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

Sven Collins, Esq.
Hooper, Lundy & Bookman, P.C.
999 18th Street, Suite 3000
Denver, CO 80202

RE: ***Jurisdictional Decision in Whole***
Pomona Valley Hospital Medical Center (Provider Number 05-0231), FYE 12/31/2009
Case Number: 25-0618

Dear Mr. Collins:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced appeal and notes an impediment to jurisdiction for the two remaining issues in the case. The pertinent facts and the jurisdictional decision of the Board are set forth below.

Pertinent Facts:

On **May 14, 2024**, Pomona Valley Hospital Medical Center ("Pomona"/Prov. No. 05-0231) was issued a Revised Notice of Program Reimbursement ("RNPR") for fiscal year end December 31, 2009. The RNPR was issued as a result of CMS Ruling No. CMS 1498-R3. The notation on the RNPR states:

> This is an addendum to the prior settlement dated May 29, 2013
> Reason for Reopening: To implement the instructions contained in Change Request 13294 concerning the Treatment of Medicare Part C days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage in cost reporting periods prior to October 1, 2013, and that use a 2013 or prior SSI ratio.[1]

On **November 6, 2024**, Hooper, Lundy & Bookman, P.C. ("HLB") filed an individual appeal on behalf of Pomona. The appeal, which was assigned **Case No. 25-0618**, included a single issue:
Continued Part C Days Appeal

On **November 7, 2024**, the Board issued an Acknowledgement & Critical Due Dates ("ACDD") notification for Case No. 25-0618.

[1] The February 21, 2024 Change Request ("CR") 13294 was issued "to Implement the Medicare Program Final Action: Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage."

On **January 3, 2025**, HLB added two issues to the appeal: Medicare DSH – Additional SSI Eligible Days and Medicare DSH – SSI Days Data Matching Errors.

On **May 21, 2025**, HLB requested the transfer of the Continued Part C Days Appeal issue to Case No. 25-4339G, an optional" Hooper Lundy & Bookman CY 2009 Continued Part C Days Appeal Group."

Board's 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 contractor determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

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

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

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

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

> (a) Right to hearing on final contractor determination.
> A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[2]

The Board has determined that it does not have jurisdiction over the Medicare DSH – Additional SSI Eligible Days (Issue 2) and the Medicare DSH – SSI Days Matching Errors (Issue 3) that Pomona appealed from the May 14, 2024 RNPR, as the issues were not adjusted in the determination.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[3] The RNPR in this case was specifically issued to adjust Part C days and the issues related to the Additional SSI Eligible Days and the SSI Days Matching Errors are separate and distinct issues, not related to the exclusion of Part C days.

Pursuant to 42 C.F.R. § 405.1889, based on the RNPR under appeal in this case, the Board would only have jurisdiction over issues related to Part C days as that was all that was adjusted as part of the Change Request. Here, Pomona referenced audit adjustment numbers 4 and 6 for both remaining issues. However, according to Pomona's audit adjustment report, there was no adjustment, change or correction made to update the data based on the Part C final rule. Further, the Board finds that there

[2] (Emphasis added).
[3] 42 C.F.R. § 405.1889(b)(1).

is no evidence to corroborate that the MAC adjusted something other than the Part C days as a result of the remand.

Accordingly, the Board finds that Pomona's appeal includes two issues which were not adjusted in the RNPR. Therefore, the Board dismisses the remaining issues:

- Medicare DSH – Additional SSI Eligible Days (Issue 2) and
- Medicare DSH – SSI Days Matching Errors (Issue 3)

As no issues remain, Case No. 25-0618 is hereby dismissed and removed from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

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

For the Board:

6/3/2026

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq. Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Admin. (J-E)

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410-786-2671

Via Electronic Delivery

Kelly Carroll, Esq.
Hooper, Lundy & Bookman, P.C.
401 9th Street NW, Suite 550
Washington, DC 20004

RE: ***Board Decision in Whole and Denial of Related Issue Transfer***
Watauga Medical Center (Provider Number 34-0051), FYE 09/30/2007
Case Number: 25-5736

Dear Ms. Carroll:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced appeal in response to the recent requests to transfer issues to group appeals and notes an impediment to jurisdiction. The pertinent facts and the jurisdictional decision of the Board are set forth below.

Pertinent Facts:

On, **March 3, 2025**, Watauga Medical Center ("Watauga") was issued a Revised Notice of Program Reimbursement ("RNPR") for fiscal year end September 30, 2007. This RNPR clearly states, "[a]s a result of Change Request 13294, the cost report is being revised to reflect the CMS published SSI ratio based upon the PRRB remand of case No. 14-0401G."[1]

On **September 4, 2025**, Hooper, Lundy & Bookman, P.C. ("HLB") filed an individual appeal on behalf of Watauga. The appeal, which was assigned **Case No. 25-5736**, included two issues:

1. Medicare DSH – SSI Days Data Matching Errors
2. Medicare DSH – Additional SSI Codes

On **September 5, 2025**, the Board issued an Acknowledgement & Critical Due Dates ("ACDD") notification for Case No. 25-5736.

On **April 29, 2026**, HLB requested the transfer of the Medicare DSH – Additional SSI Codes issue to Case No. 26-1966G, an optional "Hooper Lundy & Bookman CY 2007 Medicare DSH – Additional SSI Codes Group."

[1] RNPR at 1 (Mar. 3, 2025).

Analysis:

In reviewing the transfers, it was noted that the two issues under appeal were not adjusted in the RNPR. As stated *supra*, the RNPR was issued as a result of CR 13294. The purpose of the CR was "to provide guidance for the treatment of Medicare Part C days in the calculation of a provider's Medicare Disproportionate Share Hospital adjustment", with an effective date of March 25, 2024.[2]

Because the RNPR was issued specifically to update the *treatment of Part C days* in the calculation of the DSH adjustment, the Provider's SSI percentage was updated to include Part C days resulting from the Allina Court decisions. The Provider cited audit adjustments 3 and 4 for all issues.

According to the Audit Adjustment Report:

- **Adjustment No. 3** was "[t]o implement the PRRB Part C remand of Case #14-0401G under the terms of CMS Ruling 1739-R in accordance with the final rule for the treatment of Medicare Part C days in the Medicare disproportionate patient percentage (88 FR 37772)."
- **Adjustment No. 4** was "[t]o report previous payment data per the contractor's records."

Board's 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 contractor determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

> (a) General. (1) A Secretary determination, a contractor determination, or a decision by a reviewing entity (as described in § 405.1801(a)) 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. . .

[2] CMS Manual System Transmittal 12513, Change Request 13294 (Pub. 100-20 One-Time Notification) at 1 (Feb. 21, 2024).

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

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

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

> (a) Right to hearing on final contractor determination.
> A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of

> receipt by the provider of the final contractor or Secretary determination.[3]

The Board has determined that it does not have jurisdiction over the Medicare DSH – SSI Days Data Matching Errors (Issue 1) and the Medicare DSH – Additional SSI Codes (Issue 2) that Watauga appealed from the March 3, 2025 RNPR, as the issues were not adjusted in the determination.

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[.]"[4] The RNPR in this case was specifically issued to adjust Part C days and the issues related to the SSI Data Matching and Additional SSI Codes are separate and distinct issues, not related to Part C days.

Pursuant to 42 C.F.R. § 405.1889, based on the RNPR under appeal in this case, the Board would only have jurisdiction over issues related to Part C days as that was all that was adjusted as part of the Change Request. Here, Watauga referenced audit adjustment numbers 3 and 4 for all of the issues under appeal. However, according to Watauga's audit adjustment report, those adjustments stem from the Part C days remand and were made to update the previous payment data based on the Part C final rule. Further, the Board finds that there is no evidence to corroborate that the MAC adjusted something other than the Part C days as a result of the remand.

Accordingly, the Board finds that Watauga's appeal included two issues which were not adjusted in the RNPR. Therefore, the Board dismisses the issues:

- Medicare DSH – SSI Days Data Matching Errors (Issue 1) and
- Medicare DSH – Additional SSI Codes (Issue 2)

Relatedly, the Board ***denies the transfer*** of the Medicare DSH – Additional SSI Codes issue (2) to Case No. 26-1966G.

As no issues remain, Case No. 26-5736 is hereby dismissed and removed from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

[3] (Emphasis added).
[4] 42 C.F.R. § 405.1889(b)(1).

Board Members:

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

For the Board:

6/3/2026

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq. Federal Specialized Services
Sven Collins, Hooper, Lundy & Bookman (Rep for Group)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-L) (MAC for 26-1966G)

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Via Electronic Delivery

Kelly Carroll, Esq.
Hooper, Lundy & Bookman, P.C.
401 9th Street NW, Suite 550
Washington, DC 20004

RE: ***Board Decision in Whole and Denial of Related Issue Transfer***
Watauga Medical Center (Provider Number 34-0051), FYE 09/30/2006
Case Number: 25-5737

Dear Ms. Carroll:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced appeal in response to the recent requests to transfer issues to group appeals and notes an impediment to jurisdiction. The pertinent facts and the jurisdictional decision of the Board are set forth below.

Pertinent Facts:

On, **March 3, 2025**, Watauga Medical Center ("Watauga") was issued a Revised Notice of Program Reimbursement ("RNPR") for fiscal year end September 30, 2006. This RNPR clearly states, "[a]s a result of Change Request 13294, the cost report is being revised to reflect the CMS published SSI ratio based upon the PRRB remand of case No. 14-3330G."[1]

On **September 4, 2025**, Hooper, Lundy & Bookman, P.C. ("HLB") filed an individual appeal on behalf of Watauga. The appeal, which was assigned **Case No. 25-5737**, included three issues:

1. Medicare DSH – SSI Days Data Matching Errors
2. FYE 2006 Part C Days Issue
3. Medicare DSH – Additional SSI Codes

On **September 5, 2025**, the Board issued an Acknowledgement & Critical Due Dates ("ACDD") notification for Case No. 25-5737.

[1] RNPR at 1 (Mar. 3, 2025).

On **April 29, 2026**, HLB requested the transfer of the following issues to optional groups:

Issue	Group Case
FYE Part C Days	26-1959G - Hooper Lundy & Bookman CY 2006 Continued Part C Days Appeal Group
Medicare DSH- Additional SSI Codes	26-1962G - Hooper Lundy & Bookman CY 2006 Medicare DSH – Additional SSI Codes Group

Analysis:

In reviewing the transfers, it was noted that two of the issues were not adjusted in the RNPR under appeal. As stated *supra*, the RNPR was issued as a result of CR 13294. The purpose of the CR was "to provide guidance for the treatment of Medicare Part C days in the calculation of a provider's Medicare Disproportionate Share Hospital adjustment", with an effective date of March 25, 2024.[2]

Because the RNPR was issued specifically to update the *treatment of Part C days* in the calculation of the DSH adjustment, the Provider's SSI percentage was updated to include Part C days resulting from the Allina Court decisions. The Provider cited audit adjustments 3 and 4 for all issues.

According to the Audit Adjustment Report

- **Adjustment No. 3** was "[t]o implement the PRRB Part C remand of Case #14-3330G under the terms of CMS Ruling 1739-R in accordance with the final rule for the treatment of Medicare Part C days in the Mediare disproportionate patient percentage (88 FR 37772)."
- **Adjustment No. 4** was "[t]o report previous payment data per the contractor's records."

Board's 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 contractor determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

[2] CMS Manual System Transmittal 12513, Change Request 13294 (Pub. 100-20 One-Time Notification) at 1 (Feb. 21, 2024).

> (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 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.

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

> (a) Right to hearing on final contractor determination.
> A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.

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

The Board has determined that it does not have jurisdiction over the Medicare DSH – SSI Days Data Matching Errors (Issue 1) and the Medicare DSH – Additional SSI Codes (Issue 3) that Watauga appealed from the March 3, 2025 RNPR, as the issues were not adjusted in the determination.

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[.]"[4] The RNPR in this case was specifically issued to adjust Part C days and the issues related to the SSI Data Matching and Additional SSI Codes are separate and distinct issues, not related to Part C days.

Pursuant to 42 C.F.R. § 405.1889, based on the RNPR under appeal in this case, the Board would only have jurisdiction over issues related to Part C days as that was all that was adjusted as part of the Change Request. Here, Watauga referenced audit adjustment numbers 3 and 4 for all of the issues under appeal. However, according to Watauga's audit adjustment report, those adjustments stem from the Part C days remand and were made to update the previous payment data based on the Part C final rule. Further, the Board finds that there is no evidence to corroborate that the MAC adjusted something other than the Part C days as a result of the remand.

Accordingly, the Board finds that Watauga's appeal included two issues which were not adjusted in the RNPR. Therefore, the Board dismisses the following issues:

- Medicare DSH – SSI Days Data Matching Errors (Issue 1) and
- Medicare DSH – Additional SSI Codes (Issue 3)

Relatedly, the Board ***denies the transfer*** of the Medicare DSH – Additional SSI Codes issue (3) to Case No. 26-1962G.

As the "FYE 2006 Part C Days Issue" (2) was successfully transferred to a group (Case No. 26-1959G), and with the dismissal of the other two issues, no issues remain in Case No. 26-5737. Therefore, the appeal is hereby dismissed and removed from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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[3] (Emphasis added).
[4] 42 C.F.R. § 405.1889(b)(1).

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

For the Board:

6/3/2026

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq. Federal Specialized Services
Sven Collins, Hooper, Lundy & Bookman (Rep for Groups)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-L) (MAC for 26-1962G)
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba (J-E) MAC for 26-1959G)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
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410-786-2671

Via Electronic Delivery

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

RE: ***Request for Reconsideration and Reinstatement of Board's Dismissal of Medicaid Eligible Days & Section 1115 Waiver Days Issue***
Stormont Vail Hospital (Provider Number 17-0086)
FYE: 09/30/2013
Case Number: 17-1296

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the Request for Reconsideration and Reinstatement of the Board's Dismissal of Medicaid Eligible Days & Section 1115 Waiver Days Issue submitted by Quality Reimbursement Services, Inc. on behalf of Stormont Vail Hospital ("Provider") on March 6, 2026. The decision of the Board is set forth below.

Pertinent Facts:

On **May 6, 2024**, the Board dismissed Issue 2: Disproportionate Share Hospital ("DSH") Payment – Medicaid Eligible Days and the Section 1115 Waiver Days issue. In the dismissal, the Board found the Provider noncompliant with 42 C.F.R. §§ 405.1835(b) and (e), 405.1853(b)(2)-(3), and 412.106(b)(4)(iv) and Board Rules 7, 8, 25, and 27.[1]

Ten months later, on **March 18, 2025**, the Provider withdrew Issue 3, the remaining issue on appeal, and the case was closed as no issues remained in the appeal.

A year later, on **March 6, 2026**, the Provider requested reinstatement of the DSH Payment – Medicaid Eligible Days issue.

Provider's Reinstatement Request:

The Provider "asserts that there is no '§ 1115 Waiver Days issue,' and as such it was neither timely nor untimely added to the Provider's appeal."[2]

[1] The Board also noted a failure to comply with the instructions included in the Board's Notices which set the Board's deadlines.
[2] Request for Reconsideration and Reinstatement of Dismissal of Medicaid Eligible Days & Section 1115 Waiver Days Issue at 1 (Mar. 6, 2026).

The Provider's argument is that 1115 waiver days are a component or sub issue of the Medicaid Eligible Days issue, and regulations and Board rules do not place a time limit on adding those.[3] They go on to argue:

> [T]he Provider timely appealed the non-inclusion of Medicaid eligible days, saying '[t]he 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.' Emphasis added. The italicized language above makes clear that the Provider claimed that the MAC needed to include *all* Medicaid eligible days, and that this in fact was the single issue being appealed. By definition, section 1115 waiver days are Medicaid eligible days. Therefore, by definition, section 1115 waiver days were within the scope of the appeal.[4]
>
> . . .
>
> Rule 8 is also internally inconsistent with Rule 7. Whereas Rule 8 refers to "components" of an issue, Rule 7.1 provides that, for purposes of identifying the "issue" under appeal, the provider needs to "[g]ive a concise issue statement" that describes the cost report adjustment, including the cost report adjustment number, why the cost report adjustment is incorrect, and how the payment should be determined differently. Thus, Rule 8 is both inconsistent with the regulations and Rule 7. Further, whereas Rule 7 directs providers to Rule 8, Rule 8 directs the provider to Rule 7. This direction is flatly inconsistent with Rule 7, as explained above, or at the very least is confusing and misleading.[5]

Board's Analysis and Decision:

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

The Board disagrees with the Provider's argument that "there is no section 1115 waiver issue." As the Board indicated in its initial decision, although the Provider appealed Medicaid eligible days, that issue ***is separate and distinct*** from the § 1115 waiver days as recognized by numerous Board, Administrator and Court decisions[6] as well as the Board's Rules in effect when the appeal for this case was filed.

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[3] *Id*. at 1-2.
[4] *Id.*
[5] *Id*. at 3.
[6] *See, e.g.*, *QRS 1993-2007 DSH/Iowa Indigent Patient /Charity Care (GA) Group v. Blue Cross Blue Shield Ass'n*,

Regardless of whether the Provider *properly* included the § 1115 waiver days issue in its appeal request (which it did not), QRS also failed to properly develop the merits of § 1115 waiver day issue until the Provider's Final Position Paper. As stated in the original dismissal, this is an independent basis for dismissal of the § 1115 waiver day issue.

The Board's analysis is consistent with *Baylor All Saints Medical Center v. Becerra,*[7] issued March 21, 2025, as well as *Atrium Health Carolinas Med. Ctr. v. Kennedy,* issued July 21, 2025).[8] As such, the Board denies the reinstatement request. The Board's prior decision to dismiss 1115 waiver days was proper. Not only did the Provider fail to identify the issue in its Request for Hearing or include a list of days, it also failed to brief the issue ***or*** include a days listing until the final position paper.

Along with the arguments covered in the Board's dismissal regarding noncompliance with Board Rules 25 and 27 addressing the development of the Provider's issue, the Provider's request for reinstatement fails to establish good cause. Board Rule 47 reads, in relevant part:

> **Rule 47 Reinstatement**
>
> **47.1 Motion for Reinstatement**
>
> * * *
>
> [T]he Board will not reinstate an issue(s)/case if the provider was at fault.
>
> * * *
>
> **47.3 Dismissal for Failure to Comply with Board Procedures**
>
> Upon written motion demonstrating good cause, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, administrative oversight, settlement

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Adm'r Dec. (Jan. 15, 2013), *affirming* PRRB Dec. No. 2013-D02 (Nov. 21, 2012)*; St. Dominic-Jackson Mem'l Hosp. v. Sebelius*, No. 3:12-cv-832, 2014 WL 8515280 (S.D. Miss. 2014); *Singing River Health Sys. v. Novitas Solutions, Inc.*, PRRB Dec. 2016-D19 (Sept. 20, 2016), *rev'd* CMS Adm'r Dec. (Nov. 18, 2016); *CCT&B 2005-2006 Hurricane Katrina § 1115 Waiver UCP Days Grp. v. Novitas Solutions, Inc*., PRRB Dec. 2016-D18 (Sep. 16, 2016), *rev'd* CMS Adm'r Dec. (Nov. 18, 2016), *aff'd sub nom. Forrest Gen. Hosp. v. Hargan*, No. 2:17-CV-8, 2018 WL 11434575 (S.D. Miss. Feb. 22, 2018), *rev'd & remanded Forrest Gen. Hosp. v. Azar*, 926 F.3d 221 (5th Cir. 2019); *Southwest Consulting UMass Mem'l Health Care & Steward Health 2009 DSH CCHIP Section 1115 Waiver Days Grps. v. Nat'l Gov't Servs., Inc*., PRRB Dec. 2017-D04 (Jan. 27, 2017), *rev'd* CMS Adm'r Dec. (Mar. 21, 2017), *vacated & remanded sub nom*. *HealthAlliance Hosps., Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. Oct. 26, 2018); *Florida Section 1115 LIP Rehab DSH Waiver Days Grps. v. First Coast Serv. Options*, PRRB Decs. 2018-D21, 2018-D22 (Feb. 8, 2018), *vacated by* Adm'r Dec. (Mar. 30, 2018), *rev'd by Bethesda Health Inc. v. Azar*, 389 F. Supp. 3d 32 (DDC 2019), *aff'd by* 980 F.3d 121 (D.C. Cir. 2020).

[7] *Baylor All Saints Medical Center v. Becerra*, 2025 WL 888500 (N.D. Texas, 2025).

[8] *Atrium Health Carolinas Med. Ctr. v. Kennedy*, 2025 WL 2029801 (D.D.C. July 21, 2025).

> negotiations or a change in representative will not be considered good cause to reinstate. . .

The Board also notes the Provider's request "that the Board issue a decision on our request by May 6, 2026, so that the Provider may timely file a civil action contesting the dismissal if necessary."[9] The regulations at 42 C.F.R. § 405.1877 speak to the Provider's access to Judicial review. They read, in pertinent part:

(a) *Basis and scope.*

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

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

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

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

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

As mentioned above, the Board's final decisions subject to judicial review are listed at 42 C.F.R. § 405.1875(a)(2) and include Board hearing decisions, a Board dismissal decision, and a Board

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

EJR decision.[10] Here, the review of the dismissal determination was available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 after final disposition of the appeal, which was March 18, 2025. Therefore, the deadline for the Provider to file a civil action in relation to that decision was 60 days from March 18, 2025, so the time for filing a civil action has lapsed. The Board's decision on the Provider's Reconsideration request is not a "final Board decision" subject to judicial review.

