.2020), CMS issued Change Request 12669, Transmittal No. 11912 (March 16, 2023). The Provider asserts that under this Transmittal, the Medicare Contractor has the duty to accept the Provider's listing of section 1115 days and audit them. The Provider states that it submitted an unredacted listing to the MAC on November 11, 2024.[7]

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

[5] Provider's jurisdictional response at 1-2 (Nov. 21, 2024).
[6] Id at 2-3.
[7] Id at 4.

$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 in the appeal.

DSH Payment – Medicaid Eligible Days

1. *Medicaid Eligible Days*

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

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

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

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

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[8]

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.

[8] (Bold emphasis added.)

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

Rule 25 Preliminary Position Papers[9]

> **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.

[9] (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 Notice of Case Acknowledgement and Critical Due Dates, issued to the Provider on September 14, 2018, included instructions on the content of the Provider's preliminary position paper consistent with the above-Board Rules and regulations, along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue #5, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(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.[10]

[10] (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 April 12, 2019, the Provider filed its preliminary position paper in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[11] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $92,467 based on an estimated 150 days). The Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid

[11] Provider's Preliminary Position Paper at 8 (April 12, 2019).

> 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' 2012 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.[12]

On September 9, 2024, as an exhibit to the final position paper, QRS filed a statement indicating that "A listing of the additional Medicaid Eligible days being claimed will be submitted directly to the MAC. A redacted version of the list will be uploaded to the portal thereafter."[13] However, a ***redacted version of the listing was never uploaded to the portal.***

Additionally, QRS' statement did not explain why the listing (*which was allegedly being filed under separate cover*) was being submitted ***almost 12 years after the fiscal year at issue had closed***. This filing would have also been ***more than 5 years past the deadline for including it with its preliminary position paper*** since the position paper deadline was April 27, 2019.

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and

[12] Provider's preliminary position paper at 7-8 (April 12, 2019).
[13] Provider Final Position Paper Exhibit P-1 (September 9, 2024)

25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[14] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to submit a finalized listing of Medicaid eligible days, notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[15]

2. *Section 1115 Waiver Days*

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

The appeal was filed with the Board in August of 2018 and the regulations required the following:

(b) *Contents of request for a Board hearing on final contractor*

[14] (Emphasis added.)

[15] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

> *determination.* The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) how and why the provider believes Medicare payment must be determined differently for each disputed item…[16]

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

> The following information and supporting document must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
> - the adjustment, including the adjustment number,
> - the controlling authority,
> - why the adjustment is incorrect,
> - how the payment should be determined differently,
> - the reimbursement effect, and
> - the basis for jurisdiction before the Board.[17]

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

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

Effective August 21, 2008, following the appropriate notice and comment period, new Board

[16] 42 C.F.R. § 405.1835(b).
[17] v. 2.0 (Aug. 2018).
[18] (Bold and italic emphasis added).

regulations went into effect that limited the addition of issues to appeals.[19]

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

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

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

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

Specifically, § 412.106(b)(4) (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

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

> services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act**.
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the Section 1115 waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The DSH Medicaid eligible days issue as stated in the original appeal request cannot be construed to include Section 1115 waiver days. Additionally, there is no indication that any 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 position paper filings. First, the Provider's preliminary position paper does not even mention Section 1115 waiver days (much less even identify the specific 1115 waiver day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (2018). Pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 waiver days sub-issue.

Finally, even in the Provider's final position paper, the Provider fails to identify what Section 1115 waiver program(s) are involved and whether or not the Section 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(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.[21] Again, the Provider failed to so develop its position paper notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (2023) as applied via Board Rule 27.2.

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

Based on the above, the Board finds that the appeal did not include the *alleged* Section 1115 waiver days sub-issue consistent with 42 C.F.R. §§ 405.1835(b)(2)-(3), 412.106(b)(4)(iii), and 405.1871(a)(3) and Board Rules 7.1, 8, 25, and 27.2.[26] In the alternative, the Board finds that, even if it had been included as part of the appeal, the Board would find that the issue was not properly developed in the position paper process.