As such, the Board declines to exercise its discretion and denies the request for reconsideration. Accordingly, Case No. 17-1296 remains closed.

BOARD MEMBERS:

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

FOR THE BOARD:

6/3/2026

X Kevin D. Smith, CPA

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

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

[10] *See* 42 C.F.R. § 405.1875(a)(2).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Request for Reconsideration of Board's Dismissal of Appeal***
Providence Holy Cross Medical Center (Provider Number 05-0278)
FYE: 12/31/2001
Case Number: 26-0572

Dear Mr. Blumberg,

The Provider Reimbursement Review Board ("Board") has reviewed the Request for Reconsideration of the Board's Dismissal of Appeal submitted by Blumberg Ribner on behalf of Providence Holy Cross Medical Center ("Provider") on December 16, 2025. The decision of the Board is set forth below.

Pertinent Facts:

On **December 9, 2025**, the Board dismissed the appeal, as jurisdictionally deficient, determining that the appeal did not meet regulatory requirements. In the dismissal, the Board found the Provider noncompliant with 42 C.F.R. §§ 405.1835 - 405.1840, and Board Rules 4.1, 6.1, and 7.1. The Board found that the Provider "failed to submit the ***correct final determination,*** dated 06/02/2025, on which the appeal is based."[1] The appeal was closed on **December 10, 2025**.

On **December 16, 2025**, the Provider requested reconsideration and reinstatement.

Provider's Reinstatement Request

The Provider's Reinstatement Request reads, in pertinent part:

> On December 9, 2025, per the attached letter, the PRRB dismissed the above referenced appeal for failing to include a copy of the final determination when filing the appeal. The Provider admits that it made a mistake and uploaded the estimated impact calculation instead of the final determination when establishing the appeal via OH CDMS. Prior to the dismissal, the Provider was neither given a warning about the mistake nor an opportunity to rectify the mistake by uploading a copy of the final determination. The Provider is respectfully requesting that the PRRB reinstate the appeal to allow the Provider to cure the error and allow the appeal

[1] Board Determination re: Filing Requirements at 2 (Dec. 9, 2025) (emphasis included).

> to proceed. The error did not impact any other parties as the MAC already had a copy of the final determination.[2]

Board's Analysis and Decision:

The Board received the instant appeal on December 1, 2025. Board Rule 47 reads, in relevant part:

> **Rule 47 Reinstatement**
>
> **47.1 Motion for Reinstatement**
>
> . . .
>
> [T]he Board will not reinstate an issue(s)/case if the provider was at fault.
>
> . . .
>
> **47.3 Dismissal for Failure to Comply with Board Procedures**
>
> Upon written motion demonstrating good cause, the Board may reinstate a cause dismissed for failure to comply with Board procedures. Generally, administrative oversight, settlement negotiations or a change in representative will not be considered good cause to reinstate . . . .

The Provider's Reinstatement Request "admits that it made a mistake" in its failure to submit the correct final determination. The deadline for the appeal was Dec. 4, 2025 and the appeal was filed on Dec. 1, 2025. The Board originally dismissed the appeal on Dec. 9, 2025 for failing to meet timely filing requirements and/or jurisdictional requirements. The Provider filed the reconsideration request on Dec. 16, 2025 and included the final determination.

While the Board appreciates the Provider's efforts to timely correct the error, the Board has consistently held that, in accordance with Rule 47.3, administrative oversight is not good cause to reinstate. The Board and its staff cannot – noting that in excess of 5,000 new appeals are filed each fiscal year – be expected to identify and notify parties of errors in filings; parties must institute a self-verification procedure. The Provider has a duty pursuant to Board Rule 7 to "support the determination being appealed and the basis for its dissatisfaction for ***each*** issue under appeal consistent with 42 C.F.R. § 405.1835(b) or (d) as applicable" and also to, per Rule 7.1, "Include a copy of the **final** determination, such as the NPR, revised NPR, exception determination letter, Federal Register notice, or quality reporting payment reduction decision" and to "Identify the date the final determination was issued. Ensure the appeal is filed timely based on the appeal period in Rule 4.3."

[2] Request for Reconsideration at 1 (Dec. 16, 2025).

In this case, although the final determination was issued (and received) on June 2, 2025, the appeal was not filed until Dec. 1, 2025, three (3) days before the filing deadline. Even if the Board were able to identify all cases in which the documentation was insufficient and notify the providers of such (and the Board and its staff are **not** able to do this with the volume of cases on the docket), the last-minute nature of this appeal's filing would make that even more impossible. If the Board could have reviewed the appeal for completeness immediately upon filing (it cannot), it is unlikely there was sufficient time to cure the error within the timeframe to file the appeal. Providers and Representatives must manage their docket, in accordance with the Board's published rules. As such, the Board declines to exercise its discretion and denies the request for reconsideration. Accordingly, Case No. 26-0572 remains closed.

Board Members Participating:

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

For the Board:

6/3/2026

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Dean Wolfe, Noridian Healthcare Solutions (J-F)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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

RE: ***Notice of Dismissal of Cleveland Clinic Indian River Memorial Hospital, Inc.***
(formerly Indian River Memorial Hospital, Inc.), Prov. No. 10-0105, FYE 09/30/2018
PRRB Case No. 22-1351

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-1351. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days issue.

Background

On **March 16, 2022**, the Medicare Contractor ("MAC") issued a Notice of Program Reimbursement ("NPR") for Indian River Memorial Hospital, Inc. ("Indian River") for its fiscal year end ("FYE") September 30, 2018.

On **August 23, 2022**, Quality Reimbursement Services, Inc. ("QRS") filed an appeal on behalf of Indian River which included two (2) issues:

1. DSH Medicaid Eligible Days
2. DSH SSI Percentage (Systemic Errors)

On **August 24, 2022**, the Board issued the Acknowledgement and Critical Due Dates ("ACDD") notice, providing among other things, the filing deadlines for the parties' preliminary position papers (hereinafter "PPP"). This notice also gave the following instructions to the Provider regarding the content of its PPP:

> 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 24, 2022**, QRS added the DSH SSI Medicaid Medicare Managed Care Part C Days issue to the appeal.

On **October 14, 2022**, QRS added three more issues to the appeal:
- DSH SSI Unduly Narrow Definition of SSI Entitlement
- DSH SSI & MCD Fractions - Medicare Managed Care Part C Days (duplicative of previously added issue so withdrawn on November 7, 2022)
- DSH SSI & MCD Fractions - Dual Eligible Days

On **March 7, 2023**, the Board issued a revised Critical Due Dates notice("CDD")

On **March 17, 2023**, QRS requested the transfers of the following issues to optional groups:
- DSH SSI Percentage (Systemic Errors) - Transferred to 23-0316G[2]
- DSH SSI Unduly Narrow Definition of SSI Entitlement - Transferred to 23-0316G
- DSH SSI & MCD Fractions - Medicare Managed Care Part C Days - Transferred to 23-0317G
- DSH SSI & MCD Fractions - Dual Eligible Days - Transferred to 23-0318G

On **April 17, 2023**, the Provider timely filed its PPP.

On **July 12, 2023**, the Medicare Contractor ("MAC") timely filed its PPP.

On **November 19, 2025**, the Board issued a Notice of Hearing scheduling the case for June 5, 2026.

On **March 3, 2026**, QRS filed its final PP.

On **March 25, 2026**, the MAC filed its final PP.

On **March 31, 2026**, the MAC filed a Motion to Dismiss the Medicaid Eligible Days Issues.

On **April 30, 2026**, QRS filed the Provider's responsive jurisdictional brief.

MAC's Motion to Dismiss DSH – Medicaid Eligible Days

The MAC contends the Provider failed to file complete position papers in violation of Board Rule 25.3 and 27. Based on its failure to provide the necessary documentation (i.e., list of additional Medicaid Eligible days or any supporting documentation) the Provider has abandoned

[1] (Emphasis added.)
[2] Although the issue was titled "SSI Percentage (Systemic Errors)" the issue description described the Unduly Narrow Definition of SSI Entitlement issue, and which was ultimately transferred to an Unduly Narrow Definition of SSI Entitlement optional group.

its claim for additional Medicaid Eligible days. In addition, the Provider is attempting to untimely and improperly add the Section 1115 Waiver days issue via its PPP submission. The MAC also pointed out that the Provider was already pursuing the Waiver days issue in Case No. 23-0566G.

Provider's Jurisdictional Response

QRS timely filed a response to the MAC's jurisdictional challenge in which it argues that it has since filed an unredacted version of the redacted listing of eligible days it submitted with its final PP on April 29, 2026. QRS asserts that the Provider complied with Board rules and regulations regarding the submission on PPs and furnishing data which does not require identification of specific eligible days in PPs. In addition, QRS agrees that its Section 1115 Waiver days issue is being handled separately and does not need to be resolved in the individual appeal.

Decision of the Board

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

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

A. DSH Payment – Medicaid Eligible Days

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

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (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.[3]

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

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

Rule 25 - Preliminary Position Papers[4]

> **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.

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

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 August 24, 2022 Acknowledgement and Critical Due Dates notice issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 1, 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.[5]

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 17, 2023, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[6] Significantly, the PPP did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in

[5] (Emphasis added.)
[6] Provider's PPP at 9 (April 17, 2023).

this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $381,637 based on an estimated 579 days). The Provider's complete briefing of this issue in its PPP is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's [or Providers'] Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's [or Providers'] Medicaid Fraction of the

> disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).
>
> Based on the listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2018 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its March 31, 2026 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid eligible days issue because:

(1) the Provider was in violation of Board Rules 25.3 and 27.2 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary and final position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.; and
(2) the Provider failed to furnish an unredacted, auditable list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the Board Rules.[7]
(3) In addition, the MAC argued the Provider was attempting to untimely, and improperly, add the Section 1115 waiver days issue by including it in the narrative of its PPP and final PP submissions.

The Board notes that on March 3, 2026, QRS did include a redacted listing of "Additional Medicaid Eligible Days" as an exhibit to its final position paper. The 1-page listing shows a total of 61 additional days but does not explain why the listing was being submitted so late as it was ***almost 3 years past the deadline for including it with the Provider's PPP*** for which the deadline was April 20, 2023.

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

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[7] *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.

The Board rejects the Provider's attempts to include the eligible days listing as an exhibit to its final PP on March 3, 2026 because:

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

2. The uploaded exhibit fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); and (b) *why* the listing of the roughly 61 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 3.5 years after this appeal was filed and almost 7.5 years after the fiscal year at issue had closed).

3. Neither the Board Rules, nor the August 24, 2022 Case Acknowledgment and Critical Due Dates notice, permit the Provider to file a "Supplement" to its PPP (nor did the Provider allege in the upload that they do).

4. Given that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the PPP filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its PPP or a supplement of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the appeal request, nor the PPP, identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the uploaded listing cannot be considered a refinement of the position paper since no specific days or listing were included with the PPP.[8]

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

B. Section 1115 Waiver Days

The Board finds that the Section 1115 Waiver days issue is not a part of this appeal. In the Provider's Responsive Jurisdictional Brief filed on April. 30, 2026, QRS agreed with the MAC ". . . that its Section 1115 waiver days are being handled separately and, as such, do not need to be resolved in the subject individual appeal."

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

* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible Days (Issue No. 1). As no issues remain, the Board hereby closes Case No. 22-1351 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:

6/4/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Mark Polston, Esq.
King & Spalding, LLP
1700 Pennsylvania Avenue NW, Suite 900
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RE: ***Expedited Judicial Review Determination***

Case Number: 26-1663GC - KPC Health FFY 2026 Understated Labor Related Share CIRP Group

Dear Mr. Polston:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petition for Expedited Judicial Review ("EJR") filed on **May 14, 2026** concerning the above referenced group appeal. The Board's decision on jurisdiction and EJR for this case are set forth below.

Issue:

The Petition for EJR describes the issue as follows:

> The question presented in this appeal is whether the Secretary of Health and Human Services' (the "Secretary") exclusion of certain labor costs from the labor-related share of the standardized amount published in the fiscal year ("FY") 2026 inpatient prospective payment system ("IPPS") final rule was improper. Specifically, the Secretary has excluded from the labor related share the cost of all financial services and the costs of professional fees and home office services incurred outside the local labor market of the hospital. The members of this group appeal challenge this final payment determination because, by the plain text of the statute, the labor related share must include all hospital wage and wage-related costs, regardless of whether they vary by the local market. 42 U.S.C. § 1395ww(d)(3)(E)(i). Furthermore, the Secretary's calculation of the labor-related share to exclude these costs from the labor-related share is arbitrary and capricious.[1]

[1] Petition for Expedited Judicial Review at 1 (May 14, 2026) ("Petition for EJR").

Statutory and Regulatory Background:

1. Wage Index; Rural and Urban Classification

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[2] known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs"). The base payment rate is comprised of a standardized amount[3] for all subsection (d) hospitals located in an "urban" or "rural" area.[4]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[5] from time-to-time estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. Indeed, the statute requires the Secretary 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 standardized amount "is divided into labor-related and nonlabor-related amounts; only the proportion considered the labor-related amount is adjusted by the wage index."[6]

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals.[7] Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts.[8]

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[2] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).
[3] The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27708, 27765-27766 (May 27, 1994).
[4] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[5] of the Department of Health and Human Services.
[6] 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).
[7] 42 U.S.C. § 1395ww(d)(3)(E)(i).
[8] 71 Fed. Reg. at 48146.

As outlined above, the wage index is impacted based on data obtained from surveys of hospitals' wages and wage-related costs. When the IPPS was implemented, the Secretary included professional fees, business services, and miscellaneous expenses in the labor-related portion of the standardized amount, recognizing that they had a wage component and are labor intensive.[9] This position was reaffirmed in the FY 1991 Final Rule:

> Each of these categories is classified as labor-related because it consists of direct payments to labor inputs by the hospital or hospital payments for services that are very labor intensive. A narrower definition of labor related costs would mean that a smaller share of the adjusted standardized amounts would be adjusted by the area wage index.[10]

The position was repeated, and clarified, in the FY 2006 Final Rule:

> [W]e define the labor-related share as the national average proportion of operating costs that are attributable to wages and salaries, fringe benefits, professional fees, contract labor, and labor intensive services. These costs are included in the labor-related share because they are labor intensive, and therefore, are "hospitals" costs that are attributable to wages and wage-related costs." As was stated previously, we believe that, with the exclusion of postage, the costs included in the labor-related share are, in fact, related to, influenced by, or vary with local labor markets. However, hospital costs are not necessarily "attributable to wages and wage-related costs "merely because they may be related to, may be influenced by, or may vary with local labor markets. Therefore, it would be incorrect to say that all costs that are related to, influenced by, or vary with the local labor market must be included in the labor-related share merely because they are related to, influenced by, or vary with the local labor market.
>
> We include only labor-intensive inputs in the labor-related share.[11]

In the FY 2010 Final Rule, the Secretary explained that a cost category (*e.g.*, professional fees or home office costs) is included "in the labor-related share if the costs are *labor intensive* and *vary with the local labor market*."[12] This position was reiterated in the FY 2026 Final Rule.[13] The Secretary explained that, since, the labor-related share is intended to account for geographic differences in area wage levels, professional fees purchased outside of the local labor market are not included therein.[14] CMS conducted a survey of hospitals to determine the proportion of professional services attributable to local firms vs. national firms,[15] as well as home office costs

[9] 49 Fed. Reg. 234, 256 (Jan. 3, 1984).
[10] 55 Fed. Reg. 35990, 36046 (Sept. 4, 1990).
[11] 70 Fed. Reg. 47278, 47396 (Aug. 12, 2005).
[12] 74 Fed. Reg. 43754, 43850 (Aug. 27, 2009) (emphasis in original).
[13] 90 Fed. Reg. 36536, 36869 (Aug. 4, 2025).
[14] *Id.* at 36872.
[15] 74 Fed. Reg. at 43850-43851.

attributable to hospitals not in the same labor market as their home offices.[16] Based on this survey, the Secretary excluded the portion of these fees that were deemed "nonlabor-related."[17] In 2010, financial services were also excluded from this calculation.[18] A new survey was conducted and the same categories of costs were excluded from the labor-related share for FFY 2026.[19] This effectively excludes certain non-locally incurred "wage" costs from the labor-related share.

Positions of the Parties:

1. Providers' Appeal Request

The Board received a request to establish a Common Issue Related Party ("CIRP") group from King & Spalding, LLP on **January 31, 2026**. The participants in this group are appealing from the Federal Register Notice published **August 4, 2025**. This appeal challenges the calculation of the FFY 2026 standardized amount, arguing the "labor related share" imbedded in that calculation improperly excludes professional fees, home office costs, and costs for financial services.[20]

The Statement of the Issue submitted with the initial group appeal request reads:

> The Providers in this group appeal challenge CMS's calculation of the labor-related share of the [IPPS] standardized amount for FY 2026. The Medicare statute directs CMS to estimate the portion of the standardized payment amount that is attributable to labor costs relative to other costs and to adjust the labor-related portion of the standardized payment amount to account for the geographic differences in labor costs, i.e. the wage index. In 2009, the D.C. Circuit held that the "role of the [labor-related share] is to capture the 'universe' of costs" subject to the wage index adjustment factor. *Southeast Alabama v. Sebelius*, 527 F.2d 912, 918 (D.C. Cir. 2009). However, since FY 2010, CMS has excluded from the labor-related share costs associated with "professional fees" and "home office costs" incurred outside the hospital's labor area and the costs of "financial services." These exclusions, which are contrary to the statute and otherwise arbitrary and capricious, have artificially depressed the labor-related share, thereby reducing the Provider's Medicare reimbursement. The Provider therefore requests an order from the Board directing the Medicare contractor to recalculate the Provider's IPPS payments to reflect a labor-related share that captures the "universe" of labor costs.[21]

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[16] *Id.* at 43851-43852.
[17] *Id.* at 43847, n. 4.
[18] *Id* at 43847, n.6.
[19] 90 Fed. Reg. at 36869-70.
[20] Petition for EJR at 1.
[21] Statement of the Issue at 1 (citations omitted).

The Providers filed a Petition for Expedited Judicial Review on **May 14, 2026**.

2. Providers' Request for EJR

As noted *supra*, the Petition for EJR describes the issue as follows:

> The question presented in this appeal is whether the Secretary of Health and Human Services' (the "Secretary") exclusion of certain labor costs from the labor-related share of the standardized amount published in the fiscal year ("FY") 2026 inpatient prospective payment system ("IPPS") final rule was improper. Specifically, the Secretary has excluded from the labor related share the cost of all financial services and the costs of professional fees and home office services incurred outside the local labor market of the hospital. The members of this group appeal challenge this final payment determination because, by the plain text of the statute, the labor related share must include all hospital wage and wage-related costs, regardless of whether they vary by the local market. 42 U.S.C. § 1395ww(d)(3)(E)(i). Furthermore, the Secretary's calculation of the labor-related share to exclude these costs from the labor-related share is arbitrary and capricious.[22]

The Providers argue that only including cost categories that "vary with the local labor market" is a departure from the Secretary's prior practice, and that it contradicts with CMS' position in, and the courts ultimate holding in, *Southeast Alabama Medical Center v. Sebelius,* 572 F.3d 912 (D.C. Cir. 2009).[23] They insist that "[t]he best reading of the Medicare statute does not permit excluding wage and wage-related costs for services purchased outside the labor market from the labor-related share of the IPPS standardized amount."[24]

CMS has responded, in the 2010 IPPS Final Rule, to the position that it should not remove any portion of professional fees from the labor-related share:

> [B]ecause we now have empirical evidence we can use to establish what portion of these professional fees are actually incurred in the local labor market, in accordance with section 1886(d)(3)(E)(i) of the Act, we are including only such wage and wage-related costs in the labor-related share. To the extent the evidence shows that the fees paid do not vary with, or are not influenced by, the local labor

[22] Petition for EJR at 1.
[23] *Id.* at 5-6.
[24] *Id.* at 9 (citing *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024)).

> market, we are not including them in the labor-related share and are not subjecting them to the wage index adjustment.[25]

The Providers, however, argue that the statute *requires* the inclusion of *all* "costs which are attributable to wages and wage-related costs," and has no exception for "undisputed wage and wage-related costs from the labor-related share simply because they do not vary by the local labor market."[26] They reiterate that this position was adopted in the holding of the D.C. Circuit Court's decision in *Southeast Alabama Medical Center* in 2009, and claim CMS' failure to explain why it was adopting a "new" approach in 2010 amounts to arbitrary and capricious rulemaking.[27]

3. Medicare Contractor's Position

On **May 20, 2026**, the Medicare Contractor's designated representative, Federal Specialized Services, filed a timely response to the Petition for Expedited Judicial Review. It took no position on the Request for EJR and noted it would not be filing any jurisdictional challenges. It did explain, however, that none of the Providers in the group have filed a cost report for this fiscal year, so the Medicare Contractor "cannot determine whether a substantive claim challenge is appropriate."[28]

Decision of the Board:

1. Jurisdiction and Request for EJR

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

The participants that comprise this group appeal have filed appeals involving federal fiscal year 2026. Based on its review of the record, the Board finds that each of the participants in this group filed their appeal within 180 days of the publication of the Federal Register as required by 42 C.F.R. § 405.1835, that the providers each appealed the issue in this appeal, and that the Board is not precluded by regulation or statute from reviewing the issue in this appeal. Finally, the amount in controversy meets the $50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3). Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

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[25] 74 Fed. Reg. at 43854.
[26] Petition for EJR at 9.
[27] Id. at 9-10.
[28] Response to Provider's Request for Expedited Judicial Review at 1 (May 20, 2026).

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

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[29] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[30] 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"). All of the participants in this case have fiscal years that began on or after January 1, 2016, therefore the claim-specific dissatisfaction requirement is not applicable for purposes of jurisdiction.

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

[29] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[30] *Id.* at 70555.

> 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.[31]

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-*

[31] (Bold and underline emphasis added.)

***

> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f)(1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> (1) Board jurisdictional dismissal decision. **If the Board issues a jurisdictional dismissal decision** regarding the specific item under appeal (pursuant to § 405.1840(c)), **the Board's specific findings of fact and conclusions of law** (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must not be included in such jurisdictional dismissal decision**.[32]

These regulations are applicable to the cost reporting periods under appeal for all of the participants in the instant case, 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).

Accordingly, the Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[33] 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 on the relevant as-filed cost report.[34] The Board further notes that, when the

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[32] (Bold and underline emphasis added.)
[33] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[34] *See* 42 C.F.R. § 405.1873(a).

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.[35] Section 405.1873(b) sets forth the procedures for Board review of Substantive Claim Challenges:

> 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 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, FSS indicated that it would not be filing any Substantive Claim Challenges at this time but reserved the right to do so after the Providers' cost reports are filed. In this regard, all of the participants in this case are appealing the FFY 2026 Federal Register Notice and FSS has not challenged whether the as-filed cost reports included an appropriate claim for the appealed issue. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

3. Analysis Regarding Appealed Issue

The Board finds that the Secretary's determination to exclude certain professional fees, home office costs, and costs for financial services from the "labor-related share" when calculating the national standardized amount for all hospitals was made through notice and comment in the form

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[35] 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.

of an uncodified regulation. The Secretary has never incorporated the above policy into the Code of Federal Regulations. However, it is clear from his insistence that the definition of the labor-related share has not changed,[36] and the attempts to address stakeholder concerns through comments and responses in the Federal Register,[37] that the Secretary intended to bind the regulated parties and establish a binding uniform payment policy through formal notice and comment.

Accordingly, the Board finds that the Secretary intended this policy to be a binding but uncodified regulation. Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment for services . . . by regulation."[38] This interpretation and practice was applied when calculating the FFY 2026 standardized amount,[39] which is the subject of this appeal.

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 rates, inclusive of the standardized amount as calculated pursuant to CMS policy, as published in the FFY 2026 IPPS Final Rule. The Board does not have the authority to grant the relief sought by the Providers, namely invalidating the practice of excluding certain professional fees, home office costs, and costs for financial services from the "labor-related share" of the standardized amount calculation. As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in this case.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the issue related to the Secretary's determination to exclude certain professional fees, home office costs, and costs for financial services from the "labor-related share" when calculating the national standardized amount for FFY 2026 and that the Providers in this appeal are entitled to a hearing before the Board;

2) While all the Providers appealed cost reporting periods beginning after January 1, 2016, no substantive claim challenges[40] have been filed pursuant to 42 C.F.R. § 405.1873(a), and in accordance with the Board's Rules, to trigger either Board review under § 405.1873(b) or reporting under § 405.1873(d)(2);

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[36] 74 Fed. Reg. at 43845.
[37] *Id.* at 43852-43855
[38] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."
[39] 90 Fed. Reg. 36536, 36869 (Aug. 4, 2025).
[40] 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."

3) Based upon the Provider's assertions regarding the FFY 2026 IPPS Final Rule, there are no findings of fact for resolution by the Board;

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

5) It is without the authority to decide the legal question of whether the Secretary's determination to exclude certain professional fees, home office costs, and costs for financial services from the "labor-related share" when calculating the national standardized amount for FFY 2026 is valid.

Accordingly, the Board finds that the question of the validity of the Secretary's determination to exclude certain professional fees, home office costs, and costs for financial services from the "labor-related share" when calculating the national standardized amount for FFY 2026 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 this is the only issue under dispute in this case, the Board hereby closes Case No. 26-1663GC and removes it from its docket.

Board Members Participating:

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

FOR THE BOARD:

6/5/2026

X Kevin D. Smith, CPA

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

Enclosure: Schedule of Providers

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Scott Berends, Esq., Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Expedited Judicial Review Decision***
25-3514G Bass, Berry & Sims, PLC CY 2020 Capital DSH Group
25-3521GC UHHS CY 2022 Capital DSH CIRP Group
25-3913GC Univ of Florida Health CY 2020 Capital DSH CIRP Group
25-4534G Bass, Berry & Sims, PLC CYs 2017 & 2018 Capital DSH Group

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the **March 30, 2026** consolidated petition[1] for expedited judicial review ("EJR") for the above-referenced common issue related party ("CIRP") and optional group appeals. The decision with respect to EJR is set forth below.[2]

Issue under Dispute

In these group cases, the Providers are challenging:

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

Background:

Under the inpatient prospective payment system ("IPPS"), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for operating costs ("operating IPPS") as set forth at § 1395ww(d); and one for capital costs

[1] Providers' Petition for Expedited Judicial Review (Mar. 30, 2026) ("Request for EJR").
[2] The Request for EJR also encompassed Case Nos. 25-4472GC, 25-4715GC, 26-0311GC, 26-0316GC, and 24-2226GC, which were adjudicated on April 24, 2026, under separate cover.
[3] Request for EJR at 1.

("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]

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

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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.
[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).

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 are set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment that the Secretary adopted for purposes of capital IPPS.

3. Capital DSH Adjustment Under Capital IPPS

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

> **(g) Prospective payment for capital-related costs; return on equity capital for hospitals**
>
> (1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall,* for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .
>
> (B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;
>
> (ii) *may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located*;
>
> (iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and
>
> (iv) may provide for suitable adjustment to reflect hospital occupancy rate.
>
> (C) In this paragraph, the term ''capital-related costs'' has the meaning given such term by the Secretary under subsection (a)(4)

[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).

> 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 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

[14] (Underline and italics emphasis added.)
[15] 42 C.F.R. § 412.320(a)(1). *See also* MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 3 (rev. Nov. 2021), *available at* https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Jun. 4, 2026).
[16] 56 Fed. Reg. 43356 (Aug. 30, 1991).

> 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)$^{0\text{-}4176}$ - 1)), where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.
>
> Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.[18]

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

> *Comment*: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.
>
> *Response*: In the final rule, we are providing that urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level than other hospitals. For FY 1992, the minimum payment level is 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also be eligible for the higher minimum payment level. We are not

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

> 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 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,

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

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 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:

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[21] *Id.* at 43378.
[22] *Id.* at 43379.
[23] (Emphasis added.)

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

[24] *Id.*
[25] *Id*. at 43452-53.

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 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

[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.)

limitation, if any, should be imposed and provided several examples and alternatives.

****

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

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

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

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

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

> **§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural**.
>
> (a) *General criteria*. A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
>
> 1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration which is available via the ORHP website at http:// www.nal.usda.gov/orph or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857.

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

> (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 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

[29] 65 Fed. Reg. 47026, 47048.
[30] 56 Fed. Reg. at 43452.
[31] (Bold and underline emphasis added.)

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—
>
> (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

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

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

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

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: "A hospital is classified as a 'disproportionate share hospital' for the purposes of capital prospective payments if the hospital is located, *for purposes*

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

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

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

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

> Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB's new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.
>
> ****
>
> The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the

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

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

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

In the FY 2007 Proposed IPPS Rule, the Secretary[40] announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.[41]

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and

[39] 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004).
[40] of the Department of Health and Human Services.
[41] 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).

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 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:

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[42] *Id.*
[43] 71 Fed. Reg. 47870, 48104 (Aug. 18, 2006).
[44] *Id.* at 48105.

> (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 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

[45] (Bold emphasis added.)
[46] 621 F.Supp. 3d 13 (D.D.C. 2021).
[47] *Id.* at *25 (citations omitted).

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]

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

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

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

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[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.
[56] *Id.*

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 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

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[57] *Id.*
[58] *Id.*
[59] *Id.*
[60] *Id.* at *30.
[61] *Id.*
[62] Request for EJR at 7.
[63] *Id.* at 1, 7.

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

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

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

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

Board Decision

1. Jurisdiction

Based on its review of the record, the Board finds that it has jurisdiction over each Provider in each of these cases. The Providers have appealed from original NPRs or from the failure of the

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

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

The Board lacks the authority to decide the legal question presented here because it is a challenge to the validity of a regulation, namely 42 C.F.R. § 412.320(a)(1)(iii).[74] All of the providers in these four (4) 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 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

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

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

[74] 42 C.F.R. § 405.1842(f)(1)(ii).
[75] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[76] *Id.* at 70555.

meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). Since all the participants in these four (4) cases have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement for the Board's ***jurisdiction*** is not applicable.

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

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

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

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

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

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

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[77] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made. [78]

4. Substantive Claim Challenges

In these four (4) group cases, the Providers' Rule 20 certification was filed on **March 30, 2026**, the same day as the Request for EJR. Thus, pursuant to Board Rule 44.6, the Medicare Contractor had five business days (*i.e.*, until **April 6, 2026**) to either file a Substantive Claim Challenge or certify that it would be filing a challenge in each case. On **March 31, 2026**, the Medicare Contractor in Case 25-3521GC filed a certification that it would be filing a Substantive Claim Challenge. On **April 6, 2026**, the Medicare Contractor's designated representative, Federal Specialized Services ("FSS") filed a Response to Providers' EJR Request, noting that substantive claim challenges would be filed in Cases 25-3514G, 25-3913GC, and 25-4534G.[79]

Based on these timely certifications, the deadline for any Substantive Claim Challenges in these cases was **Monday, April 20, 2026**. The Board notes that FSS filed timely Substantive Claim

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[77] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[78] *See* 42 C.F.R. § 405.1873(a).
[79] An Amended Response was filed by FSS on **April 7, 2026**, to also include Case No. 25-3521GC.

Challenges in all four (4) cases.

Based on the foregoing, and pursuant to Board Rule 44.6, the Board issued a Scheduling Order to set a deadline (**Monday, May 11, 2026**) for the Providers' responses to the four (4) Substantive Claim Challenges. The Providers filed timely responses in each case on **May 7, 2026**.

A. Medicare Contractor's Challenges

FSS filed Substantive Claim Challenges over a number of participants in these four (4) cases as outlined below, which will collectively be referred to as "the Challenged Participants."

i. Case 25-3514G

FSS asserts that two (2) providers in this group failed to include an appropriate claim in their respective cost reports for the issue in this appeal:

- University of Michigan Health - West, Provider Number 23-0236, FYE 06/30/2020
- Corewell Health Grand Rapids Hospital, Provider Number 23-0038, FYE 12/31/2020[80]

FSS argues that these two providers did list protested items on their cost report, but that the summary of protested items for each Provider do not include Capital DSH as a separate item. They include protested amounts for DSH, generally, but nothing is included for or illustrates that Capital DSH was part of this protested amount. It also claims that none of the exceptions at subsections 42 C.F.R. § 413.24(j)(3)(i) through (3)(iii) apply.[81] It notes that a self-disallowance explanation was submitted with these Providers' appeals, but these were not submitted with (nor accepted by the Medicare Contractor) as part of the filed cost report as required by the regulations at 42 C.F.R. § 413.24(j)(3).[82]

ii. Case 25-3521GC

FSS claims that none of the four (4) Providers in this group included an appropriate claim in their respective cost reports for the issue in this appeal. It makes the same arguments for these Providers as those made in Case 25-3514G.[83]

iii. Case 25-3913GC

FSS claims that none of the three (3) Providers in this group included an appropriate claim in their respective cost reports for the issue in this appeal. It makes the same arguments for these Providers as those made in Case 25-3514G, except that one Provider listed $0 in protested amounts on its cost report.[84]

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[80] Medicare Administrative Contractor's Substantive Claim Challenge at 1 (Apr. 14, 2026).
[81] *Id.* at 4-5.
[82] *Id.*
[83] Medicare Administrative Contractor's Substantive Claim Challenge at 4-7 (Apr. 13, 2026).
[84] Medicare Administrative Contractor's Substantive Claim Challenge at 4-5 (Apr. 17, 2026).

iv. Case 25-4534G

FSS claims that none of the five (5) Providers in this group included an appropriate claim in their respective cost reports for the issue in this appeal. It makes the same arguments for these Providers as those made in Case 25-3514G, except that one Provider listed $0 in protested amounts on its cost report.[85]

v. "Non-Challenged Participants"

For all four (4) remaining participants in Case 25-3514G (collectively "the Non-Challenged Participants"), since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[86] 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 four (4) Non-Challenged Participants.

B. Providers' Responses

The Providers filed a consolidated response to the Substantive Claim Challenges.[87] For the 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, they did self-disallow the issue based on the Medicare Contractor being bound by 42 C.F.R. § 412.320(a)(1)(iii).[88] They also argue that the substantive claim requirements found in 42 C.F.R. §§ 413.24(j) and 405.1873 are unlawful and seek to challenge their validity.[89] They claim that these regulatory provisions "contravene the Board's authority as set forth in 42 U.S.C. § 1395oo."[90] They cite *Bethesda Hosp. Ass'n v. Bowen*[91] and *Banner Heart Hospital v. Burwell*[92] in support of their position that these regulations are unlawful.[93]

For the Challenged Providers, the Providers concede that "there is no dispute that the Providers did not claim the capital DSH costs at issue either as an allowable cost or a protested amount[.]"[94]

The Providers request the Board grant EJR for all four (4) cases over the Capital DSH issue, as well as the substantive claim regulations for the Challenged Participants.

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[85] Medicare Administrative Contractor's Substantive Claim Challenge at 5 (Apr. 14, 2026).
[86] 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."
[87] 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 7, 2026) ("Response to Substantive Claim Challenges").
[88] *Id.* at 3-5.
[89] *Id.* at 1, 13.
[90] *Id.* at 10.
[91] 485 U.S. 399 (1988).
[92] 201 F.Supp.3d 131 (D.D.C. 2016)
[93] Response to Substantive Claim Challenges at 11-13.
[94] *Id.* at 9.

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)"[95] 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 as to whether an appropriate claim was included.

For the Non-Challenged Participants, the Board need not make any findings of fact or conclusions of law regarding 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),[96] but they do not dispute FSS' assertion that there is insufficient support for the allegedly protested items. There were no worksheets describing how the providers calculated the estimated reimbursement for this specific item accompanying the cost report as required by 42 C.F.R. § 413.24(j)(2)(ii). The Board finds that no appropriate claim was included in the cost reports for any of the Challenged Participants.

5. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matters for the subject years and that all the participants in Cases 25-3514G, 25-3521GC, 25-3913GC, and 25-4534G 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);

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

4) Based upon the 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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[95] (Emphasis added.)
[96] Response to Substantive Claim Challenges at 3-5.

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

6) It is without the authority to decide the legal 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.[97]

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 25-3514G, 25-3521GC, 25-3913GC, and 25-4534G. The Board also finds that the question of the validity of the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Challenged Providers' requests for EJR for the issue and the subject years.

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

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

6/5/2026

X Kevin D. Smith, CPA

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

Enclosure: Schedules of Providers

cc: Judith Cummings, CGS Administrators (J-15)
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)
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Andrew Ruskin, Esq.
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RE: ***Expedited Judicial Review Determination***
K&L Gates LLP CYs 2017-2022 Capital DSH Cases
Case Numbers: 26-2453GC *et al.* (20 Cases – *see* **Appendix A**)

Dear Mr. Ruskin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' requests for expedited judicial review ("EJR") filed **May 15 and 18, 2026** in the above-referenced group appeals. The decision with respect to EJR is set forth below.

Issue under Dispute

In this case, the Providers are:

> [C]hallenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states in effect that urban hospitals may qualify for Capital [disproportionate share hospital] payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. [The Provider Group contends that] [t]his regulation is inconsistent with Social Security Act Section 1886(d)(8)(B)[[1]], which concerns acquired rural status. Subsection 1886(d) specifically notes that the hospitals that have undergone a rural reclassification are rural only for "purposes of this subsection [1886(d)]."[2]

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

[1] Codified at 42 U.S.C. § 1395ww(d)(8)(E).
[2] *E.g.*, Case No. 25-5611, Request for Expedited Judicial Review at 3 (May 15, 2026) ("Request for EJR"). *See also* Issue Statement – Capital DSH.

create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.[3] 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[4] for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.[5] 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.[6] Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[7]

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.[8] 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."[9]

A hospital may qualify for a DSH adjustment to its operating IPPS payments 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]

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[3] 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*").
[4] *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).).
[5] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). *See also Significant Vulnerabilities* at 4-5.
[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).

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.[12] 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
>
> (iv) may provide for suitable adjustment to reflect hospital occupancy rate.
>
> (C) In this paragraph, the term ''capital-related costs'' has the meaning given such term by the Secretary under subsection (a)(4)

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

> as of September 30, 1987, and does not include a return on equity capital.[13]

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.[14]

1. 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.[15] In implementing the capital IPPS, the Secretary recognized that he had discretion on whether to apply many of the adjustments statutorily required under operating IPPS to capital IPPS:

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

[13] (Underline and italics emphasis added.)
[14] 42 C.F.R. § 412.320(a)(1). *See also* MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 3 (rev. Nov. 2021), *available at* https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Jun. 4, 2026).
[15] 56 Fed. Reg. 43356 (Aug. 30, 1991).

> reflect only the higher Medicare costs associated with teaching activity and treating low income patients.[16]

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)$^{0\text{-}4176}$ - 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.[17]

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

> *Comment*: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.
>
> *Response*: In the final rule, we are providing that urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level than other hospitals. For FY 1992, the minimum payment level is 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also

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

> 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**.[18]

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

> As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1,1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(l){ii) of the regulations.[19]

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

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.[20]

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.[21]

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

> We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We believe that it is appropriate for Medicare's payment to recognize these higher Medicare patient care costs.[22]

---

[20] *Id.* at 43378.
[21] *Id.* at 43379.
[22] (Emphasis added.)

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.[23]

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 natural antilog of 1.
>
> (2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.[24]

[23] *Id.*
[24] *Id*. at 43452-53.

2. *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.[25] 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.[26]

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

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

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

limitation, if any, should be imposed and provided several examples and alternatives.

****

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

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

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

> now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.
>
> ****
>
> We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.
>
> ****
>
> *We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary*. ***Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify***. As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.[27]

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

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

[27] 65 Fed. Reg. 47054, 47088-89 (Aug. 1, 2000).

> 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.[28]

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",[29] 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**.[30]

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[28] 65 Fed. Reg. 47026, 47048.
[29] 56 Fed. Reg. at 43452.
[30] (Bold and underline emphasis added.)

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

3. 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.[31] 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.[32] 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.[33]

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.[34] 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.

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

(ii) The term *urban area* means—

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

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

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

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

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

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

(4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result

> of redesignation of an MSA by the Executive Office of Management and Budget.[35]

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."[36] 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 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.[37]

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

[35] *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).
[36] (Emphasis added.)
[37] 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

> discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.
>
> ****
>
> The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.
>
> ****
>
> As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.[38]

[38] 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004).

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

In the FY 2007 Proposed IPPS Rule, the Secretary[39] announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.[40]

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.[41]

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

[39] of the Department of Health and Human Services.
[40] 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).
[41] *Id.*

> reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.[42]

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.[43]

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.[44]**

5. *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*"),[45] wherein the hospital made the following contentions:

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[42] 71 Fed. Reg. 47870, 48104 (Aug. 18, 2006).
[43] *Id.* at 48105.
[44] (Bold emphasis added.)
[45] 621 F.Supp. 3d 13 (D.D.C. 2021).

> Toledo Hospital contends that the Secretary's 2006rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to "take into account" relative costs of capital for various hospital types and areas of location, as subsection (g) requires.[46]

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.[47] The Court also noted how Congress enacted legislation in 1999[48] 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.[49] 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).[50] 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.[51]

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.[52]

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.[53] The Court next examined, however, whether the Secretary's decision to do so was reasonable. The D.C. District Court made the following findings:

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[46] *Id.* at *25 (citations omitted).
[47] *Id.* at *18-19.
[48] 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.
[49] *Toledo* at *19.
[50] *Id.* at *19-20.
[51] *Id.* at *21.
[52] *Id.* at *22.
[53] *Id.* at *23-25.