Therefore, the Board dismisses the last remaining issue in this case –DSH Medicaid Eligible Days (Issue #5). As no issues remain, the Board hereby closes Case No. 18-1674 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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[21] For example, QRS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that "the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a Section 1115 demonstration project that provides benefits through an uncompensated care pool." However, QRS fails to explain why this sweeping statement is relevant to the Section 1115 waiver days at issue. Is QRS asserting that the Section 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 Section 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the final position paper references "uncompensated care pool."

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

[23] *Id*. at *11.

[24] *Id.*

[25] *Id.*

[26] If Section 1115 waiver days were found to be part of the appeal request and had been properly briefed, the Board would still need to address an additional jurisdictional issue – review whether it had jurisdiction over the 1115 waiver days. For example, the Board has found that when a class of days (*e.g.*, 1115 waiver days) is excluded due to choice, error, and/or advertence from the as-filed cost report, then that class of days is an unclaimed cost for which the Board would lack jurisdiction under 42 U.S.C. § 1395oo(a). *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 061852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days from the appeal because no days were claimed with the as-filed cost report due to choice, error and/or inadvertence and, as such, the practical impediment standard or futility concept in the *Norwalk* and *Danbury* Board decisions is not applicable).

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
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For the Board:

6/25/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Michael Redmond, Novitas Solutions Inc. c/o GuideWell Source (J-H)
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RE: **EJR Determination HRS Outlier Threshold Groups**
PRRB Case Numbers: 16-1705GC *et al.* (33 Cases – *See* Appendix A)

Dear Ms. Goron:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Requests for Expedited Judicial Review ("EJR") filed June 5, 2025 in the above-referenced appeals. The Board's decision with respect to EJR is set forth below.

I. Background

The issue statements in nine (9) Cases[1] are identical. The Board notes that they ***incorrectly*** assert that they are appealing their outlier threshold payments for ***fiscal year 2004***, though they actually concern fiscal years ending between 2007 and 2011. These nine (9) Cases describe the group issue as:

> **Group Issue: Outlier Payments - Fixed Loss Threshold**
>
> **Statement of Issue**
>
> Whether the Providers received the reimbursement Congress intended under the Medicare Act for treating certain cases that incurred extraordinarily high costs? Was the cost outlier threshold set improperly?
>
> **Statement of the Legal Basis**
>
> The Providers contend the Secretary's final determination of outlier payments for the fiscal year 2004 was arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law within the meaning of 5 U.S.C. Section 706(2)(A), and is short of statutory rights within the meaning of 5 U.S.C. Section 706(2)(c), because the Secretary acted in an arbitrary and capricious manner and abused her discretion when setting the

[1] *See* Appendix A, Issue Statement #2.

> outlier threshold and calculating outlier payments for federal fiscal year 2004. The Secretary failed to consider relevant factors and data which should have been taken into account when setting the criteria, failed to consider alternative methodologies when establishing the outlier thresholds and failed to demonstrate a reasonable connection between the thresholds and the factors considered. Among other things, the Secretary failed to consider relevant data which showed that the rate of increase in hospital costs per discharge was trending downward and that the relationship of hospital costs to hospital charges was changing. The Secretary thus failed to take into account the established pattern of declining cost-to-charge ratios, which play a significant part in the calculation of outlier payments, despite this problem being repeatedly pointed out in comments and despite proposed methods to account for this phenomenon and to more accurately estimate outlier payments so that thresholds could be set more accurately. Further, the Secretary failed to consider use of the "cost methodology," rather than the "charge methodology," in setting the outlier thresholds, despite the fact that the cost methodology had been more accurate in predicting outlier payments in prior years. Finally, the Secretary failed to require mid-year adjustments and failed to consider adjustments to the reconciliation process. These deficiencies in the Secretary's methodology were identified in the rulemaking comments. By ignoring the flaws in her methodology, the Secretary failed to act reasonably in calculating the amounts of outlier payment to which hospitals are entitled. As a result of these arbitrary and capricious actions, the threshold was set too high, the resulting amount of outlier payments fell short of the percentage required by the Medicare Act and hospitals did not receive the amount of outlier payments that Congress intended.[2]

The group issue statement for nineteen (19) cases[3] is materially identical except that it omits any reference to the particular fiscal year from which it is appealing.

Finally,[4] four (4) cases[5] concerning Federal Fiscal Year 2015 filed appeals from the publication of the Federal Register and describe their issue as follows:

---

[2] *See, e.g.,* Case No. 14-3805GC Group Issue Statement.
[3] *See* Appendix A, cases noted as Issue Statement #1.
[4] The Board notes that there is no Group Issue Statement in OH CDMS for Case 14-3196GC, but that the group title includes "Outlier Threshold Payments," the original provider self-disallowed a claim for "additional reimbursement" related to "the outlier payments factor," and that its PPP was materially identical to the other cases encompassed in this decision. The omission of the group issue statement appears to either be an administrative oversight or a technical error in the conversion of the legacy paper file to a digital record in OH CDMS, and neither the Medicare Contractor or its designated representative have raised any objection suggesting the issue in this case differs from the remaining cases encompassed in this decision.
[5] *See* Appendix A, Issue Statement #3.

Group Issue: Outlier Payments - Fixed Loss Threshold

Statement of Issue

Whether the Provision in the Fiscal Year 2015 Inpatient Prospective Payment System ("IPPS") Final Rule ("Final Rule") that adjusts the published standardized amount and increases the outlier threshold is procedurally invalid, arbitrary and capricious, and outside the statutory authority of the Centers for Medicare & Medicaid Services ("CMS"). Was the cost outlier threshold set improperly?

Statement of the Legal Basis

The outlier threshold for FY 2015 dramatically increased to $24,758 from $21,748 in FY 2014. The Secretary has not publicly released sufficient data to enable providers to determine whether the fixed loss threshold is a realistic estimate for purposes of meeting the 5.1% target rate. The Secretary's failure to provide sufficient data deprived providers of an opportunity to meaningfully comment on the proposed IPPS rule. Upon information and belief, the Secretary did not use the latest available data in computing the 2015 fixed loss threshold. Given that the outlier payment level for FY 2013 was only 3.0%, little justification exists for a dramatically increased fixed lost threshold for 2015. Provider further asserts that the failure of CMS consider the impact of outlier reconciliation in developing the outlier threshold was both arbitrary and capricious. Provider further asserts that the increase in the charge inflation factor was not justified on the basis of the available data, and that the Secretary's computations fail to account for local and geographic variations among hospitals. The Secretary further has an obligation to make retroactive adjustments to the outlier threshold, especially when the Secretary serially sets the fixed loss threshold at too high a level, thereby causing total outlier payments to continually fall below the 5.1% target figure.[6]

The parties have filed Preliminary Position Papers in all but two (2) cases,[7] and final position papers in five (5) cases.[8] Each group is fully formed and the Providers' representative has confirmed, pursuant to Board Rule 20, that the group is fully populated in OH CDMS or that the group was deemed complete and a hard copy schedule of providers was filed before the Board instituted mandatory electronic filing (*see* Board Rule 20.1 (2023)). On **June 5, 2025**, the Providers filed identical requests for Expedited Judicial Review ("EJR") in each case.

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[6] *See, e.g.,* Case No. 15-1553GC Group Issue Statement.
[7] The deadlines for Preliminary Position Papers ("PPPs") in Cases 16-1705GC and 16-1139GC have not yet passed. Additionally, in Case 15-2653G, a PPP was filed in 2016 and, based on Board Rule 25.3 (2015), only the cover page and preliminary documentation list was filed with the Board.
[8] Cases 15-1553GC, 15-0339GC, 15-0299GC, 14-2036GC, and 14-1606GC.