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."[54]

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

   - "The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006."[55]

   - "[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."[56]

   - "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)."[57]

   - "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."[58]

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."[59] Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants' eligibility for a capital DSH adjustment.[60]

CMS has since amended its regulations and, for discharges on or after October 1, 2023, urban hospitals that reclassified as rural are "no longer [] considered rural for purposes of determining eligibility for capital DSH payments."[61]

Providers' Requests for EJR

Materially identical Requests for EJR were filed on **May 15 and 18, 2026** in the twenty (20) cases listed in **Appendix A**. The Providers state that EJR is appropriate because they are challenging the regulation that governs capital DSH payments to urban hospitals that have been

[54] *Id.* at *29.
[55] *Id.*
[56] *Id.*
[57] *Id.*
[58] *Id.*
[59] *Id.* at *30.
[60] *Id.*
[61] 88 Fed. Reg. 58640, 59117 (Aug. 28, 2023).

reclassified under [42 U.S.C. § 1395ww](d)(8)(B) and 42 C.F.R. § 412.103 (hospitals located in urban areas and that apply for reclassification as rural).[62]

The Providers state they are

> challenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states in effect 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] [t]his regulation is inconsistent with Social Security Act Section 1886(d)(8)(B), which . . .specifically notes that the hospitals that have undergone a rural reclassification are rural only for 'purposes of this subsection [1886(d)].' The capital DSH provisions are found at Subsection 1886(g) . . . , not 1886(d), and, accordingly, the literal wording of the rural reclassification statutory provision identifies that rural status does not reach the capital DSH calculation.[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] 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*.[65]

Since the Board is bound by the regulations being challenged,[66] 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' Requests for EJR. Since the additional criteria for EJR have also been met, the Providers request the Board grant the requests.[67]

The Medicare Contractor filed timely responses in all twenty (20) cases. These responses advised that Substantive Claim Challenges had already been filed in Cases 23-1442G, 22-0019GC, 21-1801GC, 25-5728G, 24-0105GC, 23-1755GC, and 24-1074GC. Otherwise, the responses took no position on the Request for EJR and merely indicated no additional jurisdictional or substantive claim challenges were forthcoming.[68]

Board Decision

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

[62] *E.g.*, Case No. 26-2453GC, Request for EJR at 3 (May 15, 2026).
[63] *Id.* at 3.
[64] *Id.*
[65] *Id.*
[66] *See* 42 C.F.R. § 405.1867.
[67] Case No. 26-2453GC, Request for EJR at 5.
[68] *E.g.*, Case No. 24-1074GC, Response to Provider's Request for Expedited Judicial Review at 1 (May 22, 2026).

either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling. With regard to the Board's jurisdiction and the parties' dissatisfaction[69] with their final determinations, all the providers are subject to the substantive claim regulations at 42 C.F.R. §§ 413.24 and 405.1873.

1. Jurisdiction

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending on or after December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming it as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[70] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[71]

On August 21, 2008, new regulations governing the Board were effective.[72] 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*").[73] 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.[74]

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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[69] 42 C.F.R. § 405.1835(a)(1).
[70] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[71] *Bethesda*, 108 S. Ct. at 1258-59.
[72] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[73] 201 F. Supp. 3d 131 (D.D.C. 2016).
[74] *Id.* at 142.

However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

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

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

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. The regulation, § 413.24(j), specifies that, in order for a specific item to be eligible for potential reimbursement, the provider must include an appropriate cost report claim for that specific item:

> (j) **Substantive reimbursement requirement of an appropriate cost report claim**—
>
> (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

[75] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[76] *Id.* at 70555.

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

In conjunction with the regulation above, 42 C.F.R. § 405.1873(a) addresses when the Board must examine a provider's compliance with § 413.24(j):

> (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.[77]

These regulations are applicable to the cost reporting periods under appeal for all of the participants in these nine (9) groups, 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

[77] (Bold emphasis added.)

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 Medicare Contractor filed Substantive Claim Challenges, alleging noncompliance with the requirements of § 413.24(j), in Case Nos. 23-1442G, 22-0019GC, 21-1801GC, 25-5728G, 24-0105GC, 23-1755GC, and 24-1074GC.

A. Substantive Claim Challenges

In **Case 23-1442GC**, the Medicare Contractor claims that St. Barnabas Hospital (Prov. No. 33-0399, FYE 12/31/2019) did not claim reimbursement for an amount stemming from the purported understated Capital DSH Payment Amount. This Provider, however, was withdrawn from the case on August 25, 2025, making this challenge moot.

In **Case 22-0019GC**, the Medicare Contractor claims that St. Mary's Hospital (Prov. No. 11-0006, FYE 6/30/2018) did not claim reimbursement for an amount stemming from the purported understated Capital DSH Payment Amount. It argues that the audit adjustments cited by this Provider do not relate to Capital DSH, and that the schedule of protested items submitted with the relevant cost report did not include a claim for Capital DSH.[78] The Providers responded, arguing that applying the substantive claim regulations in this issue, specifically, deprives them of due process, and requests an equitable remedy: tolling any substantive claim requirement until the filing of a Request for Hearing.[79] It also argues that the substantive claim challenge regulations are invalid based on the rationale in *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399, 402 (1988) and *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131, 140 (D.D.C. 2016).[80] The Board finds that this Provider failed to make an appropriate claim for reimbursement on its cost report. The Board does not have the power to provide equitable remedies[81] and is bound by the substantive claim regulations as written.[82]

In Case **21-1801GC**, the Medicare Contractor claims that Loyola University Medical Center (Prov. No. 14-0276, FYE 6/30/2019) did not claim reimbursement for an amount stemming from the purported understated Capital DSH Payment Amount. It argues that the cost report included a Summary of Protested Amounts totaling $5,538,467. This summary included an item for "Urban redesignated to Rural hospitals only – CMS determination as Rural for 1886(g), but Urban for 1886(h)." and self-disallowing $1,216,214. The Provider also had two separate calculations for the impact of this designation for Capital DSH and GME. The Medicare Contractor argues, however, that this item was not properly self-disallowed because the Provider did not include a narrative explaining why it self-disallowed the issue under appeal.[83] The Provider responded, arguing that it submitted a "cover letter detailing each protested issue, including the Capital DSH and GME impact on page 8."[84] The Provider says this cover letter is

[78] Case No. 22-0019GC, Medicare Administrative Contractor Substantive Claim Letter at 4 (Mar. 12, 2024).
[79] Case No. 22-0019GC, Response to MAC Substantive Claim Letter at 5-6 (Apr. 10, 2024).
[80] *Id.* at 6-7.
[81] *Sebelius v. Auburn Regional Medical Center*, 133 S.Ct. 817 (2013).
[82] 42 C.F.R. § 405.1867.
[83] Case No. 21-1801GC, Medicare Administrative Contractor Substantive Claim Letter at 3-4 (Aug. 25, 2025).
[84] Case No. 21-1801GC, Response to MAC Substantive Claim Letter at 3 (Sept. 19, 2025) (citing Ex. P-1).

included as Exhibit 1 – but there is no Exhibit 1 with the responsive filing. It also points to its Exhibit P-2, the summary of protested items referenced by the Medicare Contractor. Exhibit P-2 also has the two calculations illustrating the impact of the urban designation referenced by the Medicare Contractor. The sheet with these calculations **also** contains a note that states:

> Note: For urban hospitals redesignated to rural under 42 CFR 412.103 are considered rural by CMS under SSA 1886(d), Operating DRG payment. However, SSA 1886(g), capital DRG payment and SSA 1886(h) are not being treated consistently by CMS. Ssa 1886 (d)(8) states that "… the Secretary shall treat the hospital as being located in the rural area of the State in which the hospital is located." Such hospitals are recognized by CMS as Rural for 1886(d) and 1886(g), but still considered Urban for 1886(h). The hospital is challenging CMS' treatment of redesignated hospitals as rural under 1886(g), but urban under 1886(h).[85]

The Board finds that the documents submitted with the Provider's cost report satisfied the requirements of 42 C.F.R. § 413.24(j), which are:

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.

The Provider listed the issue in this appeal as a protested item with an estimated reimbursement impact. The worksheet for this item contained a brief explanation of the issue: that urban hospitals redesignated as rural are being denied reimbursement related to their Capital DRG payments and their Capital DSH adjustments. The Board finds this was sufficient to comply with the substantive claim requirements.

In **Case 25-5728G**, the Medicare Contractor claims that Southeast Health Medical Center (Prov. No. 01-0001, FYE 9/30/2019) did not claim reimbursement for an amount stemming from the purported understated Capital DSH Payment Amount. It argues that this Provider cited no audit adjustments as the basis for its dispute and claims $0 in protested Part A amounts on its relevant cost report.[86] The Provider responded, arguing that it **did** submit language and a calculation for Capital DSH, but "inadvertently did not include a protested amount on Worksheet E, Part A, Line 75."[87] It also argues that the substantive claim challenge regulations are invalid based on

[85] *Id.* at Exh. P-2.
[86] Case No. 25-5728G, Medicare Administrative Contractor Substantive Claim Letter at 4-5 (Apr. 28, 2026).
[87] Case No. 25-5728G, Response to MAC Substantive Claim Letter at 3 (May 12, 2026).

the rationale in *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399, 402 (1988) and *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131, 140 (D.D.C. 2016).[88] The Board finds that this Provider failed to make an appropriate claim on its cost report for the issue under appeal. Again, to properly self-disallow a specific item, 42 C.F.R. 413.24(j)(2)(i) requires a Provider to "[i]nclude an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report." The Provider has conceded that it mistakenly failed to include any protested amount on its cost report and the Board is bound by the substantive claim regulations as written.[89]

In **Case 24-0105GC**, the Medicare Contractor claims both Providers in the group failed to claim reimbursement for an amount stemming from the purported understated Capital DSH Payment Amount. It argues that, for both Providers, the audit adjustments cited do not relate to Capital DSH, and that the schedules of protested items submitted with the relevant cost reports did not include a claim for Capital DSH.[90] The Providers responded, arguing that applying the substantive claim regulations in this issue, specifically, deprives them of due process, and requests an equitable remedy: tolling any substantive claim requirement until the filing of a Request for Hearing.[91] It also argues that the substantive claim challenge regulations are invalid based on the rationale in *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399, 402 (1988) and *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131, 140 (D.D.C. 2016).[92]

In **Case 23-1755GC**, the Medicare Contractor claims that Holston Valley Medical Center (Prov. No. 44-0017, FYE 6/30/2019) did not claim reimbursement for an amount stemming from the purported understated Capital DSH Payment Amount. It argues that the audit adjustment cited by this Provider does not relate to Capital DSH, and that the schedule of protested items submitted with the relevant cost report did not include a claim for Capital DSH.[93] The Providers responded, arguing that applying the substantive claim regulations in this issue, specifically, deprives them of due process, and requests an equitable remedy: tolling any substantive claim requirement until the filing of a Request for Hearing.[94] It also argues that the substantive claim challenge regulations are invalid based on the rationale in *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399, 402 (1988) and *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131, 140 (D.D.C. 2016).[95] The Board finds that this Provider failed to make an appropriate claim for reimbursement on its cost report. The Board does not have the power to provide equitable remedies[96] and is bound by the substantive claim regulations as written.[97]

In **Case 24-1074GC**, the Medicare Contractor claims Unity Hospital of Rochester (Prov. No. 33-0226, FYE 12/31/2019) did not claim reimbursement for an amount stemming from the purported understated Capital DSH Payment Amount. It argues that the audit adjustment cited

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[88] *Id.* at 3-4.
[89] 42 C.F.R. § 405.1867.
[90] Case No. 24-0105GC, Medicare Administrative Contractor Substantive Claim Letter at 4-5 (Jan. 8, 2024).
[91] Case No. 24-0105GC, Response to MAC Substantive Claim Letter at 3-5 (Feb. 1, 2024).
[92] *Id.* at 5-7.
[93] Medicare Administrative Contractor Substantive Claim Letter at 4-5 (Mar. 28, 2024).
[94] Response to MAC Substantive Claim Letter at 3-6 (Apr. 19, 2024).
[95] *Id.* at 6-7.
[96] *Sebelius v. Auburn Regional Medical Center*, 133 S.Ct. 817 (2013).
[97] 42 C.F.R. § 405.1867.

by this Provider simply removed protested amounts, and that there is a $52,215 variance in the amount of protested items listed on the cost report ($2,075,029) and on the Summary of Protested Amounts submitted with the cost report ($2,022,814). It also notes that the Protested Items Summary and Protest Narrative related to Capital DSH submitted in this appeal were not submitted with the cost report.[98] The Provider responded, explaining that both its original and amended cost reports made a claim for the Capital DSH issue in this group appeal.[99] It explains that the original cost report claimed $2,022,814 in protested items,[100] and that the amended cost report had an adjustment to different protested items resulting in the new figure of $2,075,029.[101] Both cost reports, however, claimed the same amount for the Capital DSH issue as a protested item. The Provider included exhibits, the Summary of Protested Amounts which reconcile to the protested amounts on the original and amended cost reports, which illustrate compliance with the substantive claim regulations. The Medicare Contractor said these were not submitted with the cost report, and the Provider does not address that remark. However, the Board notes that the Medicare Contractor's challenge also appears to be addressing the protested amount on the amended cost report, which includes the amount related to Capital DSH, and that the cited adjustment is the removal of that specific amount, which includes the amount. The Board has decided to consider these documents and finds that the Provider's argument that did make an appropriate claim for reimbursement on both its original and its amended cost reports for the issue under appeal is reasonably supported by the evidence.

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

The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[102] 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 finds makes the following findings of fact and conclusions of law with regard to the seven (7) Substantive Claim Challenges filed:

Case 23-1442G

- The Substantive Claim Challenge is moot.

Case 22-0019GC

- St. Mary's Hospital (Prov. No. 11-0006, FYE 6/30/2018) **did not** claim reimbursement for an amount stemming from the purported understated Capital DSH Payment Amount.

Case 21-1801GC

- Loyola University Medical Center (Prov. No. 14-0276, FYE 6/30/2019) **did** claim

[98] Case No. 24-1074GC, Medicare Administrative Contractor Substantive Claim Letter at 4-5 (Mar. 28, 2024).
[99] Case No. 24-1074GC, Response to MAC Substantive Claim Letter at 2-3 (May 29, 2024).
[100] *Id.* at 2 (citing Ex. A).
[101] *Id.* (citing Ex. B).
[102] (Emphasis added.)

reimbursement for an amount stemming from the purported understated Capital DSH Payment Amount.

Case 25-5728G

- Southeast Health (Prov. No. 01-0001, FYE 9/30/2019) **did not** claim reimbursement for an amount stemming from the purported understated Capital DSH Payment Amount

Case 24-0105GC

- Both Providers in the group **did not** claim reimbursement for an amount stemming from the purported understated Capital DSH Payment Amount

Case 23-1755GC

- Holston Valley Medical Center (Prov. No. 44-0017, FYE 6/30/2019) **did not** claim reimbursement for an amount stemming from the purported understated Capital DSH Payment Amount

Case 24-1074GC

- Unity Hospital of Rochester (Prov. No. 33-0226, FYE 12/31/2019) – **did** claim reimbursement for an amount stemming from the purported understated Capital DSH Payment Amount.

Most of the challenged providers argue that it is inequitable to apply the substantive claim regulations given the facts of these cases. The Board does not have the power to provide equitable remedies[103] and is bound by the substantive claim regulations as written.[104] The Board does, however, find it appropriate to grant EJR over the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 in addition to the Capital DSH regulation for the Providers the Board has found did not claim reimbursement for an amount stemming from the purported understated Capital DSH Payment Amount.

3. 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 this group appeal are entitled to a hearing before the Board;

2) The 5 (five) Providers outlined above have cost reporting periods beginning after January 1, 2016 but failed to include "an appropriate claim for the specific item" that is the subject of the group appeal as required under 42 C.F.R. § 413.24(j)(1);

3) The remaining Providers' cost reports included appropriate claims for a specific item as required by 42 C.F.R. § 405.1873(a);

4) 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;

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

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[103] *Sebelius v. Auburn Regional Medical Center*, 133 S.Ct. 817 (2013).
[104] 42 C.F.R. § 405.1867.

§ 405.1867); and

6) It is without the authority to decide the legal question of whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid ***and*, for the 5 (five)** Providers outlined above for which the Board found they made no appropriate claim for reimbursement on their cost reports, whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid.

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' request for EJR for the issue and the subject years. The Board also finds that, for the 5 (five) Providers outlined above for which the Board found they made no appropriate claim for reimbursement on their cost reports, 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 their request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes the twenty (20) cases listed in **Appendix A**.

Board Members Participating:

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

FOR THE BOARD:

6/9/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers
cc: Christine Goldesberry-Curry, CGS Administrators (J-15)
Cecile Huggins, Palmetto GBA (J-J)
Danelle Decker, National Government Services, Inc. (J-K)
Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-L)
Palmela VanArsdale, National Government Services, Inc. (J-6)
Dean Wolfe, Noridian Healthcare Solutions (J-F)
Scott Berends, FSS

Appendix A

Case Number	**Case Name**
26-2453GC	*Rochester Regional Health CY 2020 Capital DSH CIRP Group*
26-0265	*Southeast Health Medical Center (01-0001), FYE 09/30/2020*
26-0001	*ProMedica Toledo Hospital (36-0068), FYE 12/31/2022*
25-4473GC	*UHS CY 2021 Capital DSH CIRP Group*
25-3457GC	*Ballad Health CY 2021 Capital DSH CIRP Group*
25-5609	*Doctors Hospital of Laredo (45-0643), FYE 12/31/2019*
25-5610	*Fort Sanders Regional Medical Center (44-0125), FYE 12/31/2018*
25-5611	*St. John's Riverside Hospital (33-0208), FYE 12/31/2018*
24-2502G	*K&L Gates LLP CY 2020 Capital DSH Group*
24-0467GC	*Ballad Health CY 2020 Capital DSH CIRP Group*
24-0238GC	*Ballad Health CY 2018 Capital DSH CIRP Group*
23-1442G	*K&L Gates LLP CY 2019 Capital DSH Group*
26-1875G	*K&L Gates CY 2021 Capital DSH Group*
21-1801GC	*Trinity Health CY 2019 FY 2019 Urban to Rural Capital DSH/GME CIRP Group*
22-0019GC	*Trinity Health CY 2017-2018 Urban to Rural Capital DSH/GME CIRP Group*
23-1755GC	*Ballad Health CY 2019 Capital DSH CIRP Group*
24-0105GC	*Ballad Health CY 2017 Capital DSH CIRP Group*
24-1074GC	*Rochester Regional Health CY 2019 Capital DSH CIRP Group*
25-5728G	*K&L Gates CY 2019 Capital DSH Group*
24-1914GC	*UHS of Delaware, Inc. CY 2020 Capital DSH CIRP Group*

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Expedited Judicial Review Decision***

Case Number: 25-3526GC - Essentia Health CYs 2020-2021 Disallowance of Capital DSH Payment CIRP Group
Case Number: 25-4819GC - Essentia Health CY 2022 Disallowance of Capital DSH Payment CIRP Group
Case Number: 26-0087G - Toyon Associates CY 2022 Disallowance of Capital DSH Payment Group
Case Number: 24-1300GC - Bon Secours Mercy Health CY 2019 Disallowance of Capital DSH Payment CIRP Group
Case Number: 24-1301GC - Bon Secours Mercy Health CY 2020 Disallowance of Capital DSH Payment CIRP Group

Dear Ms. Ellis:

The Provider Reimbursement Review Board ("Board") has reviewed the **April 8, 2026** consolidated request for expedited judicial review[1] ("EJR") for the above-referenced common issue related party ("CIRP") and optional group appeals. The decision with respect to EJR is set forth below.[2]

Issue under Dispute

In these group cases, the Providers are challenging:

> [T]he regulation at 42 C.F.R. § 412.320(a)(1)(iii), in effect for periods prior to October 1, 2023, which says that an urban hospital that has reclassified as rural pursuant to 42 C.F.R. § 412.103 is categorically ineligible to receive capital DSH payments.
>
> ***
>
> The Providers maintain that the version of 42 C.F.R. § 412.320(a)(1)(iii) in effect during the pre-October 1, 2023 periods encompassed by Toyon's

[1] Consolidated Petition for Expedited Judicial Review (Apr. 8, 2026) ("Request for EJR").
[2] The Request for EJR encompasses eleven (11) group cases. Case Numbers 25-0515GC, 24-2707G, 24-2017G, 23-1348G, 23-1290GC, and 23-1166GC were adjudicated under separate cover on May 6, 2026.

> group appeals is unlawful and they seek relief in the form of the capital DSH adjustment that was wrongfully withheld from them.[3]

Background:

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

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[3] Consolidated Petition for Expedited Judicial Review, 1-2 (Apr. 8, 2026) ("Request for EJR").
[4] Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), *available at* https://oig.hhs.gov/oas/reports/region1/11700500.pdf (last visited Nov. 20, 2025) ("*Significant Vulnerabilities*").
[5] *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).
[6] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). *See also Significant Vulnerabilities* at 4-5.
[7] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[8] *Id.*
[9] *See* 42 U.S.C. § 1395ww(d)(5).

which requires the Secretary to provide an adjustment (*i.e*., an increase in the operating IPPS payment) to hospitals that "serve [] a significantly disproportionate number of low-income patients."[10]

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

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

3. Capital DSH Adjustment Under Capital IPPS

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

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

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

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

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]

1. 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***.

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[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 Jun. 8, 2026).
[16] 56 Fed. Reg. 43356 (Aug. 30, 1991).

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

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more 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)$^{0\text{-}4176}$ - 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

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

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

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

> additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(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]

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

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

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

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

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

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

> (b) *Payment adjustment factor*. (1) If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital's disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.
>
> (2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.[25]

2. *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

[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.)

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

****

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

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. *If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area. Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113*. In particular, we are

> concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106– 113, which authorizes a 30-percent expansion in a rural hospital's resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME, which are made under section 1886(h) of the Act.)
>
> Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.
>
> ****
>
> We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.
>
> ****
>
> *We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary*. ***Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify***. As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.[28]

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

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

> **§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural**.
>
> (a) *General criteria*. A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
>
> 1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration which is available via the ORHP website at http:// www.nal.usda.gov/orph or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857.
>
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
>
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 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.

[29] 65 Fed. Reg. 47048.
[30] 56 Fed. Reg. at 43452.

> (2) **Each such rate is determined for hospitals located in urban or rural areas** within the United States and within each such region respectively, **as described in paragraphs (b)** through (g) of this section.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, **except that**, effective January 1, 2000, **a hospital reclassified as rural may mean** a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or **a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103**.[31]

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

3. 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.**

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

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

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

(ii) The term *urban area* means—

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

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

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

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

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

(3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for

> designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.
>
> (4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result of redesignation of an MSA by the Executive Office of Management and Budget.[36]

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

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

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

[36] *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).
[37] (Emphasis added.)
[38] 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

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

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

> Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB's new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.
>
> ****
>
> The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed 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]

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

In the FY 2007 Proposed IPPS Rule, the Secretary[40] announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.[41]

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

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

> These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.
>
> These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to

[39] 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004).
[40] of the Department of Health and Human Services.
[41] 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).
[42] *Id.*

> incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).
>
> We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.[43]

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

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

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

[43] 71 Fed. Reg. 47870, 48104 (Aug. 18, 2006).
[44] *Id.* at 48105.

> **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]**

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

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

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

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

The appellants in *Toledo* were geographically located in an urban labor market area, but applied to the Secretary (and were approved) to reclassify as rural under § 401. The appellants thereafter applied to the MGCRB to reclassify their wage index to an urban labor market area. The appellants' Medicare Contractor later denied their requests for capital DSH adjustments due to

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[45] (Bold emphasis added.)
[46] 621 F.Supp.3d 13 (D.D.C. 2021).
[47] *Id.* at *25 (citations omitted).
[48] *Id.* at *18-19.
[49] 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a "§ 401" hospital.
[50] *Toledo* at *19.
[51] *Id.* at *19-20.
[52] *Id.* at *21.

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]

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

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

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

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

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

Notwithstanding these findings, the D.C. District Court declined to vacate 42 C.F.R. § 412.320(a)(1)(iii) because "vacatur of a rule is not an appropriate remedy on review of an

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[53] *Id.* at *22.
[54] *Id.* at *23-25.
[55] *Id.* at *29.
[56] *Id.*
[57] *Id.*
[58] *Id.*
[59] *Id.*

adjudication."[60] Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants' eligibility for a capital DSH adjustment.[61]

CMS has since amended its regulations and, for discharges on or after October 1, 2023, urban hospitals reclassified as rural are no longer considered rural for purposes of determining eligibility for capital DSH payments.[62]

Providers' Request for EJR

The Providers argue that, prior to its amendment on October 1, 2023, 42 C.F.R. § 412.320(a)(1)(iii) contradicted with the Medicare Statute and was therefore unlawful.[63] They claim that, since the plain language of Section 401 (42 U.S.C. § 1395ww(d)(8)(E)) dictates treating reclassified hospitals as "rural" for "this subsection," they must be treated as rural for purposes of 42 U.S.C. § 1395ww(d) **only**.[64] This means reclassified hospitals should **not** be treated as rural for capital PPS, which is housed in § 1395ww(g), a different subsection.[65] This interpretation would be consistent with how CMS has interpreted Section 401 in other contexts, such as reimbursement of direct costs of training residents in graduate medical education programs, which is governed by §1395ww(h).[66]

The Providers insist that, consistent with the D.C. District Court's holding in *Toledo*, 42 C.F.R. § 412.320(a)(1)(iii) (for periods prior to October 1, 2023) is arbitrary, unreasonable, and unenforceable. The Providers believe they are entitled to a DSH adjustment on their capital PPS payments because they are "located in an urban area" as defined in 42 C.F.R. § 412.64 and have more than 100 beds.[67] They also point out that the court in *Toledo* found the decision to categorically disqualify reclassified rural hospitals from capital DSH payments to be arbitrary and capricious because CMS "did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did [it] take costs into account at all" as required by 42 U.S.C. § 1395ww(g)(1)(A).[68] The Providers argue that CMS did eventually take costs into account in the IPPS Final Rule for 2023, and abandoned the policy of excluding reclassified rural hospitals, which serves as a tacit concession "that the relative capital costs of reclassified rural hospitals cannot justify categorically disqualifying reclassified rural hospitals from receiving the capital DSH adjustment."[69]

Finally, the Providers urge the Board to grant EJR since it is bound by the regulation being challenged,[70] namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), and thus, it lacks the authority to decide the legal question presented in the Providers' Request for EJR. Since the

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[60] *Id.* at *30.
[61] *Id.*
[62] 42 C.F.R. § 412.103 (2024); 88 Fed. Reg. 58640, 59117 (Aug. 28, 2023).
[63] Request for EJR at 6.
[64] *Id.*
[65] *Id.*
[66] *Id.* at 6-7.
[67] *Id.* at 8 (citing 42 C.F.R. § 412.320(a)(1)).
[68] *Id.* (quoting *Toledo* at 29).
[69] *Id.* at 9.
[70] *See* 42 C.F.R. § 405.1867.

additional criteria for EJR have also been met, the Providers request the Board grant the request.[71]

Medicare Contractor's Response:

On **April 14, 2026**, the Medicare Contractor's designated representative, Federal Specialized Services ("FSS") filed Responses to Providers' Request for EJR, noting that substantive claim challenges would be filed in Cases 24-1300GC and 24-1301GC. On **April 15, 2026**, FSS filed an Amended Response which indicated it would also be filing challenges in Cases 25-3526GC, 25-4819GC, and 26-0087G. Based on these timely certifications, the deadline for any Substantive Claim Challenges in these cases was **Friday, April 24, 2026**. Challenges were, in fact, filed between **April 20 and 24, 2026**. The Board issued a Scheduling Order on April 28, 2026, requiring that the Providers' responses to the challenges be filed no later than May 15. Providers filed responses in all five (5) cases on **May 14, 2026**. The Providers outlined in the challenges, below, shall be collectively referred to as the "Challenged Participants."

1. Case 24-1300GC

FSS filed a Substantive Claim Challenge in this case on **April 23, 2026** asserting that both providers in the group failed to include an appropriate claim on their cost reports.[72] It claims that neither party cited an audit adjustment for the Capital DSH issue. Additionally, while the Providers did identify protested amounts on their cost reports, the summary or listing of protested items submitted alongside the cost report did not establish a self-disallowed item for the Capital DSH issue. It argues that none of the exceptions at 42 C.F.R. § 413.24(j)(3)(i) through (iii) apply.[73]

The Providers filed a Response to MAC's Substantive Claim Challenge on **May 14, 2026**. They do not refute the Medicare Contractor's assertions that they did not comply with the regulatory requirements set forth in 42 C.F.R. §§ 413.24 and 405.1873 but instead argue that the requirements are unlawful. They cite *Bethesda Hosp. Ass'n v. Bowen*[74] and *Banner Heart Hospital v. Burwell*[75] in support of their position that these regulations are unlawful and in conflict with 42 U.S.C.§ 1395oo.[76]

2. Case 24-1301GC

FSS filed a Substantive Claim Challenge in this case on **April 23, 2026** asserting that all six (6) providers in the group failed to include an appropriate claim on their cost reports.[77] It claims that none of the participants cited an audit adjustment for the Capital DSH issue, or that the cited audit adjustments were not relevant to the issue under appeal. Additionally, while the Providers

[71] Request for EJR at 9-12.
[72] Case No. 24-1300GC, Medicare Administrative Contractor's Substantive Claim Challenge at 1 (Apr. 23, 2026).
[73] *Id.* at 4-5.
[74] 485 U.S. 399 (1988).
[75] 201 F.Supp.3d 131 (D.D.C. 2016)
[76] Case No. 24-1300GC, Response to MAC's Substantive Claim Challenge at 2-3 (May 14, 2026).
[77] Case No. 24-1301GC, Medicare Administrative Contractor's Substantive Claim Challenge at 1 (Apr. 23, 2026).

did identify protested amounts on their cost reports, the summary or listing of protested items submitted alongside the cost report did not establish a self-disallowed item for the Capital DSH issue. It argues that none of the exceptions at 42 C.F.R. § 413.24(j)(3)(i) through (iii) apply.[78]

The Providers filed a Response to MAC's Substantive Claim Challenge on **May 14, 2026**. They do not refute the Medicare Contractor's assertions that they did not comply with the regulatory requirements set forth in 42 C.F.R. §§ 413.24 and 405.1873 but instead argue that the requirements are unlawful. They cite *Bethesda Hosp. Ass'n v. Bowen*[79] and *Banner Heart Hospital v. Burwell*[80] in support of their position that these regulations are unlawful and in conflict with 42 U.S.C.§ 1395oo.[81]

3. Case 25-3526GC

FSS filed a Substantive Claim Challenge in this case on **April 21, 2026** asserting that all three (3) providers in the group failed to include an appropriate claim on their cost reports.[82] It claims that none of the participants cited an audit adjustment for the Capital DSH issue, or that the cited audit adjustments were not relevant to the issue under appeal. Additionally, while the Providers did identify protested amounts on their cost reports, the accompanying documentary support was insufficient to satisfy the requirements set forth in 42 C.F.R. § 413.24(j). It argues that none of the exceptions at 42 C.F.R. § 413.24(j)(3)(i) through (iii) apply.[83]

The Providers filed a Response to MAC's Substantive Claim Challenge on **May 14, 2026**. They do not refute the Medicare Contractor's assertions that they did not comply with the regulatory requirements set forth in 42 C.F.R. §§ 413.24 and 405.1873 but instead argue that the requirements are unlawful. They cite *Bethesda Hosp. Ass'n v. Bowen*[84] and *Banner Heart Hospital v. Burwell*[85] in support of their position that these regulations are unlawful and in conflict with 42 U.S.C.§ 1395oo.[86]

4. Case 25-4819GC

FSS filed a Substantive Claim Challenge in this case on **April 20, 2026** asserting that Essentia Health St. Mary's Medical Center (Provider Number 24-0002, FYE 6/30/2022) failed to include an appropriate claim on its cost report.[87] It claims that the cited audit adjustments were not relevant to the Capital DSH issue. Additionally, while the Provider did identify a protested amount on its cost report, the accompanying documentary support was insufficient to satisfy the

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[78] *Id.* at 4-8.
[79] 485 U.S. 399 (1988).
[80] 201 F.Supp.3d 131 (D.D.C. 2016)
[81] Case No. 24-1301GC, Response to MAC's Substantive Claim Challenge at 2-3 (May 14, 2026).
[82] Case No. 25-3526GC, Medicare Administrative Contractor's Substantive Claim Challenge at 1 (Apr. 21, 2026).
[83] *Id.* at 4-7.
[84] 485 U.S. 399 (1988).
[85] 201 F.Supp.3d 131 (D.D.C. 2016)
[86] Case No. 25-3526GC, Response to MAC's Substantive Claim Challenge at 2-3 (May 14, 2026).
[87] Case No. 25-4819GC, Medicare Administrative Contractor's Substantive Claim Challenge at 1 (Apr. 20, 2026).

requirements set forth in 42 C.F.R. § 413.24(j). It argues that none of the exceptions at 42 C.F.R. § 413.24(j)(3)(i) through (iii) apply.[88]

The Provider filed a Response to MAC's Substantive Claim Challenge on **May 14, 2026**. It does not refute the Medicare Contractor's assertions that it did not comply with the regulatory requirements set forth in 42 C.F.R. §§ 413.24 and 405.1873 but instead argues that the requirements are unlawful. It cites *Bethesda Hosp. Ass'n v. Bowen*[89] and *Banner Heart Hospital v. Burwell*[90] in support of its position that these regulations are unlawful and in conflict with 42 U.S.C.§ 1395oo.[91]

5. Case 26-0087G

FSS filed a Substantive Claim Challenge in this case on **April 24, 2026** asserting that Parkview Medical Center (Prov. No. 06-0020, FYE 6/30/2022) failed to include an appropriate claim on its cost report.[92] It claims that the cited audit adjustments were not relevant to the Capital DSH issue. Additionally, while the Provider did identify a protested amount on its cost report, the summary or listing of protested items submitted alongside the cost report did not establish a self-disallowed item for the Capital DSH issue. It argues that none of the exceptions at 42 C.F.R. § 413.24(j)(3)(i) through (iii) apply.[93]

The Provider filed a Response to MAC's Substantive Claim Challenge on **May 14, 2026**. It does not refute the Medicare Contractor's assertions that it did not comply with the regulatory requirements set forth in 42 C.F.R. §§ 413.24 and 405.1873 but instead argues that the requirements are unlawful. It cites *Bethesda Hosp. Ass'n v. Bowen*[94] and *Banner Heart Hospital v. Burwell*[95] in support of its position that these regulations are unlawful and in conflict with 42 U.S.C.§ 1395oo.[96]

Board Decision

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

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[88] *Id.* at 4-5.
[89] 485 U.S. 399 (1988).
[90] 201 F.Supp.3d 131 (D.D.C. 2016)
[91] Case No. 25-4819GC, Response to MAC's Substantive Claim Challenge at 2-3 (May 14, 2026).
[92] Case No. 26-0087G, Medicare Administrative Contractor's Substantive Claim Challenge at 1 (Apr. 24, 2026).
[93] *Id.* at 4.
[94] 485 U.S. 399 (1988).
[95] 201 F.Supp.3d 131 (D.D.C. 2016)
[96] Case No. 26-0087G, Response to MAC's Substantive Claim Challenge at 2-3 (May 14, 2026).

1. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [97]
- 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.[98]

The Providers have all appealed from original NPRs. Based on its review of the record, the Board finds that each of the participants in these group appeals filed their appeals within 180 days of the issuance of their respective final determinations or failure to issue a determination as required by 42 C.F.R. § 405.1835; that the providers in each case appealed the issue in their respective appeals'; and that the Board is not precluded by regulation or statute from reviewing the issue in these appeals. Finally, in each case, the amount in controversy meets the $50,000 threshold for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3).

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).[99] All of the providers in these five (5) groups, however, are subject to the substantive claim regulations at 42 C.F.R. §§ 413.24 and 405.1873.

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

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

[98] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.
[99] 42 C.F.R. § 405.1842(f)(1)(ii).

2. Jurisdiction – Appropriate Cost Report Claim (FYEs On or After December 31 ,2016)

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[100] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[101] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement ("NPR") issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). Since all the participants in these five (5) cases have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement for the Board's ***jurisdiction*** is not applicable.

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

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

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

[100] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[101] *Id.* at 70555.

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

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

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

These regulations are applicable to the cost reporting periods under appeal for all 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"[102] 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. [103]

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

The Board finds that none of the Challenged Providers outlined, *supra*, have made an appropriate claim on their cost reports in compliance with 42 C.F.R. § 413.24(j). The Board finds that none of the Providers dispute the Medicare Contractors' contentions that they failed to make such a claim.

For the remaining participants in these group cases who are not one of the Challenged Providers (collectively "the Non-Challenged Providers"), since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[104] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered for the Non-Challenged Providers. 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.

4. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that the participants in Cases 24-1300GC, 24-1301GC, 25-3526GC, 25-4819GC, and 26-0087G are entitled to a hearing before the Board;

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

3) 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;

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[102] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[103] *See* 42 C.F.R. § 405.1873(a).
[104] 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."

4) 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;

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

6) It is without the authority to decide the legal question of whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is unlawful.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' EJR Request for the issue and the subject years in Cases 24-1300GC, 24-1301GC, 25-3526GC, 25-4819GC, and 26-0087G. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes the cases and will remove them from its docket.

Board Members Participating:

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

FOR THE BOARD:

6/9/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

cc: Pamela VanArsdale, National Government Services, Inc. (J-6)
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Judith Cummings, CGS Administrators (J-15)
Scott Berends, Esq., FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Lisa Ellis
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1800 Sutter Street, Suite 600
Concord, CA 94520

RE: ***Expedited Judicial Review Determination***
Case Numbers: 24-1996GC *et al.* (9 Cases - *see* **Appendix A**)
Toyon Associates Rural Floor Wage Index Groups

Dear Ms. Ellis:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Consolidated Petition for Expedited Judicial Review ("EJR") filed on **April 27, 2026** concerning the above referenced common issue related party ("CIRP") and optional group appeals. The Board's decision on jurisdiction and EJR for these cases is set forth below.

Issue:

The Board received requests to establish these nine (9) Common Issue Related Party ("CIRP") and optional groups from Toyon Associates, Inc. between **June 24, 2024** and **October 12, 2025**. The participants in these groups are all appealing from the original Notices of Program Reimbursement ("NPRs") with regard to the calculation of the rural floor for their fiscal years ending ("FYEs") in calendar years ("CYs") 2019 through 2022. Specifically, the Providers argue that, for the FYEs at issue, CMS unlawfully excluded reclassified rural hospitals from the data used to calculate the rural wage index and the rural floor.[1] On **April 27, 2026**, the Providers filed a Consolidated[2] Petition for Expedited Judicial Review over this issue.

Statutory and Regulatory Background:

1. Wage Index; Rural and Urban Classification

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[3] known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs").

[1] Consolidated Petition for Expedited Judicial Review at 2-3 (Apr. 27, 2026).
[2] The Consolidated Request for EJR included eight (8) additional cases which were adjudicated on May 19, 2026.
[3] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).

The base payment rate is comprised of a standardized amount[4] for all subsection (d) hospitals located in an "urban" or "rural" area.[5]

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

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives "an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts."[8]

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

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[4] The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27708, 27765-27766 (May 27, 1994). Section 1395ww(d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).
[5] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[6] of the Department of Health and Human Services.
[7] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index (last visited Jun. 9, 2026).
[8] *Id.*
[9] *Robert Wood Johnson University Hosp. v. Thompson*, 297 F. 3d. 273, 276 (3d Cir. 2002).

established the Medicare Geographic Review Board (MGCRB) to administer the reclassification process.[10,11]

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

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

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

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

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[10] *Id*
[11] 42 U.S.C. § 1395ww(d)(10)(D)(v).
[12] *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Public L. 106-113, app. F. § 401, 113, Stat. 1501, 1501A-321 (Nov. 29, 1999). Codified as 42 U.S.C. § 1395ww(d)(8).
[13] *Id.* (emphasis added).
[14] H.R. Conf. Rep. No. 106-479, 512 (1999).

2. Rural Floor Adjustment

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

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

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

3. Changes to the Wage Index Calculation

In the FFY 2019 IPPS proposed rule,[17] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information ("RFI") as part of the FFY 2020 IPPS proposed rule.[18] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[19] In the FFY 2020 IPPS Final Rule, the Secretary proposed several policies to address wage index disparities.[20] Relevant to the issue under appeal here are the Secretary's proposals to prevent allegedly inappropriate payment increases due to rural reclassifications made under the

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

provisions of 42 C.F.R. § 412.103.[21,22] The Secretary finalized without modification the proposals

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

The Secretary contends that this policy "is necessary and appropriate to address the unanticipated effects of rural reclassification on the rural floor and resulting wage index disparities, including the effects of the manipulation of the rural floor by certain hospitals."[24] The Secretary concludes that "the inclusion of reclassified hospitals in the rural floor calculation has had the unforeseen effect of exacerbating the wage index disparities between low and high wage index hospitals."[25]

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

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[21] 42 C.F.R. § 412.103 states in relevant part that:

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

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

urban hospitals being paid less than the average rural hospital in their States.'"[27]

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

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

CMS has continued the application of the FY 2020 IPPS Final Rule's policy in the FY 2021[34] and FY 2022[35] IPPS Final Rules. CMS has also adopted the FY 2020 IPPS Final Rule's policy in its OPPS Final Rules for FYs 2020,[36] 2021,[37] and 2022.[38] The continued application of this policy means that, for FFYs 2020-2022, CMS will calculate the rural floor in a state without reference to the wage index that applies for any hospitals in that state which were reclassified as rural pursuant to Section 401 for both IPPS and OPPS. The Prospective Payment System for

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[27] *Id*.
[28] *Id*.
[29] *Id*.
[30] *Id.*
[31] *Id*.
[32] *Id*.
[33] *Id.*
[34] 85 Fed. Reg. 58432, 58766 (Sept. 18, 2020).
[35] 86 Fed. Reg. 44774, 45175 (Aug. 12, 2021).
[36] 84 Fed. Reg. 61142, 61187-61188 (Nov. 12, 2019) (stating "as proposed, we are using the FY 2020 hospital IPPS post-reclassified wage index for urban and rural areas as the wage index under the OPPS to determine the wage adjustments for both the OPPS payment rate and the copayment standardized amount for CY 2020.").
[37] 85 Fed. Reg. 85866, 85916-17 (Dec. 29, 2020) (stating "We also are continuing to apply for the CY 2021 OPPS wage index any other adjustments for the FY 2021 IPPS post-reclassified wage index, including, but not limited to, the rural floor adjustment . . . .").
[38] 86 Fed. Reg. 63458, 63511 (Nov. 16, 2021) (stating "We are continuing to apply for the CY 2022 OPPS wage index any adjustments for the FY 2022 IPPS post-reclassified wage index, including, but not limited to, the rural floor adjustment . . . .").

inpatient hospital capital costs is also calculated using the hospital wage index values applicable to the hospital under IPPS.[39]

Positions of the Parties:

1. Providers' Appeal Requests

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

> The Providers in this group appeal challenge the calculation of their wage index values for the reporting periods under appeal. CMS ignored a clear congressional directive that if followed have resulted in higher wage index adjustments for the Providers. The agency's error had the effect of diluting the payments the Providers received under the inpatient and outpatient prospective payment systems ("IPPS" and "OPPS") and the capital prospective payment system ("capital PPS") during the cost reporting periods under appeal.
>
> The Medicare statute says that if a hospital located in an urban area elects to reclassify as rural, CMS "shall treat the hospital as being located in the rural area…of the State in which the hospital is located" for all purposes of the IPPS and OPPS. 42 U.S.C. §§ 1395ww(8)(d)(E); 1395*l*(t)(16)(A). This includes the annual wage index calculation required by 42 U.S.C. § 1395ww(d)(3)(E).
>
> CMS ignored this clear instruction in calculating the wage index values in the federal fiscal years for the reporting periods overlapping with this appeal. First, CMS failed to treat reclassified rural hospitals the same as geographically rural hospitals (i.e., hospitals actually located in rural areas) in calculating the rural wage index [by excluding reclassified rural hospitals.]
>
> * * *
>
> Second, CMS again failed to treat reclassified rural hospitals the same as geographically rural hospitals when it excluded the wage data of reclassified rural hospitals from the calculation of the rural floor under section 4410 of the Balanced Budget Act of 1997 and the "the wage index for rural areas in the State in which the county is located" under 42 U.S.C. § 1395ww(d)(8)(C)(iii) (collectively, the "rural floors") for FFYs 2020 through 2022. *See Citrus HMA,*

[39] 42 C.F.R. 412.316(a) ("CMS adjusts for local cost variation based on the hospital wage index value that is applicable to the hospital under subpart D of this part.").