II. Relevant Law – Outlier Threshold

Part A of the Medicare Act covers "inpatient hospital services." Originally, Medicare reimbursed hospitals based on the "reasonable costs" of these services.[9] Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[10] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[11] These predetermined, standardized amounts are calculated by the Secretary first determining a nationwide average allowable cost per discharge,[12] which is then further adjusted based on a wage index specific to the locality of the hospital.[13] Each discharge is also adjusted based on the severity of illness, which are classified as distinct diagnosis-related groups ("DRGs").[14] These DRGs are intended to weight the reimbursement based on "the relationship between the cost of treating patients within that group and the average cost of treating all Medicare patients."[15]

While the PPS provides a fixed amount of reimbursement per patient regardless of actual costs incurred in rendering services,[16] Congress also authorized supplemental "outlier payments," or additional reimbursement for patients' care if the cost was atypically high.[17] Hospitals may request outlier payments "in any case where charges, adjusted to cost, exceed . . . the sum of the applicable DRG prospective payment rate . . . plus a fixed dollar amount determined by the Secretary."[18]

Ensuring that costs are "adjusted to cost" involves evaluating a hospital's "cost-to-charge ratio," which represents the hospital's "average markup" of inpatient hospital services.[19] Outlier payments may be requested if the adjusted costs exceed the DRG rate plus a "fixed dollar amount" – commonly referred to as the "fixed loss threshold."[20] This amount essentially makes a hospital responsible for a portion of the treatment's excessive costs.[21] The Secretary is mandated to ensure that the fixed loss threshold for a given fiscal year results in outlier payments between five (5) and six (6) percent of total payments projected or estimated to be made under the IPPS.[22] The sum of the DRG rate plus the fixed loss threshold is known as the "outlier

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[9] *See* 42 U.S.C. § 1395f(b)(1).
[10] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[11] *Id.*
[12] 42 U.S.C. § 1395ww(d)(2)(A)-(C).
[13] 42 U.S.C. § 1395ww(d)(2)(H).
[14] 42 U.S.C. § 1395ww(d)(4).
[15] *See Cape Cod Hosp. v. Sebelius*, 630F.3d 203, 205-206 (D.C. Cir. 2011).
[16] *See Sebelius v. Auburn Reg'l Med. Ctr.*, 133 S.Ct. 817, 822 (2013).
[17] *See County of L.A. v. Shalala*, 192 F.3d 1005, 1009 (1999); 42 U.S.C. § 1395ww(d)(5)(A).
[18] 42 U.S.C. § 1395ww(d)(5)(A)(ii).
[19] *See Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d 46, 49-50 (D.C. Cir. 2015) (citing *Appalachian Reg'l Healthcare, Inc. v. Shalala*, 131 F.3d 1050, 1052 (D.C. Cir. 1997)); 42 C.F.R. § 412.84(i).
[20] *See Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d at 50.
[21] *See Boca Raton Comm. Hosp., Inc. v. Tenet Health Care Corp.*, 582 F.3d 1227, 1229 (11th Cir. 2009).
[22] 42 U.S.C. § 1395ww(d)(5)(A)(iv).

threshold."[23] Hospitals are typically paid 80% of the costs above the applicable outlier threshold.[24]

As noted by the United States District Court for the District of Columbia, basing outlier payment eligibility on a hospital's own cost-to-charge ratio "led to rampant inflation of hospital charges, a problem that came to be known as 'turbo-charging.'"[25] To combat turbo-charging, the Secretary began using more recent data and also reserved the right to recalculate a hospital's eligibility for outlier payments using actual cost data at the time of settlement, a process known as reconciliation.[26]

III. Positions of the Parties

As noted above, the Providers' group issue statements outline a number of challenges to their outlier payments, claiming the process was arbitrary, capricious, an abuse-of discretion-or otherwise not in accordance with law within the meaning of the Administrative Procedure Act.[27] They take issue with the outlier thresholds set by the Secretary because they argue that she failed to consider relevant data which would have impacted their cost-to-charge ratios; failed to consider use of the more accurate "cost methodology" versus the "charge methodology"; and failed to require mid-year adjustments to the threshold or adjustments to the reconciliation process.