> *LLC, d/b/a Seven Rivers Regional Medical Center v. Becerra*, 597 F. Suipp.3d 450 (D.D.C. 2022) (finding that the statute required that the rural wage index and rural floor be one and the same). In FYs 2020 through 2022, the *rural wage index* included both geographically rural hospitals and reclassified rural hospitals, but the *rural floor* included only geographically rural hospitals.[40]

2. Providers' Request for EJR

The Consolidated Petition for EJR describes the issue as follows:

> The question presented in these appeals is whether CMS miscalculated the wage index for the Providers in the federal fiscal years overlapping with the Providers' cost reporting periods under appeal (the "Overlapping FFYs"). The Medicare statute provides that "Section 401" hospitals (or "reclassified rural" hospitals) must be treated as being located in a rural area for all purposes under the IPPS. In other words, for *all* purposes of IPPS, reclassified rural hospitals must be treated the same as *geographically* rural hospitals (e.g., hospitals physically located in rural areas). CMS ignored this instruction in calculating the wage index values for the Overlapping FFYs. This error had the effect of understating the wage index values that were assigned to the Providers.[41]

The Providers argue that, for the FYEs at issue, CMS unlawfully excluded reclassified rural hospitals from the data used to calculate the rural wage index.[42] CMS changed this approach in the FY 2024 IPPS Rule, but only on a prospective basis.[43] In addition to miscalculating the rural wage index, the Providers explain that excluding reclassified rural hospitals from wage data resulted in the miscalculation of the rural floor for FYs ending in 2020 through 2022.[44] They seek to have their inpatient prospective payment system ("IPPS"), outpatient prospective payment system ("OPPS") and capital prospective payment system ("CPPS") payments recalculated, and are seeking EJR as they believe the Board lacks the authority to grant this relief.[45]

3. Medicare Contractor's Position

On **May 4, 2026**, the Medicare Contractor's designated representative, Federal Specialized Services, filed a timely response to the Consolidated Requests for Expedited Judicial Review. It took no position on the Request for EJR and indicated that FSS would be filing a Substantive Claim and/or Jurisdictional Challenge in the following cases:

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[40] *E.g.*, Case No. 24-1996GC, Issue Statement at 1-2 (June 24, 2024).
[41] Consolidated Petition for Expedited Judicial Review at 1 (Apr. 27, 2026).
[42] *Id.* at 2.
[43] *Id.* (citing 88 Fed. Reg. 58640, 58972 (Aug. 28, 2023)).
[44] *Id.* at 3.
[45] *Id.* at 3-7.

- 24-1996GC
- 24-2486GC
- 25-0831GC
- 25-4017GC
- 25-4378GC
- 25-4688G
- 25-5197GC
- 26-0086GC

Later that day, FSS filed a Revised Response to the Consolidated Request for EJR, which was identical except that it indicated it would also be filing a Substantive Claim Challenge in Case 24-2249GC.

Decision of the Board:

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

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

The participants that comprise these nine (9) group appeals have filed appeals involving federal fiscal years 2019 to 2022. Based on its review of the record, the Board finds that each of the participants in these groups filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835, that the providers each appealed the issue in this appeal, and that the Board is not precluded by regulation or statute from reviewing the issue in this appeal. Finally, the amount in controversy meets the $50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3). Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying Providers. The estimated amounts in controversy are subject to recalculation by the Medicare contractors for the actual final amounts in each case.

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

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[46] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[47] 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

[46] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[47] *Id.* at 70555.

specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the NPR issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). All of the participants in these cases have fiscal years that began on or after January 1, 2016, so the claim-specific dissatisfaction requirement is not applicable to the Board's analysis regarding **jurisdiction**. The Board must, however, prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

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

> (1) *General Requirement*. In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), **must include an appropriate claim for the specific item**, by either—
>
> (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.[48]

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

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

[48] (Bold and underline emphasis added.)

> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> (1) Board jurisdictional dismissal decision. **If the Board issues a jurisdictional dismissal decision** regarding the specific item under appeal (pursuant to § 405.1840(c)), **the Board's specific findings of fact and conclusions of law** (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must not be included in such jurisdictional dismissal decision**.[49]

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

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

As previously noted, Substantive Claim Challenges were filed in all nine (9) of the cases noted in **Appendix A**, and these are discussed below. The Providers encompassed in these nine (9) challenges will be collectively referred to as "the Challenged Providers."

Substantive Claim Challenges were filed in all nine (9) cases noted in **Appendix A**, and are discussed, below. The Providers encompassed in these nine (9) challenges will be collectively referred to as "the Challenged Providers."

i. Case 24-1996GC

FSS filed a Substantive Claim Challenge on **May 13, 2026**. The challenge argues that none of the three (3) Providers in this group made an appropriate claim on their cost reports for the issue being appealed. It claims that none of the audit adjustments cited by the Providers actually relate to rural floor wage index, or the Providers' rural classification. Additionally, while the Providers

[49] (Bold and underline emphasis added.)

did include protested amounts on their cost reports, the accompanying Summary of Protested Items for each appeal did not list the Rural Floor Wage Index issue.[50]

ii. Case 24-2249GC

FSS filed a Substantive Claim Challenge on **May 13, 2026**. The challenge argues that none of the four (4) Providers in this group made an appropriate claim on their cost reports for the issue being appealed. It claims that none of the audit adjustments cited by the Providers actually relate to rural floor wage index, or the Providers' rural classification. Additionally, while the Providers did include protested amounts on their cost reports, the accompanying Summary of Protested Items for each appeal did not list the Rural Floor Wage Index issue.[51]

iii. Case 24-2486GC

FSS filed a Substantive Claim Challenge on **May 11, 2026**. The challenge argues that Memorial Hospital of Gardena (Provider Number 05-0468) failed to make an appropriate claim on their cost reports for the issue being appealed for FYEs 12/31/2019 and 12/31/2020. It claims that none of the audit adjustments cited by the Provider actually relate to rural floor wage index, or the Provider's rural classification. Additionally, while the Provider did include protested amounts on its cost reports, the accompanying Summary of Protested Items for each appeal did not list the Rural Floor Wage Index issue.[52]

iv. Case 25-0831GC

FSS filed a Substantive Claim Challenge on **May 12, 2026**. The challenge argues that none of the six (6) Providers in this group made an appropriate claim on their cost reports for the issue being appealed. It claims that none of the audit adjustments cited by the Providers actually relate to rural floor wage index, or the Providers' rural classification. Additionally, while the Providers did include protested amounts on their cost reports, the accompanying Summary of Protested Items for each appeal did not list the Rural Floor Wage Index issue.[53]

v. Case 25-4378GC

FSS filed a Substantive Claim Challenge on **May 14, 2026**. The challenge argues that Community Hospital of Huntington Park (Provider Number 05-0091) and East Los Angeles Doctors Hospital (Provider Number 05-0641) did not make an appropriate claim on their cost reports for the issue being appealed. It claims that none of the audit adjustments cited by the Providers actually relate to rural floor wage index, or the Providers' rural classification. Additionally, while the Providers did include protested amounts on their cost reports, the accompanying Summary of Protested Items for each appeal did not list the Rural Floor Wage Index issue.[54]

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[50] Case No. 24-1996GC, Medicare Administrative Contractor's Substantive Claim Challenge at 4-6 (May 13, 2026).
[51] Case No. 24-2249GC, Medicare Administrative Contractor's Substantive Claim Challenge at 4-7 (May 13, 2026).
[52] Case No. 24-2486GC, Medicare Administrative Contractor's Substantive Claim Challenge at 4-5 (May 11, 2026).
[53] Case No. 25-0831GC, Medicare Administrative Contractor's Substantive Claim Challenge at 4-8 (May 12, 2026).
[54] Case No. 25-4378GC, Medicare Administrative Contractor's Substantive Claim Challenge at 4-5 (May 14, 2026).

vi. Case 25-4688G

FSS filed a Substantive Claim Challenge on **May 8, 2026**. The challenge argues that six of the Providers in this group failed to make an appropriate claim on their cost reports for the issue being appealed:

- Oak Valley Hospital District (05-0067) (FYE 6/30/2022)
- Comanche County Memorial Hospital (37-0056) (FYE 6/30/2022)
- Duncan Regional Hospital, Inc. (37-0023) (FYE 6/30/2022)
- Northeastern Health System (37-0089) (FYE 6/30/2022)
- Valley Medical Center (50-0088) (FYE 6/30/2022)
- Tucson Medical Center (03-0006) (FYE 12/31/2022)

It claims that none of the audit adjustments cited by the Providers actually relate to rural floor wage index, or the Providers' rural classification. Additionally, while some Providers did include protested amounts on their cost reports, the accompanying Summary of Protested Items for each appeal did not list the Rural Floor Wage Index issue.[55]

vii. Case 25-5197GC

FSS filed a Substantive Claim Challenge on **May 15, 2026**. The challenge argues that neither of the two (2) Providers in this group made an appropriate claim on their cost reports for the issue being appealed. It claims that none of the audit adjustments cited by the Providers actually relate to rural floor wage index, or the Providers' rural classification. Additionally, while the Providers did include protested amounts on their cost reports, the accompanying Summary of Protested Items for each appeal did not list the Rural Floor Wage Index issue.[56]

viii. Case 25-4017GC

FSS filed a Substantive Claim Challenge on **May 14, 2026**. The challenge argues that neither of the two (2) Providers in this group made an appropriate claim on their cost reports for the issue being appealed. It claims that none of the audit adjustments cited by the Providers actually relate to rural floor wage index, or the Providers' rural classification. Additionally, neither Provider included any protested amounts on their cost reports.[57]

ix. Case 26-0086GC

FSS filed a Substantive Claim Challenge on **May 12, 2026**. The challenge argues that neither of the two (2) Providers in this group made an appropriate claim on their cost reports for the issue being appealed. It claims that none of the audit adjustments cited by the Providers actually relate

[55] Case No. 25-4688G, Medicare Administrative Contractor's Substantive Claim Challenge at 4-8 (May 8, 2026).
[56] Case No. 25-5197GC, Medicare Administrative Contractor's Substantive Claim Challenge at 4-5 (May 15, 2026).
[57] Case No. 25-4017GC, Medicare Administrative Contractor's Substantive Claim Challenge at 4-5 (May 14, 2026).

to rural floor wage index, or the Providers' rural classification. Additionally, neither Provider included any protested amounts on their cost reports.[58]

x. *Non-Challenged Participants*

For all remaining participants in these cases (collectively "the Non-Challenged Participants"), since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[59] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. 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.

xi. *Providers' Responses*

The Providers filed timely, materially identical responses to all the Substantive Claim Challenges outlined above. The Providers do not dispute that they failed to include an appropriate cost report claim for the issue under appeal. Instead, they argue that the regulations requiring an appropriate cost report claim are unlawful and unenforceable. They cite *Bethesda Hosp. Ass'n v. Bowen*[60] and *Banner Heart Hospital v. Burwell*[61] in support of their position that these regulations are unlawful.[62]

xii. *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))"[63] 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 Challenged Providers do not dispute that they failed to include an appropriate cost report claim for the Rural Floor Wage Index issue under appeal. Based upon the records before it, the Board specifically finds that they did not.

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[58] Case No. 26-0086GC, Medicare Administrative Contractor's Substantive Claim Challenge at 4-5 (May 12, 2026).
[59] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."
[60] 485 U.S. 399 (1988).
[61] 201 F.Supp.3d 131 (D.D.C. 2016)
[62] *E.g.*, Case 24-1996GC, Response to MAC's Substantive Claim Challenge at 1-3 (June 3, 2026).
[63] (Emphasis added.)

3. Analysis Regarding Appealed Issue

As set forth below, the Board finds that the Secretary's determination to (1) "calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103)"; and (2) "for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . . (as implemented at § 412.103) from the calculation of 'the wage index for rural areas in the State in which the county is located' referred to in section [1395ww](d)(8)(C)(iii). . . ."[64] was made through notice and comment in the form of an uncodified regulation.[65]

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

> After consideration of the public comments we received, for the reasons discussed in this final rule and in the proposed rule, we are finalizing without modification our proposal to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103). Additionally, we are finalizing without modification our proposal, for purposes of applying the provisions of section 1886(d)(8)(C)(iii) of the Act, to remove the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103) from the calculation of "the wage index for rural areas in the State in which the county is located" referred to in section 1886(d)(8)(C)(iii) of the Act.[66]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as the "Uncodified Regulations on Rural Floor Calculation and Wage Index." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation.[67]

As noted *supra*, CMS has continued the application of the FY 2020 IPPS Final Rule's policy in the FY 2021[68] and FY 2022[69] IPPS Final Rules. CMS has also adopted the FY 2020 IPPS Final

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[64] 84 Fed. Reg. 42044 at 42336.
[65] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals."
[66] 84 Fed. Reg. at 42336.
[67] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."
[68] 85 Fed. Reg. 58432, 58766 (Sept. 18, 2020).
[69] 86 Fed. Reg. 44774, 45175 (Aug. 12, 2021).

Rule's policy in its OPPS Final Rules for FYs 2020,[70] 2021,[71] and 2022. [72] The continued application of this policy means that, for FFYs 2020-2022, CMS will calculate the rural floor in a state without reference to the wage index that applies for any hospitals in that state which were reclassified as rural pursuant to Section 401 for both IPPS and OPPS. The Prospective Payment System for inpatient hospital capital costs is also calculated using the hospital wage index values applicable to the hospital under IPPS.[73]

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2020 IPPS Final Rule (and as continued for FYs 2021 and 2022) and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulations on Rural Floor Calculation and Wage Index which they allege (1) does not treat reclassified "Section 401" hospitals as being located in a rural are as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[74] As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in the nine (9) cases listed in **Appendix A**.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the Uncodified Regulations on Rural Floor Calculation and Wage Index Issue for the subject years in the nine (9) cases listed in **Appendix A** and that the Providers in the group appeals are entitled to a hearing before the Board;

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

3) The review process in 42 C.F.R. § 405.1873(a)-(b) has not been triggered for the remaining Non-Challenged Participants and, therefore, there are no findings regarding

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[70] 84 Fed. Reg. 61142, 61187-61188 (Nov. 12, 2019) (stating "as proposed, we are using the FY 2020 hospital IPPS post-reclassified wage index for urban and rural areas as the wage index under the OPPS to determine the wage adjustments for both the OPPS payment rate and the copayment standardized amount for CY 2020.").
[71] 85 Fed. Reg. 85866, 85916-17 (Dec. 29, 2020) (stating "We also are continuing to apply for the CY 2021 OPPS wage index any other adjustments for the FY 2021 IPPS post-reclassified wage index, including, but not limited to, the rural floor adjustment . . . .").
[72] 86 Fed. Reg. 63458, 63511 (Nov. 16, 2021) (stating "We are continuing to apply for the CY 2022 OPPS wage index any adjustments for the FY 2022 IPPS post-reclassified wage index, including, but not limited to, the rural floor adjustment . . . .").
[73] 42 C.F.R. 412.316(a) ("CMS adjusts for local cost variation based on the hospital wage index value that is applicable to the hospital under subpart D of this part.").
[74] *See* Consolidated Petition for Expedited Judicial Review at 1, 3-4.

whether their cost reports included appropriate claims for the specific item at issue in these appeals;

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

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

6) It is without the authority to decide the legal question of whether the codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2020 IPPS Final Rule (and carried forward not FFY 2021 and 20122) are valid.

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

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes the nine (9) Cases listed in **Appendix A** and removes them from its docket.

Board Members Participating:

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

FOR THE BOARD:

6/9/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Christine Goldesberry-Curry, CGS Administrators (J-15)
Danelle Decker, National Government Services, Inc. (J-K)
Scott Berends, Esq., Federal Specialized Services

Appendix A

PRRB Case Number	PRRB Case: Case Name
25-0831GC	*Cleveland Clinic Fdn. CY 2021 Rural Floor Wage Index CIRP Group*
24-2249GC	*Bon Secours Mercy Health CY 2020 Rural Floor Wage Index CIRP Group*
25-5197GC	*Emanate Health CY 2021 Rural Floor Wage Index CIRP Group*
25-4378GC	*Pipeline CY 2021 Rural Floor Wage Index CIRP Group*
24-2486GC	*Pipeline CYs 2019 & 2020 Rural Floor Wage Index CIRP Group*
24-1996GC	*Scripps Health CY 2019 CA Rural Floor Wage Index CIRP Group*
25-4688G	*Toyon Associates CY 2022 Rural Floor Wage Index Group*
26-0086GC	*Mohawk Valley CY 2021 Rural Floor Wage Index CIRP Group*
25-4017GC	*Mohawk Valley CY 2020 Rural Floor Wage Index CIRP 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

Mordechai Rosenbaum, Comptroller
AristaCare at Whiting
245 Birchwood Avenue
Cranford, NJ 07016

Re: ***Dismissal for Failure to Meet Minimum Filing Requirements***
PRRB Case No. 26-2449 ~ AristaCare at Whiting, Provider No. 31-5309, FFY 2026

Dear Mr. Rosenbaum:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced appeal request. After review of the facts outlined below, the Board has determined that the appeal request is fatally flawed as it was not filed in accordance with the regulations and Board Rules. The Board's review and determination are set forth below.

Pertinent Facts:

On **May 5, 2026**, AristaCare at Whiting ("AristaCare"/"Provider") filed an appeal with the Board to establish Case No. 26-2449. The appeal was filed from a determination entitled "Notice of Quality Reporting Program Non Compliance Decision Upheld" ("QRP Determination") dated November 17, 2025.

The Provider's appeal request did not, however, include:

- a sufficient letter of Representation; and
- a calculation of the reimbursement impact on the facility (Board Rule 6.4).[1]

On **May 6, 2026**, the Board issued an Acknowledgement and Critical Due Dates Notice in which it set a briefing schedule for the Parties to file preliminary position papers and requested a revised Representation Letter and Calculation Support.[2] The deadline for the required support documents was set for **May 21, 2026**.

On **May 26, 2026**, the Board issued a Final Request for Information ("RFI") and gave the Provider a final deadline of **June 5, 2026** to file the calculation support.[3]

[1] Board Rules Version 3.2 (Dec 15, 2023)
[2] The Representation letter filed with the appeal was found to be insufficient as it did not meet the requirements of Board Rule 5.4. Specifically, the letter did not include the Provider Number, fiscal or calendar year in dispute, nor did it include the phone number and email address for the contact person listed as the Representative.
[3] In the Final RFI, the Board opted not to include a request for a revised Representation letter. Although some of the required information was absent from the initial submission, it was accessible through the Office of Hearings Case & Document Management System ("OH CDMS").

To date, the Provider has not complied with either of the Board's Requests for Information.

Rules/Regulations:

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

42 C.F.R. § 405.1835 establishes the right to a Board hearing and the required contents for an appeal request. Specifically, 42 C.F.R. § 405.1835(a)(2) requires that "[t]he amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more."

Board Rules 5.4 and 6.4 further address individual appeal requirements related to Representative letters and Calculation Support.

Board Rule 6.1.1 indicates that the Board will dismiss appeal requests that do not meet the *minimum* filing requirements as identified in 42 C.F.R. § 405.1835(b).

Finally, Board Rule 4.4.2 discusses Due Dates for Filings. It indicates:

> All filings other than an appeal request or request to add issues . . . must be received by the Board not later than the date specified on the Board's notice or, if silent, the date specified in these Rules. If a party fails to file by the established due date, the Board may take action as described in 42 C.F.R. § 405.1868.