The Providers have filed Preliminary Position Papers in the majority of these cases which are materially identical. They allege that CMS set the cost outlier threshold too high and "withheld 5.1% of DRG payments from Providers to fund outlier payments. However, CMS failed to return 5.1% to Providers."[28] They essentially argue that the Secretary's methodology in calculating the outlier cost threshold invited the abusive turbo-charging carried out by some hospitals, and that the use of this methodology persisted "[d]espite multiple warnings from providers, and red flags raised by the data on which the Secretary relied, and without valid justification[.]"[29]

The Providers note that, for the fiscal years at issue in these appeals, outlier payments were set at 5.1 percent of operating DRG payments, but outlier payments ultimately totaled less than this.[30] They argue the "Secretary's final determination of outlier payments for the fiscal years at issue

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[23] *See Banner Health v. Price*, 867 F.3d 1323, 1329 (D.C Cir. 2017) (citing *Boca Raton v. Tenet Health*, 582 F.3d at 1229); 42 U.S.C. § 1395ww(d)(5)(A)(ii).
[24] 42 C.F.R. § 412.84(k).
[25] *Billings Clinic v. Azar*, 901 F.3d 301, 306 (D.C. Cir. 2018) (citing *Banner Health v. Price*, 867 F.3d at 1333).
[26] *Id.* (citing 68 Fed. Reg. 34494, 34499 (June 9, 2003)).
[27] 5 U.S.C. § 706(2).
[28] *E.g.*, PRRB Case 15-3394GC, Provider's Preliminary Position Paper at 2 (Dec. 7, 2023).
[29] *Id.* at 12-13.
[30] *Id.* at 16 (For the various years in these appeals the Board notes that FFY 2007 total outlier payments were estimated to be 4.64%; FFY 2009 were estimated to be 5.3%; FFY 2010 were estimated to be 4.7%; FFY 2011 were estimated to be 4.8%; FFY 2012 were estimated to be 5.0%; FFY 2013 were estimated to be 4.77%; FFY 2014 were estimated to be 5.71%; and FFY 2015 were estimated to be 4.6%).

herein is arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law."[31] They argue that the Secretary adjusted cost-to-charge ratios in a manner that was contrary to evidence before the agency, despite warnings from commenters; failed to account for the impact of reconciliation; failed to respond to respond to valid comments and adjust the thresholds to achieve the 5.1% target; and failed to provide relevant data used in calculating the thresholds.[32] In later-filed position papers, the Providers acknowledge that the Secretary's methodology was affirmed by the D.C. Circuit using the Supreme Court's *Chevron*[33] interpretive rules, they suggest that the new standard in *Loper Bright*[34] may result in a finding that the Secretary's interpretation of the governing statute is invalid.[35]

The Medicare Contractor argues that substantially identical arguments were considered, and rejected, by the D.C. District Court in *District Hosp. Partners, L.P. v. Sebelius*.[36] It asks the Board to adopt the reasoning of the court and affirm the adjustments to outlier payments or, in the alternative, allow the Providers to seek expedited judicial review in accordance with 42 C.F.R. § 405.1842.[37] In fact, in these thirty-three (33) cases, the Medicare Contractor's designated representative, Federal Specialized Services, has filed Responses to the Requests for EJR noting "that a jurisdictional challenge will not be filed. A substantive claim challenge will not be filed. The MAC will not challenge Provider's request for expedited judicial review."[38]