Board Determination:

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

Although the Provider listed an estimated reimbursement impact of $125,000 for the "2% Percentage Reduction" issue in OH CDMS, the calculation support uploaded to demonstrate the reimbursement impact is a copy of the Provider's appeal request which does **not** include a calculation or explanation of how the reimbursement impact was determined. As noted, the regulation at 42 C.F.R. § 405.1835(a)(2) and Board Rule 6.4 require an estimate of the reimbursement impact.[4]

The Board finds that the Provider was afforded two separate opportunities to cure the noted deficiency. The Provider has failed to respond to both the Board's May 6, 2026 and May 26, 2026 Requests. Accordingly, the Board hereby dismisses Case No. 26-2449 since the appeal

[4] Also see FAQ for Quality Reimbursement Appeals at https://www.cms.gov/files/document/faqs-quality-reporting-appeals.pdf. The provider ". . . must estimate the financial impact of the payment reduction and include a dollar amount in the Amount in Controversy data field. You must upload a copy of the calculation used to determine the amount in controversy, including an explanation of any factors used to calculate this estimate."

request is fatally flawed and does not meet the *minimum* filing requirements as outlined above and for failure to respond timely to the Board's RFIs. Based on the above, the Board closes this case and removes it from its docket.

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

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

For the Board:

6/11/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

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***
Lakeway Regional Hospital (Prov. No. 44-0067), FYE 12/28/2018
Case No. 23-0106

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0106. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Payment - Medicaid Eligible Days issue.

Background:

A. *Procedural History for Case No. 23-0106*

On **May 11, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 28, 2018.

On **October 20, 2022**, the Board received the Provider's individual appeal request. The Appeal Request was filed by the parent organization, Community Health Systems, Inc. (hereinafter "CHS") and included five (5) issues:

1. DSH Pymt /SSI % (Provider Specific)[1]
2. DSH Pymt /SSI % (Systemic Errors)[2]
3. DSH Pymt/Medicaid Eligible Days
4. Medicare Managed Care Part C Days – SSI & Medicaid Fraction[3]
5. Dual Eligible Days – SSI & Medicaid Fraction[4]

[1] On May 27, 2026, this issue was withdrawn.
[2] On May 30, 2023, the Provider transferred the issue to PRRB Case No. 21-1206GC
[3] On May 30, 2023, the Provider transferred the issue to PRRB Case No. 20-2149GC.
[4] On May 30, 2023, the Provider transferred the issue to PRRB Case No. 21-0066GC. Note: the Provider did not request Bifurcation of Issue 5-Dual Eligible Days- SSI and Medicaid Fractions as in similar cases.

On **October 21, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP").[5] This Notice also gave the following instructions to the Provider regarding the content of its PPP:

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

On May 30, 2022, CHS transferred the following issues to common issue related party ("CIRP") groups in accordance with the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1):

- SSI Percentage (Systemic Errors) to Case No. 21-1206GC:
- Medicare Managed Care Part C Days - SSI & Medicaid Fraction to Case No. 20-2149GC; and
- Dual Eligible Days - SSI & Medicaid Fraction to Case No. 21-0066GC.

On **June 14, 2023**, CHS filed the Provider's PPP.

On **August 25, 2023**, the MAC filed a Jurisdictional Challenge over the SSI Percentage (Provider Specific) and Medicaid Eligible Days issues.

On **September 1, 2023** CHS requested a change in representation to Quality Reimbursement Services, Inc. ("QRS").[7]

On **October 11, 2023**, the MAC filed its PPP.

On **November 24, 2023**, QRS filed a Redacted Medicaid Eligible Days listing as a "Supplement" to its PPP.

On **June 18, 2024**, QRS filed its response to the earlier challenge to jurisdiction.

On **March 27, 2026**, the Board issued a Notice of Hearing, scheduling the case for a hearing on **September 2, 2026**.

On **May 27, 2026**, QRS withdrew the SSI Provider Specific issue.

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[5] On March 21, 2023, the Board issued a Critical Due Dates Notice with updated deadlines.
[6] (Emphasis added.)
[7] The Board acknowledged the change in representation on September 5, 2023.

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

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

> **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.[8]
>
> Audit Adjustment Number(s): 14, 15, S-D
>
> Estimated Reimbursement Amount: $20,748

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[9] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[10]

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

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

[8] Issue Statement at 3 (Oct. 20, 2022).
[9] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[10] Provider's PPP at 9 (June 14, 2023).

Section 1115 Waiver Days

Finally, the MAC argues that the Provider is attempting to untimely and improperly add the Section 1115 Waiver days issue as a sub-issue via its PPP filed on June 14, 2023, which was well beyond the 240-day deadline to add an issue. Therefore, the MAC contends that the Section 1115 Waiver days, which is a separate issue from the Medicaid eligible days issue, should be dismissed on the grounds that it was untimely and improperly added to the case.

Provider's Jurisdictional Response: Issue 3- Medicaid Eligible Days

The Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."[11]

Although on June 18, 2024, the Provider filed a response to the Jurisdictional Challenge, it was submitted almost 9 months beyond the September 24, 2023 due date. Therefore, QRS' arguments will not be considered.

Board Analysis and Decision:

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

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

A. Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider's issue statement for Issue 3 is stated, *supra*. The Provider did not include a list of the specific additional Medicaid eligible days that are in dispute in this case in either the initial appeal or the PPP.

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

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

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

> underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

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

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[12]

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

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

Rule 25 - Preliminary Position Papers[13]

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

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

25.1 Content of Position Paper Narrative

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

25.1.1 The Provider's Position Paper

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

25.2 Position Paper Exhibits

25.2.1 General

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

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The October 21, 2022 Acknowledgement and Critical Due Dates notice issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

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

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[14]

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

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

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

[14] (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.

On June 14, 2023, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[15] Significantly, the PPP did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $20,748 based on an estimated 50 days). The Provider's complete briefing of this issue in its PPP is as follows:

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

[15] Provider's PPP at 10 (June 14, 2023).

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

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

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

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

In its August 25, 2023 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid Eligible days issue because the Provider was in violation of Board Rules 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its PPP. Moreover, the Provider neglected to include all supporting documentation (***i.e.***, furnish an unredacted, auditable list of additional Medicaid eligible days), or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with and 42 C.F.R. § 405.1853 and Board Rule 25.2.2. Thus, the MAC asserted that the Provider essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the Board Rules.[16] In addition, the MAC contends that the Provider attempted to untimely, and improperly, add the Section 1115 waiver days issue by including it in its PPP submission.

On November 24, 2023, QRS uploaded a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing" in the Office of Hearings Case and Document Management System ("OH CDMS"). The 1-page listing showed 22 "Additional ME Days." The Listing does not explain why it was being submitted more than ***5 months past the June 19, 2023 deadline for including it with the Provider's PPP***.

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

The Board rejects the Provider's attempts to include the eligible days listing uploaded to OH CDMS on November 24, 2023 (*purportedly, as a supplement to its PPP*) because:

1. The upload was filed ***5 months*** *after the deadline* for the exhibits to be included with the PPP filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)).

2. The uploaded exhibit fails to explain the following critical information: (a) *why* it was being filed so late (*i.e.*, upon what basis or authority should the Board accept the late filing); and (b) *why* the listing was not previously available, *in whole or in part* (*i.e.*, it is

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

not clear why the Provider failed to identify a single day at issue until more than a year after this appeal was filed and almost 5 years after the fiscal year at issue had closed).

3. Neither the Board Rules, nor the October 21, 2022 Case Acknowledgment and Critical Due Dates notice, permit the Provider to file a "Supplement" to its PPP (nor did the Provider allege in the upload that they do).

4. Given that the *material* facts (*e.g.*, the days at issue) and all available exhibits were required to be part of the PPP filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its PPP or a supplement of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the appeal request, nor the PPP, identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the uploaded listing cannot be considered a refinement of the position paper since no specific days or listing were included with the PPP.[17]

5. Finally, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[18] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the PPP filing (much less provide the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

B. Section 1115 Waiver Days

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

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

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

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

> including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[19]

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

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

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

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[20]

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

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

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

[19] 42 C.F.R. § 405.1835(b).
[20] (Bold and italic emphasis added).
[21] *See* 73 Fed. Reg. 30190 (May 23, 2008).

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

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

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid Eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.[22] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying Section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a Section 1115 Waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **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.**

[22] 65 FR 47054, 47087 (Aug. 1, 2000).

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

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

Regardless, even if the Provider had included in its appeal request (***which it did not***), the Provider failed to properly develop the issue in its PPP filing. Although the Provider's PPP *mentions* Section 1115 Waiver days, it does not identify the specific 1115 Waiver day program(s) at issue). In addition, the PPP does not discuss whether or not the Section 1115 Waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the final PP is perfunctory in that it only makes cursory conclusions.[23] Again, the Provider failed to so develop its PPP, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Nov. 2021).

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

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of

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

Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[24] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[25] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[26] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[27] Here, the Board makes the same finding based on similar *overly generalized language.*

* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible days (Issue No. 3) including Section 1115 Waiver days. As no issues remain, the Board hereby closes Case No. 23-0106 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:

6/11/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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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***
Case No. 23-0745 - Laredo Medical Center (Prov. No. 45-0029), FYE 09/30/2018

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0745. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Payment - Medicaid Eligible Days issue.

Background:

A. *Procedural History for Case No. 23-0745*

On **August 18, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2018.

On **February 1, 2023**, the Board received the Provider's individual appeal request. The Appeal Request was filed by the parent organization, Community Health Systems, Inc. (*hereinafter* "CHS") and included five (5) issues:

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

On **February 2, 2023**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

[1] On May 27, 2026, this issue was withdrawn.
[2] On May 30, 2023, the Provider transferred the issue to PRRB Case No. 21-1206GC
[3] On May 30, 2023, the Provider transferred the issue to PRRB Case No. 20-2149GC.
[4] On May 30, 2023, the Provider transferred the issue to PRRB Case No. 21-0066GC.

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

On **August 7, 2023**, CHS requested the transfer of issues 2, 4 and 5 to common issue related party ("CIRP") groups in accordance with 42 C.F.R. § 405.1837(b)(1).

On **September 14, 2023**, CHS requested a change in representation to Quality Reimbursement Services, Inc. ("QRS").[6]

On **September 25, 2023**, the Provider filed its PPP.

On **January 5, 2024,** the Medicare Contractor ("MAC") filed a jurisdictional challenge, requesting the dismissal of Issue Nos. 1 and 3.

On **January 16, 2024,** the MAC filed its PPP.

On **March 10, 2026**, the Board issued a Notice of Hearing, scheduling the case for a hearing on **September 3, 2026**.

On **May 27, 2026**, QRS withdrew the SSI Provider Specific issue.

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

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

> **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

[5] (Emphasis added.)
[6] The Board acknowledged the change in representation on September 15, 2023.

> 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.[7]
>
> Audit Adjustment Number(s): 5, 15, 34, 35, S-D
>
> Estimated Reimbursement Amount: $79,076

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]

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

> [M]edicaid eligible days (including section 1115 waiver days (where applicable), which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days where applicable).[10]

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

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

Section 1115 Waiver Days

Finally, the MAC argues that the Provider is attempting to untimely and improperly add the Section 1115 waiver days issue as a sub-issue via its PPP filed on September 25, 2023, which was well beyond the 240-day deadline to add an issue. Therefore, the MAC contends that the Section 1115

[7] Issue Statement at 3 (Feb. 1, 2023).
[8] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[9] Provider's PPP at 9-10 (Sept. 25, 2023).
[10] *Id.* at 9-10.

waiver days, which is a separate issue from the Medicaid eligible days issue, should be dismissed on the grounds that it was untimely and improperly added to the case.

Provider's Jurisdictional Response: Issue 3- Medicaid Eligible Days

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."[11] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed.

Board Analysis and Decision:

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

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

A. Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider's issue statement for Issue 3 is stated, *supra*. The Provider did not include a list of the specific additional Medicaid eligible days that are in dispute in this case in the initial appeal and included an incomplete listing with its PPP. However, QRS' filing did not explain why the listing was not final (i.e., why it was "pending finalization") when it was submitted almost 5 years after the fiscal year at issue had closed. Additionally, the Provider did not explain why the roughly 6,862 included in this belated listing is larger than the original estimate of 200 days included with the appeal request.

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

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

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

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

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[12]

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

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

Rule 25 - Preliminary Position Papers[13]

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

25.1 Content of Position Paper Narrative

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

25.1.1 The Provider's Position Paper

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.

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

B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

25.2 Position Paper Exhibits

25.2.1 General

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

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The February 2, 2023 Acknowledgement and Critical Due Dates notice issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

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

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[14]

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

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

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

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

- if it has 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.

On September 25, 2023, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the unredacted listing was being sent to the MAC under separate cover.[15] Although the Provider's PPP did include an exhibit with a 36-page listing of 6,862 days, the listing titled "1115 Waiver and Additional Medicaid Days Consolidated," was incomplete and included a caveat that said the "Listing was pending finalization upon receipt of State eligibility data."

[14] (Emphasis added.)
[15] Provider's PPP at 10 (September 25, 2023).

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

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).
>
> Based on the listing of Medicaid Eligible Days being sent under separate cover, including Section 1115 waiver days, the Provider

> contends that the total number of days reflected in its 2018 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.
>
> With respect to section 1115 waiver days, the courts have firmly rejected CMS's interpretation of its regulations, holding instead that the plain language of the statute and the regulations require inclusion in the Medicaid Fraction of the days belonging to individuals who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool. *See Forrest General Hospital*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43(D.D.C. 2018); *Bethesda Health Inc., v. Azar*, 389 F. Supp. 3d 32, (D.D.C. 2019), *aff'd*, 980 F.3d 121 (D.C. Cir. 2020). CMS has acquiesced in Bethesda and is now following the statute and the plain meaning of its own regulations (which regulations represent the official policy of CMS all along). *See* CMS Manual Instructions System, Change Request 12669, Transmittal No. 11912 (March 163, 2023) ("Transmittal 11912"), attached as Exhibit P-4.

In its January 5, 2024 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid Eligible days issue because the Provider was in violation of Board Rules 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its PPP. Moreover, the MAC contends that the Provider neglected to include all supporting documentation (***i.e.***, furnish an **unredacted, auditable list** of additional Medicaid eligible days), or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with and 42 C.F.R. § 405.1853 and Board Rule 25.2.2.[16] Thus, the MAC asserted that the Provider essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the Board Rules.[17]

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

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

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

finds that the Provider failed to fully develop the merits of the Medicaid eligible days issue because, although a listing was included with the PPP, the Provider failed to explain why the listing of 6.862 days was so much larger than the original estimate of 200 days included in the appeal request. Finally, the listing clearly had not been verified with the State (as denoted by the header "Listing pending finalization upon receipt of State eligibility data") and, as such, fails to meet the minimum threshold burden of proof under 42 C.F.R. § 412.106(b)(4)(iv). Thus, the Board finds that the Provider has abandoned the issue.

B. Section 1115 Waiver Days

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

The appeal was filed with the Board in February of 2023 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[18]

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

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

Board Rule 8 (Nov.2021) explains that when framing issues for adjustments involving multiple components, that providers must specifically identify each item in dispute, and "…each contested

[18] 42 C.F.R. § 405.1835(b).

component must be appealed as a separate issue and described as narrowly as possible…". The Rule goes on:

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[19]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[20]

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

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

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

In this regard, the Board notes that Section 1115 Waiver days are not traditional Medicaid Eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.[21] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying Section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a Section 1115 Waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

> (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.

[19] (Bold and italic emphasis added).
[20] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[21] 65 FR 47054, 47087 (Aug. 1, 2000).

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

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

Regardless, even if the Provider had included in its appeal request (***which it did not***), the Provider failed to properly develop the issue in its PPP filing. Although the Provider's PPP *mentions* Section 1115 Waiver days, it does not identify the specific 1115 Waiver days program(s) at issue). In addition, the PPP does not discuss whether or not the Section 1115 Waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under Section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the final PP is perfunctory in that it only makes cursory conclusions.[22] Again, the Provider failed to so develop its PPP, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 23 (Nov. 2021).

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

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

The Board's finding that neither the appeal request nor the PPP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[23] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[24] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[25] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[26] Here, the Board makes the same finding based on similar *overly generalized language.*

* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible days (Issue No. 3) including Section 1115 Waiver days. As no issues remain, the Board hereby closes Case No. 23-0745 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:

6/11/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal of Cleveland Clinic Indian River Memorial Hospital, Inc.***
(formerly Indian River Memorial Hospital, Inc.), Prov. No. 10-0105, FYE 09/30/2017
PRRB Case No. 22-0297

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-0297. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days issue.

Background

On **August 13, 2021**, the Medicare Contractor ("MAC") issued a Notice of Program Reimbursement ("NPR") for Indian River Memorial Hospital, Inc. ("Indian River") for its fiscal year end ("FYE") September 30, 2017.

On **October 20, 2021**, Quality Reimbursement Services, Inc. ("QRS") filed an appeal on behalf of Indian River which included two (2) issues:

1. DSH SSI Percentage (Systemic Errors)
2. DSH Medicaid Eligible Days

On **December 21, 2021**, the Board issued the Acknowledgement and Critical Due Dates ("ACDD") notice, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP"). This notice also gave the following instructions to the Provider regarding the content of its PPP:

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

made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[1]

On **August 17, 2022**, the Provider timely filed its PPP.

On **October 13, 2022**, the Medicare Contractor ("MAC") filed a jurisdictional challenge and substantive claim challenge.

On **November 18, 2022**, the MAC timely filed its PPP.

On **September 24, 2025**, the Board issued a Notice of Hearing scheduling the case for June 22, 2026.

On **January 28, 2026**, QRS withdrew the SSI Provider Specific issue.

On **March 24, 2026**, QRS filed its final PP and on **April 14, 2026**, the MAC filed its final PP.

MAC's Jurisdictional Challenge – Medicaid Eligible Days[2]

The MAC contends the Provider failed to file complete position papers in violation of Board Rule 25.3 and 27. Based on its failure to provide the necessary documentation (i.e., list of additional Medicaid Eligible days or any supporting documentation) the Provider has abandoned its claim for additional Medicaid Eligible days.

Provider's Jurisdictional Response

Board Rule 44.4.3 states "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." QRS did not file a timely response to the Jurisdictional Challenge for which the deadline expired on November 12, 2022 (30 days after the October 13, 2022 filing).

Decision of the Board

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

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

[1] (Emphasis added.)
[2] The MAC's jurisdictional challenge also objected to the SSI Provider Specific issue but since that issue was subsequently withdrawn, it will not be addressed.

A. DSH Payment – Medicaid Eligible Days

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

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

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

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

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

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

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

Rule 25 - Preliminary Position Papers[4]

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

COMMENTARY:

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

25.1 Content of Position Paper Narrative

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

25.1.1 The Provider's Position Paper

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

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the 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 December 21, 2021 ACDD notice issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 2, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[5]

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:

[5] (Emphasis added.)

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

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

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

On August 17, 2022, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[6] Significantly, the PPP did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $371,947 based on an estimated 536 days). The Provider's complete briefing of this issue in its PPP is as follows:

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

[6] Provider's PPP at 8 (Aug. 17, 2022).

> [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2017 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its October 13, 2022 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid eligible days issue because the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary and final position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Thus, the MAC asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the Board Rules.[7]

The Board notes that on March 24, 2026, QRS did include a redacted listing of "Additional In-state Medicaid Eligible Days" as an exhibit to its final PP. The 1-page listing shows a total of 84 additional days but does not explain why the listing was being submitted so late as it was ***more than 3.5 years past the deadline for including it with the Provider's PPP*** for which the deadline was August 17, 2022.

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

---

[7] *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.

The Board rejects the Provider's attempts to include the Medicaid Eligible Days listing as an Exhibit to its final PP on March 24, 2026 because:

1. The upload was filed more than ***3.5 years*** *after the deadline* for the exhibits to be included with the PPP filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)).

2. The uploaded exhibit fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); and (b) *why* the listing of the roughly 84 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 4 years after this appeal was filed and more than 8.5 years after the fiscal year at issue had closed).

3. Neither the Board Rules, nor the December 21, 2021 ACDD notice, permit the Provider to file a "Supplement" to its PPP (nor did the Provider allege in the Exhibit that they do).

4. Given that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the PPP filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its PPP or a supplement of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the appeal request, nor the PPP, identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the uploaded listing cannot be considered a refinement of the position paper since no specific days or listing were included with the PPP.[8]

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

* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible Days (Issue No. 2). As no issues remain, the Board hereby closes Case No. 22-0297 and removes it from the Board's docket.[10]

---

[8] *See, e.g.,* Board Rule 27.3 (Nov. 2021) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."
[9] (Emphasis added.)
[10] Although a substantive challenge was simultaneously filed with the jurisdictional challenge, it will not be addressed due to dismissal due to jurisdiction.

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:

6/11/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

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/c
Case No. 25-4597

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 25-4597. 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. 25-4597*

On **December 18, 2024**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2021.

On **June 2, 2025**, the Board received the Provider's individual appeal request. The initial appeal request included five (5) issues:

1. DSH – SSI Percentage (Provider Specific)[1]
2. DSH - Medicaid Eligible Days
3. Medicare Managed Care Part C Days – SSI & Medicaid Fractions[2]
4. Improper Rulemaking – SSI Dual Eligible Days[3]
5. Improper Rulemaking – Medicaid Fraction - Dual Eligible Days[4]

The Provider is commonly owned/controlled by Community Health Systems, Inc. ("CHS") and, therefore, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **December 8, 2025**, the Provider transferred Issues 3, 4 and 5 to various CHS CIRP groups.

[1] On January 27, 2026, this issue was withdrawn.
[2] On December 8, 2025, this issue was transferred to Case No. 24-1834GC.
[3] On December 8, 2025, this issue was transferred to Case No. 24-1835GC.
[4] On December 8, 2025, this issue was transferred to Case No. 24-1836GC.

On **June 3, 2025**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

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

On **January 27, 2026**, CHS withdrew the SSI Provider Specific issue (#1).

On **January 27, 2026**, CHS filed the Provider's PPP.

On **January 29, 2026,** CHS requested a change in representation to Quality Reimbursement Services, Inc. ("QRS"), which the Board acknowledged the following day.

On **January 30, 2026,** QRS filed a "Supplement to Position Paper/Redacted ME Days Listing."

On **March 19, 2026**, the Medicare Contractor ("MAC") filed a Request for an Auditable Medicaid Eligible Days listing.

On **April 29, 2026**, the MAC filed its PPP.

On **May 11, 2026**, the MAC filed a jurisdictional challenge over the Medicaid Eligible Days issue.

MAC's Contentions- Issue #2 - DSH – Medicaid Eligible Days

The MAC contends the Provider failed to properly develop its argument within its PPP in accordance with Board Rule 25. The MAC maintains the Provider failed to submit an **unredacted auditable** listing of additional Medicaid eligible days or any other supporting documents or explanation for why it cannot produce those documents.

Section 1115 Waiver Days

Additionally, the MAC contends the Provider is attempting to untimely add the Section 1115 Waiver days issue as a sub-issue via its PPP filed on January 27, 2026.[6] The Provider originally

[5] (Emphasis added.)
[6] MAC's Jurisdictional Challenge at 7.

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.

The appeal request did not identify or mention the Section 1115 Waiver days issue. It was not until the PPP was filed that the Provider raised the issue –(*which was 205 days 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.[7]

Provider's Jurisdictional Response

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."[8] The Representative did not file a responsive brief by the June 10, 2026 deadline.

Decision of the Board

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

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

A. DSH Payment – Medicaid Eligible Days

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

With regard to the filing of an individual appeal, Board Rule 7 - Support for Appealed Final Determination, Availability of Issue-Related Information and Basis for Dissatisfaction (Dec. 2023) states:

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

[7] MAC's Jurisdictional Challenge at 9.
[8] Board Rule 44.4.3, v. 3.2 (Dec. 2023).

> 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.[9]

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

Board Rule 25 (Dec. 2023) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

Rule 25 - Preliminary Position Papers[10]

> **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.

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

25.1 Content of Position Paper Narrative

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

25.1.1 The Provider's Position Paper

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

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

> **25.3 Filing Requirements to the Board**
>
> Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.
>
> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The June 3, 2025 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 2, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[11]

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.

[11] (Emphasis added.)

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 January 27, 2026, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[12] Significantly, the PPP did ***not*** include *the material fact* of how many Medicaid Eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $94,534 based on an estimated 216 days). The Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> 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

[12] Provider's PPP at 9.

> eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2021 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.
>
> With respect to section 1115 waiver days, the courts have firmly rejected CMS's interpretation of its regulations, holding instead that the plain language of the statute and the regulations require inclusion in the Medicaid Fraction of the days belonging to individuals who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool. *See Forrest General Hospital*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43(D.D.C. 2018); *Bethesda Health Inc., v. Azar*, 389 F. Supp. 3d 32, (D.D.C. 2019), *aff'd*, 980 F.3d 121 (D.C. Cir. 2020). CMS has acquiesced in *Bethesda* and is now following the statute and the plain meaning of its own regulations (which regulations represent the official policy of CMS all along) 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.

In its May 11, 2026 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid Eligible days issue because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish an unredacted, auditable list of additional Medicaid eligible days

with its PPP in violation of Board Rules 25.3 and 25.2.2. Thus, the MAC asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the Board Rules.[13]

In addition, the MAC argued the Provider was attempting to untimely and improperly add the Section 1115 waiver days issue by including it in its PPP submission.[14]

Although QRS filed a "Supplement to Position Paper/Redacted ME Days listing" on January 30, 2026 (two days after the PPP deadline), the 20-page exhibit, showing 2,767 Additional Medicaid Eligible days, included the caveat that the "Listing [is] pending finalization upon receipt of State eligibility data." The listing does not explain why so many days (2,767) were being submitted at this late date or why it was not final (*i.e.*, why it was "pending finalization"), even though it was being filed ***almost 5 years after the fiscal year at issue had closed***. In addition, the 2,767 days included in the belated listing is *significantly* larger than the original estimate of 216 days included with the appeal request. Regardless, the filing ***was submitted past the deadline for including it with the Provider's PPP*** for which the deadline was January 28, 2026.

The Board concurs with the MAC- that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(4)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid Eligible days issue because the provider 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 a Supplement to its January 27, 2026 PPP because:

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

2. The Supplement failed to explain the following critical information: (a) *why* it was being filed late (*i.e.*, upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the roughly 2,767 days was not previously available, *in whole or in part* (*i.e.*, it is not clear why the Provider failed to identify a single day at issue until nearly 8

[13] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.
[14] MAC Jurisdictional Challenge at 7.

months after this appeal was filed and almost 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 June 3, 2025 Case Acknowledgment and Critical Due Dates notice permit the Provider to file a "Supplement" to its PPP (nor did the Provider allege that they do).

4. Given that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the PPP, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its PPP or a supplement of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the PPP, nor the subsequent listing uploaded by QRS, identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the "Supplement" uploaded by QRS cannot be considered a refinement of the PPP since no specific days or listing were included with the PPP (indeed the *tentative* 2,767 days listed in the late Supplement are, without explanation, *significantly* larger than the original estimated 216 days included with the appeal request).[15]

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

B. 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 Section 1115 Waiver days.

The appeal was filed with the Board in June of 2025 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…

[15] *See, e.g.,* Board Rule 27.3 (Dec. 2023) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."
[16] (Emphasis added.)

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

Board Rule 7.2.1 (2023) 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 relevand adjustment(s), including the adjustment number(s),
> - the controlling authority,
> - why the adjustment(s) is incorrect,
> - how the payment should be determined differently,
> - the reimbursement effect, and
> - the basis for jurisdiction before the Board.

Board Rule 8 (2023) 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). . .***[18]

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

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

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[17] 42 C.F.R. § 405.1835(b).
[18] (Bold and italic emphasis added).
[19] *See* 73 Fed. Reg. 30190 (May 23, 2008).

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

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

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

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

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

[20] 65 FR 47054, 47087 (Aug. 1, 2000).

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

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

Regardless, even if the Provider had included in its appeal request (which it did not), the Provider failed to properly develop the issue in its PPP filing. The Provider's PPP does not 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 (Dec. 2023). 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. Rather, the PPP is perfunctory in that it only makes cursory conclusions.[21] Again, the Provider failed to so develop its PPP notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Dec. 2023).

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

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

how the fraction should have been calculated differently."[24] 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.[25] 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 2). As no issues remain, the Board hereby closes Case No. 25-4597 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:

6/12/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Cecile Huggins, Palmetto GBA (J-J)
Wilson Leong, FSS

[24] *Id.*
[25] *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

Heidi Forrence, Administrator
Bedford Hills Center
30 Colby Court
Bedford, NH 03110

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

Bedford Hills Center, Provider No. 30-5060, FYE 12/31/2026, Case No. 26-2479

Dear Ms. Forrence:

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

Pertinent Facts:

On **May 11, 2026**, Bedford Hills Center ("Bedford Hills"/the "Provider") filed an appeal with the Board to establish Case No. 26-2479. The appeal was filed from a determination entitled "Notice of Quality Reporting Program Noncompliance Decision Upheld" ("QRP Determination") dated November 17, 2025.

Bedford Hill's appeal request did not, however, include:

- A valid Letter of Representation (Board Rule 5.4); and
- A comprehensive Issue Statement (42 C.F.R. § 405.1835(b) and Board Rules 6, 7 & 8).[1]

On **May 12, 2026**, the Board issued an Acknowledgement and Critical Due Dates ("ACDD") Notice in which it set a briefing schedule for the Parties to file preliminary position papers and requested the following corrected documentation: Representation Letter and Issue Statement. The deadline for the corrected support required for the appeal was set for **May 27, 2026**.

On **May 28, 2026**, after the Provider did not file a response, the Board issued a Request for Information ("RFI") giving the Provider one final opportunity to correct its submissions. The final deadline for the corrected documentation was set for **June 8, 2026**.

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

Rules/Regulations:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied

[1] Board Rules Version 3.2 (Dec 15, 2023)

with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

42 C.F.R. § 405.1835 establishes the right to a Board hearing and the required contents for an appeal request. Specifically, Board Rules 5.4 and 6 through 8 address individual appeal requirements related to Representative letters and Issue Support. Finally, Board Rule 6.1.1 indicates that the Board will dismiss appeal requests that do not meet the *minimum* filing requirements as identified in 42 C.F.R. § 405.1835(b).

Board Determination:

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

First, although the Provider's appeal request included a one sentence statement that there was "[n]o representation for this case," the Board twice advised the Provider, that even if it was self-representing, a Representation letter was required. Pursuant to Board Rule 5.4, the Representation letter, must be on company letterhead and must be signed and dated by an owner/officer of the Provider. The letter must reflect the provider's name, number, and fiscal year under appeal, as well as the contact information (***i.e.***, name, address, phone number and email address) for the person handling the appeal.

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

> For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final contractor or Secretary determination under appeal, including an account of all of the following:
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
>
> (iii) If the provider self-disallows a specific item (as specified in § 413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.[2]

The Issue Statement included in the subject appeal was a copy of the Provider's original request for reconsideration of the noncompliance determination that resulted in the 2% reduction to its FY 2026 annual payment. Although the upload includes various enclosures, the letter does not go into any detail to

[2] 42 C.F.R. § 405.1837(b)(2)

explain why the Medicare payment is incorrect, why it must be determined differently or the basis for jurisdiction before the Board.

Finally, the Board finds that the Provider was afforded two separate opportunities to cure the noted deficiencies. The Provider has failed to respond to both the Board's May 12, 2026 and May 28, 2026 Requests. Accordingly, the Board hereby dismisses Case No. 26-2479 since the appeal request is fatally flawed and does not meet the *minimum* filing requirements as outlined above and for failure to timely respond to the Board's Requests for Information. Based on the above, the Board closes this case and removes it from its docket.

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

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

For the Board:

6/15/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Mr. Johnny Toney
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P.O. Box 6474 Mailstop INA101-AF-42
Indianapolis, IN 46206-6474

RE: Determination re: Filing Requirements
Stonewood Hospice (A91663)
Appealed Period: FFY 2024
PRRB Case No.: 26-2524

Dear Mr. Toney and Ms. Johnson:

The above-captioned appeal was filed with the Provider Reimbursement Review Board ("Board") via the Office of Hearings Case and Document Management System ("OH CDMS"). After review of the facts outlined below, the Board has determined that the appeal request was not filed in accordance with the Board Rules and regulations. The Board's review and determination is set forth below.

BACKGROUND:

On May 15, 2026, the Provider filed a Quality Reporting Program appeal disputing the 4% payment reduction. The Provider entered the final determination date as July 30, 2025 but indicated in OH CDMS, on the Actual Date Determination Received field, that the final determination was not received until October 7, 2025. As a result, OH CDMS marked the appeal as being filed untimely as it calculated that the appeal was filed 289 days past the entered final determination date of July 30, 2025.

The Board's rules allow the providers 185 days (180 days plus a 5-day mailing presumption) to file an appeal. The Provider entered a final determination date of July 30, 2025; 185 days from July 30, 2025 was January 31, 2026. The Provider indicated that it did not receive the final determination until October 7, 2025; 185 days from October 7, 2025 was April 10, 2026. The Board notes that the subject appeal was filed on May 15, 2026 which occurred later than the allowable 185-day timeframe to file an appeal. Based on the filing date July 30, 2025, the appeal was filed 289 days from that date. Based on the filing date of October 7, 2025, the appeal was filed 220 days from that date.

The Medicare Contractor's ("MAC") notice, dated July 30, 2025, regarding the 4% reduction states, "If you believe you have been in compliance with the quality data reporting requirement and have been identified for this payment reduction in error ***vou must submit an email requesting reconsideration*** and provide documentation demonstrating your compliance." The last paragraph of the MAC's notice further advises, "***A hospice must submit a request for reconsideration and receive a decision on that request before they can file an appeal with the Provider Reimbursement Review Board (PRRB).***" (Emphasis added.)

The Board notes that as proof of receipt that it received the MAC's July 30, 2025 notice on October 7, 2025, the Provider uploaded a copy of an email from CMS advising that the Provider's request for assistance had been resolved.

The Board further notes that the document filed as the final determination is the MAC's *preliminary* notice advising that if the Provider disagrees, it must submit a request for reconsideration. The Board cannot locate any supporting documentation in the filed case record indicating that the Provider had requested a reconsideration and had received a decision on that reconsideration request.

Lastly, the Board notes that the Provider failed to submit a sufficient Issue Statement as defined in the Board's Rules. The Provider uploaded another copy of the MAC's July 30, 2025 notice as its Issue Statement.

RULES/REGULATIONS:

Rule 1.1: Authority The Provider Reimbursement Review Board Rules will be referred to as "Rules." These Rules govern proceedings before the Provider Reimbursement Review Board ("PRRB" or "Board") and they are consistent with § 1878 of the Social Security Act (codified at 42 U.S.C. § 1395oo) and 42 C.F.R. §§ 405.1801 – 405.1889. The Board has discretion to take action as outlined in 42 C.F.R. § 405.1868 if a party fails to comply with these Rules or fails to comply with a Board Order or Instruction. While these Rules cite regulatory cross-references as a guide, the omission of a cross-reference does not excuse the parties from meeting all controlling statutory and regulatory requirements.

Rule 4.1: General Requirements See 42 C.F.R. §§ 405.1835 - 405.1840. **The Board will dismiss appeals that fail to meet the *timely filing requirements* and/or jurisdictional requirements.** A jurisdictional challenge (see Rule 44.4) may be raised at any time during the appeal; however, for judicial economy, the Board strongly encourages filing any challenges as soon as possible. The Board may review jurisdiction on its own motion at any time. The parties cannot waive jurisdictional requirements.

Rule 4.3: Contractor/CMS/Secretary Final Determination Final determinations include:

- Notices of Program Reimbursement;
- Revised Notices of Program Reimbursement;
- Exception Determinations;
- Quality Reporting Program Payment Reduction Determinations; and

- Other determinations issued by CMS or its contractors with regard to the amount of total reimbursement due the provider.

The date of receipt of a contractor/CMS/Secretary final determination is presumed to be five (5) days after the date of issuance. This presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date. See 42 C.F.R. § 405.1801(a)(1)(iii). The appeal period begins on the date of receipt of the contractor final determination as defined above and ends 180 days from that date.

Rule 4.5: Date of Receipt by the Board

The timeliness of a filing is determined based on the date of receipt by the Board. The date of receipt is presumed to be: A. The date of filing in OH CDMS as evidenced by the Confirmation of Correspondence generated by the system; or B. If the filing is permitted pursuant to an exemption under Rule 2.1.2, the date of receipt is:

- The date of delivery to the Board as evidenced by the courier's tracking bill for documents transmitted by a nationally recognized next-day courier. It is the responsibility of the provider to maintain a record of the delivery. See 42 C.F.R. § 405.1801(a)(2)(i).

- The date stamped "received" by the Board on documents submitted by regular mail, hand delivery, or couriers not recognized as a national next-day courier. This provision also applies if the party is unable to supply the next-day courier's tracking bill as noted above. See 42 C.F.R. § 405.1801(a)(2)(ii).

Rule 7.1.2.4: Quality Reporting Payment Reduction Decision

Identify the type of quality reporting payment program. Also provide the original decision from CMS in which the payment reduction was identified (preliminary decision) and the final reconsideration decision on which the appeal is based.

7.2 Issue-Related Information

Rule 7.2.1: General Information

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:

  o the relevant adjustment(s), including the adjustment number(s),
  o the controlling authority (e.g., specific regulation, Federal Register issuance, manual provision, or Ruling),
  o why the adjustment(s) is incorrect,
  o how the payment should be determined differently,
  o the reimbursement effect, and

o the basis for jurisdiction before the Board

• A copy of the applicable audit adjustment report page(s) or a statement addressing why an adjustment report is not applicable or available.

• A calculation or other support for the reimbursement effect noted in the issue statement.

• Support for protested items or claim of dissatisfaction as noted in Rules 7.3 and 7.4 before the Board.

BOARD DETERMINATION:

Based on the documentation filed, the Board has determined that the appeal was not filed in accordance with the Board Rules and the cited regulations noted above. Both dates the Provider provided as final determination dates, July 30, 2025 and October 7, 2025, are beyond the 185-day allowable timeframe to file an appeal.

In addition, the Provider failed to file a sufficient Issue Statement outlining exactly what it was disputing and the justification for Board review. And, lastly, the document used as the final determination is a preliminary notice; the Provider has not provided documentation that it requested a reconsideration of the MAC's notice and that it received a final decision regarding a reconsideration request.

The Board has determined that the Provider failed to meet the minimum filing requirements as set forth in 42 C.F.R. §§ 405.1835 - 405.1840 and the Board Rules cited above. As a result, the Board hereby dismisses case number 26-2524, in its entirety, and removes it from its docket.

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

Board Members:

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

FOR THE BOARD:

6/16/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Blvd.
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Via Electronic Delivery

Michael Newell
Southwest Consulting Associates
2805 North Dallas Parkway, Suite 620
Plano, TX 75093-8724

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

Case Number: 25-0575GC - Baystate Health CY 2010 Medicare Part C CIRP Group
Case Number: 25-2898GC - Carilion Clinic CY 2010 DSH Medicare Part C Days CIRP Group

Dear Mr. Newell:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed on **May 29, 2026** in the above-referenced group appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Board received requests to establish two optional groups on **November 3, 2024** and **February 17, 2025**. Both groups contain providers appealing from original and/or revised Notices of Program Reimbursement ("NPRs" and/or "RNPRs") which implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Providers' Fiscal Years Ended ("FYEs") in 2010.

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

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] *E.g.*, Case No. 25-0575GC, Statement of Group Issue at 1 (Nov. 3, 2024).
[3] *Id.* at 2.

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[4] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

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

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

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

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[13]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[14]

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

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

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

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

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

> included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

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

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

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

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[16] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[17] *Id.*
[18] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[19] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[20] *Id.*
[21] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[22] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[23] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[24]

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

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

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

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

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

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

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

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

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

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[40]

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

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

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

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[39] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[40] CMS Ruling 1739-R at 1-2.
[41] 88 Fed. Reg. 37772 (June 9, 2023).
[42] 88 Fed. Reg. at 37788 (emphasis in original).

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

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

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

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

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

> notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[46]

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

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

Providers' Position:

A. Providers' Appeal Requests

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

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

The Providers characterized the relevant background facts as follows:

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

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[46] *Id.* (emphasis added).
[47] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).
[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.
[51] *E.g.*, Case No. 25-0575GC, Appeal Request, Statement of Jurisdiction at 1 (citations omitted).
[52] *E.g.*, Case No. 25-0575GC, Appeal Request, Statement of Group Issue at 1.
[53] *Id.*

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

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

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

Based on the above, the Providers maintain that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule "is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[55]

B. Providers' Petitions for EJR

The Providers have requested EJR over the "post-*Allina* retroactive Part C policy issue" because they believe they have met the requirements for a hearing before the Board, but the Board lacks the authority to decide the substantive and procedural validity of CMS' final rule published in the Federal Register on June 9, 2023.[56] They seek a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.[57] The request states again that "[t]he Providers contend that the new, post-*Allina* retroactive part C days rule, applied in the [NPRs and/or RNPRs] appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[58] Since the Board is bound by this regulation,[59] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

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[54] *E.g.*, Case No. 25-0575GC, Appeal Request, Statement of Issue at 1 (citing to 139 S. Ct. at 1816).
[55] *Id.* (citing 4 U.S.C. § 706(2)).
[56] *E.g.*, Case No. 25-0575GC, Providers' Petition for Expedited Judicial Review at 13 (May 29, 2026).
[57] *Id.* at 16.
[58] *Id.* at 1-2.
[59] 42 C.F.R. § 405.1867.

The Medicare Contractor's representative, Federal Specialized Services, filed timely responses to the Requests for EJR in both cases simply advising that it "will not file a jurisdictional challenge . . . . will not file a substantive claim challenge."[60]

Decision of the Board:

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

A. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [61]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[62]

For these two (2) groups, the providers all appealed from original and/or revised NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. All the providers were directly added to their respective groups within 180 days of the issuance of their NPRs and/or RNPRs. Finally, the amount in controversy exceeds $50,000 in both cases.

The Board finds that the Providers in Cases 25-0575GC and 25-2898GC have all filed timely appeals from their original and/or revised NPRs concerning the same common issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these NPRs and/or RNPRs. The Board also finds that the amount in controversy in each case exceeds $50,000 as required by 42 C.F.R. § 405.1837(a)(3). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

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[60] *E.g.*, Case No. 25-0575GC, Response to Provider's Request for Expedited Judicial Review at 1 (June 5, 2026).
[61] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[62] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in Case Nos. 25-0575GC and 25-2898GC and that the Providers in both group appeals are entitled to a hearing before the Board;

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

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

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

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

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes Case Nos. 25-0575GC and 25-2898GC and removes them from its docket.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Shakeba DuBose, Esq.

FOR THE BOARD:

6/23/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

cc: Dana Johnson, Palmetto GBA c/o National Government Services, Inc.(J-M)
Byron Lamprecht, WPS Government Health Administrators (J-5)
Scott Berends, Federal Specialized Services