IV. Decision of the Board

A. *Expedited Judicial Review*

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

i. Jurisdiction

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

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[31] *Id.* at 16-17.
[32] *Id.* at 17-18.
[33] *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).
[34] *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024).
[35] *E.g.*, PRRB Case 15-1553GC, Provider's Final Position Paper at 21 (May 20, 2025).
[36] *E.g.*, PRRB Case 14-2036GC, MAC Final Position Paper at 7 (June 17, 2025) (citing 973 F. Supp. 2d, 1 (D.D.C. 2014). The case was ultimately affirmed in part, reversed in part, and remanded, though the general rationale of the District Court was affirmed. *Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d 46 (D.C. Cir. 2015).
[37] *E.g.,* PRRB Case 14-2036GC, MAC Final Position Paper at 8.
[38] *E.g.*, PRRB Case 14-2036GC, Response to Provider's Request for Expedited Judicial Review (Jun. 12, 2025).

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [39]
- The matter at issue involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[40]

The Providers' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[41] The Providers have also all made timely appeals from original NPRs, the failure of the Medicare Contractor to issue a timely final determination,[42] or the publication of an applicable Federal Register.

a. Dissatisfaction - FYEs Prior to December 31, 2008 (Bethesda)

Case 14-1606GC and 14-2554GC involve Providers with FYEs September 30, 2007 and December 31, 2007, respectively.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming an issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[43] In that case, the Supreme Court concluded that a cost report submitted in full compliance with

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[39] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[40] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[41] *See* 42 C.F.R. § 405.1837(a)(3).
[42] The regulation at 42 C.F.R. § 405.1835(c) permits a provider to file an appeal with the Board where:

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

[43] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R ("[i]n self-disallowing an item, the provider submits a cost report that complies with Medicare payment policy for the item and then appeals the item to the [Board]; the contractor's NPR would not include any disallowance for the item, and the provider would effectively self- disallow the item.").

the Secretary's rules and regulations, "does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. No statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the [Medicare Contractor]" where the contractor "is without the power to award reimbursement."[44]

The Board has determined that that the Outlier Threshold methodology at issue in these cases is governed by 42 U.S.C. § 1395ww(d)(5) and 42 C.F.R. § 412.84, which are statutory and regulatory provisions that left the Medicare Contractors without the authority to make the payment in the manner sought by the Providers in these cases. As such, since the Providers filed their cost reports in compliance with this regulation/policy, the Outlier Threshold issue is governed by the ruling in *Bethesda* and the Providers are not barred from claiming dissatisfaction with the amount of reimbursement allowed by the regulation/policy

b. Dissatisfaction - FYEs December 31, 2008 to December 31, 2016 (1727-R)

The remaining thirty-one (31) Cases involve FYEs between December 31, 2008 and December 31, 2016.

On August 21, 2008, new regulations governing the Board were effective.[45] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[46] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[47]

The Secretary did not appeal the decision in *Banner* and decided to largely apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on December 31, 2008 and which began before January 1, 2016, Under this ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable.

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[44] *Bethesda* at 1258-59.
[45] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[46] 201 F. Supp. 3d 131 (D.D.C. 2016).
[47] *Id.* at 142.

However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

The Board has determined that the Outlier Threshold methodology at issue in these cases is governed by CMS Ruling CMS-1727-R since the Providers are challenging the policy as set forth in 42 U.S.C. § 1395ww(d)(5) and 42 C.F.R. § 412.84 and that Board review of the issues is not otherwise precluded by statute or regulation.

V. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that the participants in the thirty-three (33) Cases listed in **Appendix A** are entitled to a hearing before the Board;

2) Based upon the participants' assertions regarding the Outlier Threshold issue as governed by 42 U.S.C. § 1395ww(d)(5) and 42 C.F.R. § 412.84, there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether the Outlier Threshold issue as governed by 42 U.S.C. § 1395ww(d)(5) and 42 C.F.R. § 412.84, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of the Outlier Threshold issue as governed by 42 U.S.C. § 1395ww(d)(5) and 42 C.F.R. § 412.84 properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' EJR Request for the issue and the subject years in the thirty-three (33) Cases listed in **Appendix A**. 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 thirty-thee (33) cases, the Board hereby closes the cases and removes them from its docket.

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

Board Members Participating:

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FOR THE BOARD:

6/30/2025

X Kevin D. Smith, CPA

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

cc: Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Byron Lamprecht, WPS Government Health Administrators (J-8)
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Appendix A

PRRB Case	PRRB Case Name	Issue Statement
16-1705GC	HRS Prime Healthcare 2014 Outlier Threshold Payments CIRP Group	#1
16-1139GC	HRS UHHS 2013 Outlier Threshold Payments CIRP Group	#1
15-3394GC	HRS ProMedica HS 2013 Outlier Threshold Payments CIRP Group	#1
15-2633GC	HRS UHHS 2012 Outlier Threshold Payments CIRP	#1
15-2421GC	HRS ProMedica Health System 2012 Outlier Threshold Payments CIRP	#1
15-1970GC	HRS SCHS 2012 Outlier Threshold Payments CIRP	#1
15-1555GC	HRS ProMedica HS FFY 2015 Outlier Fixed Loss Threshold CIRP Group	#3
15-2653G	HRS 2011 Outlier Threshold Payments Group II	#1
15-1554GC	HRS UHHS FFY 2015 Outlier Fixed Loss Threshold CIRP Group	#3
15-1424GC	HRS UHHS 2011 Outlier Threshold Payments CIRP Group	#1
15-0179GC	HRS ProMedica Health System 2011 Outlier Threshold Payments CIRP	#1
14-3805GC	HRS UHHS 2010 Outlier Threshold Payments CIRP Group	#2
14-3254GC	HRS SCHS 2011 Outlier Threshold Payments CIRP Group	#2
14-3129GC	HRS ProMedica Health System 2010 Outlier Threshold Payments CIRP Group	#2
14-3196GC	HRS SCHS 2010 Outlier Threshold Payments CIRP Group	*
14-1858GC	HRS ProMedica HS 2009 Outlier Threshold Payments CIRP Group	#2
14-1765GC	HRS UHHS 2009 Outlier Threshold Payments CIRP Group	#2
14-1672GC	HRS SCHS 2009 Outlier Threshold Payments CIRP	#2
15-2682GC	HRS Prime Healthcare 2013 Outlier Threshold Payments CIRP	#1
15-1535GC	HRS Prime Healthcare FFY 2015 Outlier Fixed Loss Threshold CIRP Group	#3
14-2554GC	HRS Prime Healthcare 2007 Outlier Threshold CIRP Group	#2
16-1746GC	HRS FMOLHS 2013 Outlier Threshold Payments CIRP	#1
15-2487GC	QRS FMOLHS 2011 Outlier Threshold Payments CIRP	#1
15-1553GC	HRS WKHS FFY 2015 Outlier Fixed Loss Threshold CIRP Group	#3
15-0675GC	HRS FMOLHS 2012 Outlier Threshold Payments CIRP Group	#1
15-0339GC	HRS WKHS 2011 Outlier Threshold Payments CIRP Group	#1
15-0299GC	HRS WKHS 2010 Outlier Threshold Payments CIRP Group	#1
14-2036GC	HRS Willis-Knighton Health Systems 2009 Outlier Threshold Payments CIRP Group	#2
14-1606GC	HRS Willis Knighton Health Systems 2007 Outlier Threshold CIRP	#2
15-1893GC	HRS Willis-Knighton Health Systems 2012 Outlier Threshold Payments CIRP	#1
16-0570GC	HRS ECHN 2013 Outlier Threshold Payments CIRP Group	#1
15-2178GC	HRS ECHN 2012 Outlier Threshold Payments CIRP	#1
15-1983GC	ECHN CYs 2010 & 2011 Outlier Threshold Payments CIRP Group	#1